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ANNUAL MEETING: A PREVIEW

OUR TOP TEN IN SAN DIEGO

Eileen E. Reynolds, MD, and Carol M. Mangione, MD

It's hard to believe that the 2001 Annual Meeting in San Diego is right around the corner. Our committee of over 200 members has worked hard to create an outstanding meeting, and we want to take this opportunity to share with you some of the most exciting plans.

At this point, the workshops, precourses, interest groups, and scientific abstracts have been submitted, reviewed, ranked, and accepted. There have been a record number of submissions this year, and we anticipate outstanding contributions in research, clinical medicine, and teaching. It's hard to choose what to mention from so many great sessions, but here are a few of the highlights we anticipate:

1. **The theme:** Addressing Disparities in Health: Roles for General Internists. One of the country's primary public health goals is addressing and eliminating health disparities. Our membership has reacted enthusiastically to this theme, and there will be a strong "disparities" presence at the meeting, from speakers to abstracts, precourses, and workshops. This is a field in which SGIMers continue to lead the nation, and we hope that this year's meeting will provide an opportunity to learn more about this important topic.
2. **Dr. David Satcher**, Surgeon General. Dr. Satcher, who has prioritized addressing disparities in *Healthy People 2010*, will address us during the theme plenary session. There will be ample time for questions and discussion. This

session will be moderated by Nicole Lurie, MD, and will include the four best abstracts submitted in the "Disparities in Health" category.

3. **Special symposium on Drugs, Doctors, and Conflict of Interest.** As financial pressures in academic medical centers intensify, more members face critical decisions about whether to conduct research collaboratively with pharmaceutical companies and what the role of these companies should be in supporting the education of doctors and patients. In a special discussion designed to highlight the current debate for general internists, Tom Delbanco, MD, will moderate a panel that will include George Lundberg, MD, Jeffrey Drazen, MD, David Blumenthal, MD, and Seth Landefeld, MD. We believe that this topic is timely and very important, and we expect some lively and spirited discussion from this panel!
4. **Speak up.** Talk with the Council at a special meeting about the recent decision to begin an Anticoagulation-Thromboembolism Research Consortium with funds from AstraZeneca.
5. **New recommendations from the U.S. Preventive Services Task Force.** Task Force members will be presenting five new recommendations at the meeting.
6. **Peterson Lecturer, Reed V. Tuckson, MD.** Dr. Tuckson is a gifted speaker.

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In Favor of Pharmaceutical Funding for the ATRC

John C. Peirce, MD

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I have been involved substantially with the debate regarding the formation of the Anticoagulation-Thromboembolism Research Consortium (ATRC) since last July, when I became Chair of the Development Committee. I have considerable sympathy for those who have deeply held beliefs that SGIM should not take money from investor-owned companies who will profit from our activities. And, in this situation, I think they are wrong. Clearly, those of us in health care who stand to gain in profit, power, and prestige from our activities run the risk of placing these benefits above those of the people we serve. This is an age-old struggle that, using a religious metaphor, is referred to as the struggle between God and Mammon. There is considerable evidence that pharmaceutical firms have placed their profits, power, and prestige above the good of the people they serve, and that they have co-opted physicians into activities that are ethically questionable. This is a substantial concern, and I am pleased that there are SGIM members like Seth Landefeld who have expressed vigorous concern about what is happening.

So why do I believe they are wrong? First, I see this problem as one not isolated to the pharmaceutical industry, but one that is much more systemic. Hospitals are so preoccupied with their “bottom lines” that they have stopped providing community services that are unprofitable. Universities rank themselves according to the dollars they receive from external sources, and they expect their faculty to generate endowment funds. The majority of physicians in the United States are for-profit corporate entities, and a not insignificant few are engaged in practices that are ethically questionable. Specialists with annual incomes in the upper quarter of all physicians hold health

care systems hostage for more revenues. Orthopedic surgeons boycott hospitals with trauma services unless they are subsidized. Ophthalmologists, who practice in their own facilities, refuse to provide 24-hour-a-day, seven-day-a-week coverage for emergency eye problems because it interferes with their lifestyle. Radiologists move to situations where 24/7 coverage is not part of practice requirements. I am concerned that focusing only on the pharmaceutical industry without addressing the more systemic issues leaves us looking self-righteous by making them our sacrificial scapegoat. I would love to have SGIM address health care’s general preoccupation with profits, power, and prestige, and how it has become toxic to the care of those who need our services, but this needs to be done on a broader scale.

Second, the proposed ban on pharmaceutical funding suggests a policy of intentional estrangement. As a physician who has been attracted to the Society for its concern about the importance of relationships, this proposal runs contrary to what I see as one of the Society’s core values. I certainly have supported civil action taken in the past, such as that in the civil rights movement, but I also am reminded that the Reverend Dr. King only undertook civil disobedience when he felt that all other means of peaceful pressure and negotiation had been exhausted.

Finally, the major compelling case for questioning the wisdom of proceeding with the ATRC is whether the Society has the wherewithal to manage such an enterprise. Very legitimate concerns have been raised in this regard. This is an area in which we have limited historical experience, so arguments for or against are largely

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WE CAN BECOME MORE THAN OURSELVES

Sankey V. Williams, MD

Although I've been home from Japan several days now, my biological clock still doesn't match the local time because of the long flight home and the 14-hour difference in time.

I went to Japan for the ninth annual meeting of the Japanese Society of General Medicine, which was held at the National Tokyo Medical Center. While there, I learned something about general medicine in Japan. The first hospital program was started in 1976 to teach residents primary care, and the first university program was started in 1981. Now, about half of the government-run medical schools have programs.

The Japanese Society of General Medicine (JSGM) was founded in 1993 by a few people who wanted to give each other mutual support and to attract new people to the discipline. It has about 600 members today. A journal was started in 1996, and in 1999 its name was changed to *General Medicine*. It is being published in English for the first time this year.

The similarities between JSGM and SGIM are striking. Our society may be a few years older and thus further along, but it seems to me that we're both traveling the same path. One of the reasons I went to Japan was to help members of JSGM learn from SGIM's longer experience.

While there are similarities between JSGM and SGIM, there are big differences in health between the two countries. By any measure, Japan is doing much better than we are. People in Japan have the longest life expectancy in the world and the fifth lowest infant mortality rate, while we rank in the bottom half of developed countries on both measures. To achieve this high level of health, the Japanese pay about half what we pay per person for medical

care. No one really knows all the reasons why the people of Japan are so healthy, but they have universal access to medical care and they have invested much more heavily in outpatient care than we have. One result is that they have the highest rate of physician visits and the lowest rate of hospital admissions among industrialized nations and about one third as much surgery as in the United States. It's clear to me that we should be learning from their experience as well as sharing with them what we know.



The tourist in me also found curious differences in things other than health care. I was expecting better sushi in Japan, but I didn't expect to enjoy a simple lunch of vegetable broth and tofu so much. The ancient scraps of cloth in the Tokyo National Museum suggest how much

more important clothing design is to Japanese culture than to our culture. Watching the countryside from the window of the train to Kyoto, I was impressed with how intensively the land is used. Many a suburban house had a small rice field where I was used to seeing a lawn. The lavender color of the earthmoving machines used for road

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SGIM FORUM

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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>

2001 ANNUAL MEETING: A PREVIEW

Annual Meeting Offers Activities for Students, Residents, and Fellows

Carol Storey-Johnson, MD, and Allison L. Diamant, MD

If we were to list the top 10 reasons to attend the 2001 Annual Meeting, one of them would certainly be the location. San Diego, California, will provide a wonderful backdrop to the very important focus of the meeting: “Addressing Disparities in Health: Roles for General Internists.” The Annual Meeting will provide an exciting opportunity for medical students, residents, and fellows to interact with leaders in the field of general internal medicine, to meet peers from other institutions, and to learn about cutting-edge research. In addition, several activities have been planned to inform students, residents, and fellows about careers in general internal medicine and to enrich their learning at the Annual Meeting.

The first of these activities is the Students, Residents, and Fellows and/or First-Time Attendees Reception, Thursday, May 3, 6:30-7:30 PM. The reception will provide an opportunity for students, residents, and fellows to find out about sessions of special interest to them and to network with people who have similar interests. The location of the reception will be announced in the final program that will be mailed out a few weeks prior to the meeting. We encourage all students, residents, and fellows to attend the reception, whether or not this is their first annual meeting.

A second exciting activity available to students, residents, and fellows is the One-on-One Mentoring Program, which will provide an opportunity for students, residents, and fellows and junior faculty to sit down and talk with a senior SGIM mentor. Mentors and mentees will be matched based upon mutual interests and expectations. The mentor-mentee pair will meet in person during the Annual Meeting and may decide to continue the relationship

beyond that time. Students, residents, and fellows interested in participating are strongly encouraged to complete the sign-up form included in the registration materials.

SGIM actively seeks diversity in career stage, academic interest, race/ethnicity, cultural background, religion, gender, age, and sexual preference at all levels of the organization. To assist students, residents, and fellows and other members in expanding their participation in SGIM, a workshop has been developed that will demystify and accelerate the process by which members can become involved in SGIM

activities. This workshop, SGIM 101, will be held Friday, May 4, 3:30-5:00 PM. The location will be announced in the final program.

To encourage student participation in the 24th Annual Meeting, scholarship support is available for a limited number of medical students. The registration fee for the meeting will be waived for the first 25 medical students who register. Please see the registration materials for full details of this program. We hope that students will use all available scholarships to attend what will be a very exciting meeting. See you in San Diego! **SGIM**

Workshop and Interest Group to Examine Medical Care During Pregnancy

Jeffrey Pickard, MD

I just finished my morning clinic and I am excited because I've just seen a patient with a medical problem I rarely get to see until it is too late. What makes this even more unusual is that this woman is a recent immigrant from Mexico and knows little, if anything, about our health care system. Yet she had the foresight to come in for consultation now before it is too late. She speaks only Spanish and, unfortunately, I speak none. Nevertheless, with the help of a translator, we were able to start to address her concerns. She has a seizure disorder for which she takes phenytoin. This controls her seizures better than the three previous medications she has tried, although she still is not seizure-free. However, this is not why she came to see me. She is married and she and her husband want to start a family. She would like to get pregnant and came in for preconception counseling because she is concerned about how her epilepsy and phenytoin will affect

the pregnancy and the baby. She wants to know what will happen to her seizures once she becomes pregnant. She wants to know what the risk is of her child having epilepsy. Most of all, she wants to know if there is anything she can do to improve her chances of having a normal pregnancy outcome. In my role as a general internist and consultant at a high-risk obstetric clinic, I have seen countless patients and many pregnant women with epilepsy, but I honestly can't remember the last time I had the opportunity to counsel a woman with epilepsy before she became pregnant.

General internists are in an ideal position to counsel and treat women of childbearing age before, during, and after pregnancy, yet very few of us do. As part of routine health care maintenance, we discuss smoking, alcohol, drug use, diet, exercise, seat belts, and immunizations but often forget about

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RESEARCH FUNDING CORNER

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner highlights two SGIM members who have been successful in obtaining funding for the study of issues related to alcohol and substance abuse: Drs. Jeffrey Samet and Richard Saitz of Boston Medical Center. The research of Drs. Samet and Saitz has improved the care of medical patients with alcohol and other drug use, including HIV patients. Both have been named Robert Wood Johnson Foundation Generalist Physician Faculty Scholars, and both have been successful in obtaining NIH funding for their work. This month we highlight Rich's award entitled "Hospital-Based Brief Intervention For Alcohol Problems" and Jeff's entitled "Clinical Impact of HCV and Alcohol in HIV-Infected Persons."

Forum: Why did you apply for this award?

Jeffery Samet: The submission was in response to an RFA from NIDA/NIAAA for studies on HIV, hepatitis C, and alcohol and drug abuse.

Richard Saitz: I applied through the R01 program because I believed it provided adequate support to do a large research study correctly. It is a key step for an independent investigator. Prior to applying for the award I had completed several unfunded research projects and had received the Robert Wood Johnson Generalist Physician Faculty Scholar award, so this was the logical next step.

Forum: How many times did you have to revise and resubmit?

JS: None.

RS: None.

Forum: What advice would you give others interested in applying for this award?

JS: Submitting a grant application is a

process that should thoroughly excite your intellectual curiosity as well as your creative juices. That level of enthusiasm will be required to get you through the application process, not to mention the actual work of the grant. You must make a case for the subject, your somewhat unique opportunity to address the subject, and your ability to get the job done. The "you" here is not the singular form of this pronoun but rather the entire team.

RS: Start very early. Have a solid idea to begin working on at least three months before the deadline. That assumes that you already have some pilot data and a track record with publications and collaborators. Develop the proposal and get a review from someone not involved in the project. Be meticulous. Be repetitive and consistent. Talk to leading researchers who have studied similar topics and don't hesitate to speak with project officers (not to tell you whether to submit, but so that you can be as informed as possible). Determine the sample size and prepare other support pages, biosketches, and budgets as soon as

possible, so you can focus on polishing the research proposal.

Forum: Describe the application process.

JS: This was a crash response, which took nearly all the time of an eight-week period with many people contributing to the effort. The lion's share, however, was contributed by the PI and co-PI. This was an all-consuming process.

RS: To write the 25-page proposal the basic outline of the science needs to be done early, because budgets and other forms follow, and you don't want the busy work to distract you from the science. As the submission deadline approaches, you can develop a detailed budget and justification. Prepare biosketches and other support pages early. Also, talk to consultants and develop any necessary subcontracts. Submit the application with a cover letter to the institute to which you are applying, specifying the request for applications or program announcement to which you are responding. Wait.

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American Heart Association-Bugher Foundation

Awards for the Investigation of Stroke

The American Heart Association-Bugher Foundation Awards for the Investigation of Stroke are intended to stimulate the development of better stroke preventive measures and better stroke interventions in the future. Proposals may address any aspect of brain vascular function related to stroke. Support is available for basic and clinical studies, including all aspects of primary and secondary prevention and acute treatment of stroke.

Application deadline: July 19, 2001

Award: \$100,000 per year, for a total four-year maximum of \$400,000

Information and application forms are available on the American Heart Association website:

www.americanheart.org/research

The Anticoagulation-Thromboembolism Research Consortium

Richard H. White, MD, and John C. Peirce, MD

President Sankey Williams recently informed SGIM members about the formation of the Anticoagulation-Thromboembolism Research Consortium (ATRC), a group of SGIM members who came together to conduct collaborative clinical research and educational projects using Web-based technology. In the January *Forum*, Sankey presented a very brief overview of the initiative along with a description of the process that led to Council approval. Some Council members expressed significant concern that funds to launch this effort came from an unrestricted development grant from a pharmaceutical company. Differing points of view about this project were discussed in the February *Forum* in articles by President-Elect Kurt Kroenke and Past-President Seth Landefeld. These articles also appear on the SGIM website (www.sgim.org). In this article, we provide a history of this project and present our views about the appropriateness of SGIM sponsorship for this initiative.

The SGIM Anticoagulation-Thromboembolism Interest Group has met annually for the past 12 years. The Interest Group conceived the idea of a Web-based research consortium. Interest group members have long recognized that thrombosis-related research efforts in the United States seldom show the degree of collaboration exhibited by groups in Canada, the Netherlands, Sweden, and Italy. A small group, headed by Steve Fihn, did some clinical studies in the early 1990s, but these efforts gradually disbanded for lack of funding. The Interest Group increased their organizational efforts in 1999 after gaining further insight from Mike Hogarth, a University of California-Davis information technology expert. Dr. Hogarth described what was needed to develop a Web-based data

collection system.

Following the 1999 meeting of the Anticoagulation-Thromboembolism Interest Group, we held informal discussions with several pharmaceutical representatives who shared our enthusiasm about launching a Web-based research registry. These included representatives from Merck, Aventis, and Pharmacia & Upjohn. In the spring of 2000, the idea of creating a Web-based research effort was presented to the educational liaison from AstraZeneca, a company that currently markets no anticoagulants but is planning on entering this marketplace in the next two to three years. They were interested in helping us launch this project by providing an unrestricted development grant of \$200,000 to create the software and start any research projects of our choosing.

We discussed the creation of this collaborative research effort at the 2000 Anticoagulation-Thromboembolism Interest Group session. Some attendees expressed concern about the quality of science produced by "registry" efforts. We decided to focus on conducting methodologically rigorous clinical studies. Overall, participants expressed a great deal of interest in this initiative. Everyone agreed about certain principles: the effort must be open to all SGIM members, and we must conduct only research studies conceived and directed by SGIM members. A group of the most interested members coalesced to form a Steering Committee (ATRC Steering Committee) and to create a proposal for the SGIM Council.

The next phase in the creation of the ATRC involved defining the purpose and principles upon which the ATRC would be founded and outlining how we planned to organize ourselves. Jack Peirce, from the Development

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Genetics in Primary Care: A Faculty Development Initiative

P. Preston Reynolds, MD, PhD, FACP

In 1998 the Health Resources and Services Administration (HRSA), in cooperation with the Agency for Healthcare Research and Quality (AHRQ) and the National Human Genome Research Institute, National Institutes of Health (NIH), launched Genetics in Primary Care: A Faculty Development Initiative (GPC). The goal of this initiative is to increase the competency of generalist physicians in the new genetics. GPC is an outgrowth of earlier efforts by HRSA to enhance collaboration among the generalist disciplines through federal grant programs that focused on primary care medical student education. GPC is funded by a three-year, \$1.6 million contract to the Society of Teachers of Family Medicine (STFM), which administers the program.

The first year of the GPC initiative was devoted to program planning, including the appointment of a national advisory board. As SGIM's representative, I joined physicians and health professionals from 36 other organizations, half with expertise in genetics and half with expertise in primary care medicine. The national advisory board met in the fall of 1999 and again in the spring of 2000. We spent several days learning about the increasing relevance of genetics to primary care practice. We developed a template for a national genetics curriculum for primary care faculty. We recommended that this curriculum be case-based and that it be used in a train-the-trainer model, which would prepare faculty to integrate genetics into their teaching programs.

In the spring of 2000, we asked medical schools to submit letters of intent, indicating their desire to submit a formal proposal to participate in the GPC course. Much to our surprise, we received over 100 letters. We asked

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PHYSICIAN ROLE IN HEALTH CARE DISPARITIES

Jada Bussey-Jones, MD

Racial disparities in health care quality have been documented extensively in the medical literature. These disparities become more striking in the context of increasing diversity of the United States population. According to the U.S. Census Bureau, minorities are expected to represent 36 percent of the U.S. population by the year 2020¹. Despite efforts to close the gaps in health, minority groups continue to be at risk for poor health outcomes. Before the age of 44, African Americans, Latinos/Hispanics, and Native Americans have higher mortality rates at each age than their white counterparts. Infant mortality rates, one of the best indicators of the health of a population, are twice as high among African-American infants as whites². Minorities are also less likely to receive vaccinations and other preventive care^{3,4}.

Sociocultural, biologic, environmental, institutional, and socioeconomic factors play a role in the current disparities in health experienced by minorities. Many of these issues, such as socioeconomic status, unsafe housing, violence, education, employment, and illegal immigrant status, are outside of the health care system. However, there are factors within the health care system, such as obstacles to access to care, lack of interpreter services, and other system and organizational issues, that may contribute to disparities. As a provider, an even more personal issue—that of possible provider bias and competence in treating patients with differing cultural backgrounds—may play a role in health care disparities.

Although the United States health care system as a whole will clearly need to respond to the increasing needs of our racially diverse population, the potential role of provider bias and ineffective doctor-patient communica-

tion in maintaining these health disparities is perhaps even more compelling and relevant to individual physicians. Several studies have demonstrated that even when the larger social and institutional issues such as insurance coverage, socioeconomic status, and health status are similar, differences in treatment persist when comparing whites to minority populations. One multi-hospital study found lapses in the most basic levels of clinical care when comparing African-American and white Medicare beneficiaries⁵. Several investigators also have shown that African Americans are more likely to receive inadequate analgesia in the acute setting for long-bone fractures, fewer referrals for renal transplantation, lower rates of limb-sparing surgery for peripheral vascular disease, higher rates of amputation, and less surgical treatment for early and potentially curable lung cancer⁶⁻⁹. Even more consistent is the literature on African Americans with ischemic heart disease, showing lower rates of catheterization and coronary artery bypass grafting regardless of insurance status¹⁰⁻¹⁴.

The above examples make a clear case for the importance of cultural competence among physicians and health care professionals. These reports suggest that minority patients may not be receiving referrals and prescriptions for medically indicated treatments. Is the issue patient preference? Do minority patients trust the health care system? Were the procedures not explained in a culturally sensitive way? Did the physician offer the treatment? In several reports, patient preference was accounted for and the disparities remained, suggesting a role for individual physician bias, whether conscious or unconscious. The medical profession will need to examine closely the influences of provider bias, patient

preference, and communication to better understand the extent to which they may compromise health outcomes.

Plans to care for an even more ethnically and racially diverse population must include building cultural competence. This has many implications for the academic physician. Medical educators must be prepared to comply with Liaison Committee on Medical Education standards that state “faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments”¹⁵. It is the responsibility of the clinician-educators to both model and train physicians to recognize their own biases, and equip them with the skills to bridge cultural differences. Additionally, the specific roles of physician bias, cultural competence, and physician-patient communication in maintaining health disparities still need to be established. Researchers could help to identify how biases are formed and the means to overcome them when caring for our patients. Taking these initial steps may improve health care outcomes, decrease health care disparities, and improve overall satisfaction for the patient and the health care provider.

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OUR TOP TEN

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The premise of his address will be that disparities in health in America's various racial and ethnic populations are discomfiting to, and pose a continuum of inescapable challenges for the modern general internist.

7. **Scientific abstract sessions.** In response to concerns raised by the membership, the Program Committee has restructured the oral abstract sessions so that there are fewer competing sessions at any given time. In addition, this year invited senior scientists will attend each session. We hope that these changes will ensure that the sessions have a critical mass present to give constructive feedback, ask probing questions, and discuss controversial areas. To make the most of these sessions, the Program Committee wants to encourage *all* senior scientists to attend these sessions. The junior faculty presenters are depending on you!
8. **Unknown vignette session.** The number of vignette submissions has more than doubled in the past two years. We are again holding an "unknown" session. Come match your diagnostic skills with Faith Fitzgerald, MD, Larry Tierney, MD, and Jack Ende, MD, who will moderate the discussion.
9. **Research methods, clinical medicine, and teaching skills.** We have precourses on methodologic issues when studying disparities in health, on clinical medicine, on leadership and teaching skills, on evidence-based medicine, and on end-of-life care. We have clinical updates, presented by senior leaders, on HIV, women's health, geriatrics, and general internal medicine. We have workshops on how to get involved in SGIM, on statistical methods, health policy, funding opportunities, medical applications for the Palm Pilot, joint injection techniques, career advancement, sexual history-taking, death and dying, and

working with interpreters. We have meet-the-professor sessions with Mike Barry, Suzanne and Bob Fletcher, Rodney Hood (president of the National Medical Association), Steve McPhee, Kelley Skeff, Tom Inui, and many, many others. See innovations in action at the Innovations in Practice Management and Medical Education sessions. Be interested, and go to interest groups, now meeting at three different times to allow you to be interested in more than one thing (you are generalists, after all).

10. **Old friends, new friends, feed the mind and the soul.** Come to the meeting that rejuvenates you every year, that reminds you about all the others doing the things that you love to do. Have dinner with friends (we left one evening free for that), take a walk around the beautiful marina, get new ideas for research projects or teaching innovations. There's much, much more. We didn't get a chance to mention your opportunity to meet the National Office staff, who work so hard for us all year, or to hear the Presidential Address. (Do you think Sankey Williams will have the courage to break with the recent tradition of reading from a children's book during his talk?) We haven't mentioned the great dinner. Okay, it will probably still be chicken, fish, or vegetables, but the hotel's catering service has won "best catering" four years running in San Diego, there will be a fabulous jazz ensemble playing, and we have arranged for cash bar service nearby. And we have moved it back to Friday night, hoping that almost all registrants will attend. We haven't told you about Shamu, the killer whale who lives nearby, or the trip we have arranged for you or your kids to the San Diego Zoo. We haven't mentioned that all the sessions will be in one hotel (okay, it has two separate towers, but at least it shouldn't be raining). We haven't told you that you can come for free (only if you are one of the first 25

medical students to register). And we haven't told you that it will be sunny and in the 70's for your stay (we hope).

We are excited about the Annual Meeting, in San Diego, May 2-5. We are proud of the program that our committee has put together. We are impressed with the quality of the submissions we have received. We are delighted to welcome outstanding and eminent speakers and generalists. We are committed to advancing our theme. And, most of all, we are looking forward to seeing you in San Diego. For more information, go to www.sgim.org or call (800) 822-3060. **SGIM**

PHYSICIAN ROLE

continued from previous page

4. Prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*. 1997;46(RR08):1-24.
5. Kahn KL, Pearson ML, Harrison ER, et al. Health care for black and poor hospitalized Medicare patients. *JAMA*. 1994;271:1169-74.
6. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. *JAMA*. 1993;269:1537-9.
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8. Guadagnoli E, Ayanian JZ, Gibbons G, et al. The influence of race on the use of surgical procedures for treatment of peripheral vascular disease of the lower extremities. *Arch Surg*. 1995;130:381-6.
9. Bach PB, et al. Racial differences in the treatment of early-stage lung cancer. *N Engl J Med*. 1999;341:1198-205.
10. Whittle J, et al. Do patient preferences contribute to racial differences in cardiovascular procedure use? *JGIM*. 1997;12:267-73.
11. Ayanian JZ, et al. Racial differences in the use of revascularization procedures after coronary angiography. *JAMA*. 1993;269:2642-6.

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PHARMACEUTICAL FUNDING

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conjectural. It places a burden on those responsible for the governance and operation of the Society. Effective oversight is key. During the eight months of my tenure as Chair of the Development Committee, I have found an amazing array of historical actions, talent, thoughtful deliberation, and hard work. Three policies and procedures on external funding, allowing for funds from for-profit companies, were passed by the Council during the tenure of Seth Landefeld as President. These policies helped establish funding from pharmaceutical companies to get the work of our Evidence-Based Medicine group off the ground. Three standing committees—research, ethics, and development—have reviewed and commented on the evolution of the ATRC. As President, Sankey Williams has bent over backward to ensure that everyone has had a chance for input, including at the Annual Meeting. The Steering Committee of the ATRC is devoting substantial time and effort to ensure that the necessary checks and balances are put in place for effective governance and operations. Most of all, I have been impressed with the time and effort put in by all members of the Council to ensure that this project goes forward in a good way.

All this does not guarantee a positive outcome. To me, though, it says that the Society is serious about governing its affairs well and will be able to take timely action to ensure that its values are acted on in a good manner. *SGIM*

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GENETICS IN PRIMARY CARE

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these schools to respond to a detailed request for proposals (RFP), assessing the need for genetics in their medical student and resident curricula and the level of genetics expertise within their generalist faculty. We received 53 full proposals for review. This strengthened the conviction of the GPC executive committee regarding the need for this program. They persuaded the participating federal agencies to provide additional resources to expand the number of teams selected from 10 to 20. In June 2000, these interdisciplinary teams were notified of their selection. With the RFP and team selection complete, we began planning for the first round of training in October 2000, just four months away.

Throughout the summer of 2000, a team of education specialists selected the content areas and wrote the curriculum. Wylie Burke, MD, PhD, a geneticist-educator from the University of Washington led the curriculum development team. Dr. Burke selected eight core content areas relevant to primary care practice, including the role of genetic testing in the primary care

setting. The eight core topics included: cardiovascular disease, breast cancer, colorectal cancer, dementia, developmental delay, congenital hearing loss, hemochromatosis, and ELSI — Ethical, Legal, and Social Issues relevant to the new genetics. I served as a member of the curriculum development team and as a faculty member for the train-the-trainer program.

In October 2000, over eighty faculty from around the country convened in Chicago for two and a half days of training. The sessions valued the most highly by participants were the small group workshops where we used cases to initiate a discussion of the integration of genetics into primary care education. These discussions were lively, with geneticists and generalists actively learning and debating issues such as test sensitivity and specificity and the complexity and importance of written informed consent. This was the first time that many generalist faculty had worked with genetics faculty from their institution. Over the two and a half days of training, the generalist

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MEDICAL CARE DURING PREGNANCY

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contraception and the possibility of pregnancy. Because we don't bring it up, women who may be contemplating pregnancy don't discuss it with us. Even more concerning is the fact that up to 50 percent of pregnancies in the United States are either unplanned or unwanted. As the primary physician for these women, if we don't incorporate preconception counseling into their regular care, they may not come in again until after a missed menstrual period. And by then, it is often too late. Critical fetal development occurs early in the first trimester, often before a woman even realizes she is pregnant and sees her obstetrician for the first time. In addition, a woman may now choose to delay pregnancy until she is later in her childbearing years. This makes it more likely that she may have a medical condition or is taking a medication that could affect her fertility and her ability to have an uncomplicated pregnancy and deliver a normal, healthy child. By participating in the preconception, prenatal, and postpartum care of our patients, we remain medically engaged during one of the most important and meaningful periods in their lives.

This year, at the Annual Meeting in San Diego, a workshop entitled "Prescribing and Diagnostic Imaging in Pregnancy" will be offered Friday, May 4, 1:30-3:00 PM. This case-based, interactive session will cover common diagnostic and therapeutic issues during pregnancy and lactation. The discussants will be Ray Powrie, MD, and Lucia Larson, MD, from Brown University, and myself. All of us are members of SGIM and the Society of Obstetric Medicine (SOM). SOM is an international group of internists (and some obstetricians) whose common clinical and research interests involve the care of women with medical problems during pregnancy. We encourage you to participate in the workshop to become more comfortable and more involved in the care of your patients who are or who are about to be pregnant.

On Saturday, May 5, at 7:00 AM,

Michael Carson, MD, Robert Wood Johnson School of Medicine, is hosting an interest group on "Medical Problems in Pregnancy/Obstetric Medicine." Mike is a member of both SGIM and SOM and has extensive experience in

MORE THAN OURSELVES

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repair looks appropriate in Japan but probably wouldn't be adopted here.

When traveling in other cultures, it's easy to focus on differences. What was more important about JSGM's annual meeting was its similarity with SGIM's annual meetings, especially those earlier in our history. JSGM's meeting lasted only a single day, but there was the same energy and excitement. All day, the halls were clogged with small groups of eager faces buzzing with conversation. The 120-page program book everyone carried around had the unpretentious look our program books used to have before we could afford fancier help. The presentations were well rehearsed, and the audiences attentive, if a little more respectful than

this area. The program will include clinical reviews and a stimulating and lively discussion. It should be the perfect start to a great day of meetings. We hope to see you at one or both of these sessions. **SGIM**

I'm used to at home. There was green tea instead of coffee, but it was still caffeine and it was still an excuse to stand around and talk.

Although I can't understand a single word of Japanese, except the word for "thank you," I enjoyed this meeting, which was almost entirely in Japanese. It made me remember our history and clarified why SGIM has been so important to me. What's more, it reminded me that through our patients, students, and colleagues we become much more than we can be by ourselves. I hope to recapture these feelings at our Annual Meeting this year in San Diego. I hope you're there to share them with me. **SGIM**

RESEARCH FUNDING CORNER

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Wait. Receive an impersonal form letter that says your application was received. Wait. Wait. Wait. Receive pink sheets that summarize the reviewers' comments. Then wait some more until you get a notice of grant award or you call to find out how likely it is that you were funded. Then start working on revisions.

Forum: How long did it take you to put together an application?

JS: Eight weeks.

RS: Three months.

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

PHYSICIAN ROLE

continued from page 8

12. Peterson ED, et al. Racial variation in cardiac procedure use and survival following acute myocardial infarction in the Department of Veteran Affairs. *JAMA*. 1994;271:1175-80.
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15. Liaison Committee on Medical Education website (www.lcme.org).

RESEARCH CONSORTIUM

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Committee, played a key role in focusing our efforts and creating documents for review by several SGIM Committees and Council. (These documents are available from the SGIM National Office). After articulation of our founding purpose and principles, we submitted a proposal to the Council and participated in the lengthy debates that ensued about the merits of launching the ATRC project.

One of the key messages that the membership has provided to the Council in recent years is that SGIM is too often simply a meeting and a journal and really has little presence in our daily professional lives. In response, the Council has been striving to identify ways to support members in more tangible ways, particularly through the structure of the interest groups. And when surveyed, a recurring theme among the members of the Anticoagulation-Thromboembolism Interest Group has been that many of them want assistance in becoming involved in research. This initiative has the potential to help them do so.

This initiative is being designed specifically not to compete with members but to include as many as possible. We are working to foster creativity and collaborative research efforts by members. Any SGIM member can make a proposal and potentially lead a project using the Web-based resources. We believe this effort will promote research opportunities rather than create conflict.

We are organizing in a fashion that allows members of the ATRC to know the nature, scope, and extent of our activities. This is a cooperative project, designed to enhance the reputation of SGIM, not corrupt it. Each site must have documented IRB approval to enter data. The ATRC Steering Committee is cognizant of HIPPA regulations, which apply to the "entity" that hosts the Web server. New regulations will be effective as of Oct 1, 2002, and we will adhere to these regulations. Again, this is an important task for the ATRC Steering

Committee. In essence, these regulations are designed to ensure confidentiality of patient information. Software is being developed with state-of-the-art security. All data collected will be devoid of patient identifiers. Using appropriate, secure software, we will make sure that we meet HIPPA standards.

We view the development of the ATRC as an exciting opportunity for SGIM. We are grateful to have received the extramural funding that was necessary to launch this project. We also are grateful to our colleagues, who have reminded us that receiving

funding from a pharmaceutical company, even an unrestricted developmental grant like the one we received from AstraZeneca, creates the potential for dualism. Because of this potential, we have worked hard to develop founding principles and a modus operandi that avoid any significant conflict of interest. As SGIM members and as physicians, our core missions are patient care, teaching, and research. We are grateful to seize this opportunity to develop the ATRC to advance these missions. **SGIM**

Editor's Note—Drs. White and Peirce are members of the ATRC Steering Committee.

GENETICS IN PRIMARY CARE

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faculty developed a greater appreciation for the role of geneticists in patient care and in teaching. Jim Evans, MD, a general internist with fellowship training in genetics from the University of North Carolina, gave an excellent presentation on the utility of genetic testing from the perspective of a generalist physician. Suddenly for many, this new content took on meaning, because the framework for analysis was one they understood, namely, evidence-based medicine, cost effectiveness, doctor-patient communication, and screening versus diagnostic testing. Participants also learned about various websites commonly used by genetic counselors and geneticists. These websites enable generalist physicians to access the best databases on gene testing and genetic disorders.

Between October 2000 and April 2001, these 20 faculty teams will implement genetics curricula for medical students, residents, and faculty. They also will complete a more detailed needs assessment for their institutions. The cases will be "beta tested." Feedback on their effectiveness and suggestions for improvement will be integrated into an expanded and revised final curriculum product. In February and March 2001, members of the

national advisory board will visit each team. At the conclusion of the GPC program, we will make the curriculum publicly available through the GPC website.

An external team from the University of Wisconsin will evaluate GPC. The evaluators are working to ensure a fair review process and uniform scoring of applications. Each faculty team has completed a pre-course and a post-course test. In addition, the evaluation team will assess the ability of the teams to use the curricular materials to effect change in their medical schools and residency training programs, identifying barriers to their success and resources available to assist them in their efforts.

Every national and regional survey to date has identified a need for primary care physicians to enhance their knowledge and skills in delivering the new genetics. We believe that GPC is an innovative approach to meeting this need, and to helping medical school and residency faculty evaluate more effectively the risks and benefits of providing genetic testing in their clinical practice.

For more information, see the GPC website (www.hrsa.gov/bhpr/dm/genpc.html). **SGIM**

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ACADEMIC INTERNIST—ASSOCIATE PROGRAM DIRECTOR, INTERNAL MEDICINE RESIDENCY. Unity Health System, a University of Rochester affiliate, is seeking a board-certified general internist to join our general medicine unit and assist with residency program administration. Contact James Dolan, MD 1555 Long Pond Rd, Rochester, NY 14626, E-mail: jdolan@unityhealth.org.

ACADEMIC INTERNIST—RESEARCH. Unity Health System, a University of Rochester affiliate, is seeking a board certified, fellowship-trained general internist to help develop a research program in health services research and medical decision making. 50% protected time. Contact James Dolan, MD 1555 Long Pond Rd, Rochester, NY 14626, E-mail: jdolan@unityhealth.org.

ASSISTANT PROFESSOR - GENERAL INTERNIST. The Division of General Medicine

and Geriatrics, Department of Internal Medicine, University of Virginia Health System is seeking a general internist at the Assistant Professor level, board certified in Internal Medicine, for a full-time position in an academic rural practice. Responsibilities will include a personal clinical practice and medical student and resident teaching. Individuals with practice experience in a rural setting and/or fellowship are encouraged to apply. Salary plus practice incentive plan. Send Curriculum Vitae to: Mary Beth Meachum-Whitehill, Division Administrator, General Medicine, University of Virginia Health System, Box 800744, Charlottesville, VA 22908. The University of Virginia is an Equal Opportunity/Affirmative Action Employer.

ASSISTANT PROFESSOR—HOSPITALIST. The University of Kentucky Department of Internal Medicine, Division of General Internal Medicine, is seeking to expand its hospitalist faculty program with a position available at the level of assistant professor. The position will focus on care of patients admitted to the Department's general medical inpatient services, clinical instruction of medical and pharmacy students and residents. Send CV to T. Shawn Caudill, MD, Division Chief, Division of General Internal Medicine, University of Kentucky Medical Center, K512 Kentucky Clinic, Lexington, KY 40536-0284. (859) 257-5499. An Equal Opportunity Employer.

FACULTY DEVELOPMENT TRAINING. 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, PhD, 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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