Society of General Internal Medicine

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE

SGIM FORUM

Volume 24 • Number 8 • August 2001

2001 Annual Meeting: A Look Back

EVALUATIONS UNDERSCORE SUCCESS OF 2001 ANNUAL MEETING

Michael Green, MD, MSc

On May 2 through 5, 2001, 1,547 SGIM members gathered under the sunny San Diego skies to teach each other, share their work, honor their achievements, and chart a course for the future. The theme of health care disparities, like a thread through a tapestry, ran through the abstracts, workshops, plenary sessions, and speeches. The first full day began with Surgeon General David Satcher's "prescription" to eliminate disparities and ended with a thrilling exhortation to action by Reed Tuckson in his Peterson Lecture. Other highlights included John Eisenberg's acceptance of the inaugural National Award for Career Achievement in Research (now named after him), Sankey Williams' reflections on what SGIM should be, a spirited town meeting with Council, and an emotional tribute to Elnora Rhodes.

SGIM uses the Annual Meeting evaluations for several purposes. First, to assist future meeting planners, we assess the attendees' satisfaction with various aspects of the meeting. We also compare the content, attendance statistics, and satisfaction ratings to past meetings. Finally, the workshop and precourse evaluations provide feedback to the presenters and serve as the criteria for awards.

This meeting's attendance of 1,547 was just short of last year's high of 1,578. For the first time this year's attendees had the option of electronically returning the evaluation form, which may explain the record response rate of 47%. Clinician-educators (44%) and clinician-investigators (28%) comprised the majority of attendees, most of whom work in a university setting (72%). On a scale of 1 (worst ever) to 10 (best attended), the overall meeting rating was 7.9, representing the highest rating since 1995.

The content of this year's meeting received extremely high ratings. Special sessions included a plenary abstract session dedicated to the study of disparities, a symposium examining the relationship between physicians and the pharmaceutical industry, a clinical vignette unknown session, innovations in practice management and education, a poster session for HRSA-funded projects, and the ever popular updates in general medicine, geriatrics, women's health, and HIV infection. Eighty-nine percent of respondents planned to implement a new skill, program, or idea that they learned at the meeting.

This year the planning committee extended the length of the meeting to three and one half days to increase the amount of free time, run fewer simultaneous sessions, and accommodate a larger program. There was overwhelming support for this change, and 87% of respondents would prefer this for future meetings. The meeting logistics received a

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UpToDate Offers Discount for Trainees

Lorraine Tracton

Until August 31, 2001, trainee groups may order subscriptions to *UpToDate* for a special rate of $145 per person. This is a 25% ($50) reduction from the regular trainee discount, and is 70% less than the current full subscription price for other individuals. To qualify for these savings, a minimum of ten or more residents or fellows in the same training program must subscribe to *UpToDate* as a group. Ordering instructions are available on the SGIM website (**www.sgim.org**) or by calling (800) 998-6374 or (781) 237-4788.

"We want to make the *UpToDate* program accessible for every trainee," said Dr. Burton Rose, Editor-in-Chief for *UpToDate*. We believe that broad access to *UpToDate* can aid medical education and will improve patient care over the long term."

UpToDate is a clinical reference library, on CD-ROM and online, that provides fast answers to clinical questions and authoritative advice on complex patient problems. *UpToDate* is the only clinical resource sponsored by six major medical societies. Designed and written by physicians for physicians, *UpToDate*'s expert faculty provide a comprehensive, practical synthesis of the latest scientific evidence and specific recommendations for diagnosis and treatment. Material is updated continuously as important new data are published. *UpToDate* includes the equivalent of over 40,000 pages of text, plus over 100,000 Medline abstracts, 10,000 graphics, and a complete drug information database.

The *UpToDate* program includes adult primary care and internal medicine, cardiovascular medicine, endocrinology and diabetes, gastroenterology and hepatology, hematology, infectious diseases, nephrology and hypertension, oncology, pulmonary and critical care medicine, and rheumatology. Several other sections are in development. All of this material is integrated within one program that can be used at the point of care, as the doctor is seeing the patient. *SGIM*

SGIM Seeks FORUM Editor

SGIM is soliciting nominations for a three-year term (July 2002 to June 2005) for *Forum* Editor.

Members interested in nominating themselves or colleagues for this volunteer position should contact:

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MENTORSHIP

Kurt Kroenke, MD

Mentorship is a critical ingredient in the making of an academic career. The relationship between a veteran and a rookie, a senior and a junior partner, is the rocket that lifts off slowly from the space pad, defies gravity in escaping the earth's atmosphere, and disengages once the astronaut's capsule is in orbit and ready for independent flight. Mentorship is difficult to define in that there are no good synonyms. Teacher, supervisor, coach, role model, and advisor – each is partly right but inexact and incomplete. There is also not much written about mentorship in academic medicine, and actual research on the topic is quite limited. The lack of clear definitions or definitive scholarship makes mentorship a nebulous undertaking, a voyage without a map, compass or agreed-upon destination. My own reading has been eclectic and patchy.[1-8] Yet, I have been called upon for the past 15 years to serve as a mentor, usually without explicit expectations or guidelines. I knew that the mentee expected quite a bit of me, and I likewise had high hopes for the relationship. Sometimes it worked well; at other times one or both of us came away from the experience disappointed. Occasionally, it was a poor match, but it was probably also a casualty of ill-defined processes and outcomes. The knowledge that business and other fields have contributed to our understanding of mentorship is not widely accessible to physicians, and also speaks indistinctly on a number of issues unique to academic medicine.

SGIM is an ideal place to foster a better understanding of mentorship. First, we are responsible for many fellows and junior faculty interested in academic careers. Second, we are a professional society that has been a lead agent in the field of medical education. While our educational scholarship has predominantly focused on residents and students, it is a natural extension to embrace mentorship and, in so doing, provide a service for our own discipline as well as academic medicine in general. Third, we are a society that values diversity. As Kathleen Figaro points out in another article in this issue of *Forum*, minority faculty often face special challenges in finding mentors. SGIM can help address those challenges.

The following are some practical guidelines, more experiential than evidence-based. While these suggestions may be placeholders awaiting quantitative and qualitative scholarship, the questions raised below can serve as an interim agenda for the dialogue between mentor and mentee. I use the more inclusive term, *scholarship* (rather than the narrower term, research), because it better captures the wide range of academic contributions made by clinician-investigators and clinician-educators.

Selecting a Mentor

How does one select a mentor? Sometimes there is a perfect match between the scholarly interests of a fellow or junior faculty and his or her potential

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SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.
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 Look Back

The Serendipity of Having Both Luck and Fun in Academic General Internal Medicine

John M. Eisenberg, MD, MBA

Editor's Note*—At the 2001 Annual Meeting, John Eisenberg received the first National Award for Career Achievement in Research. This article is an expanded version of the comments made by Dr. Eisenberg upon receiving this award.*

Thank you, Sankey, and thank you, all of you, my extended professional family. When I come to SGIM meetings—and for many of you, I suspect it is the same—it is always like a return to my hometown, so much that is familiar and comforting, and still, every year there is so much that is new and changed for the better.

Oh yes, things have changed. I was looking through some old files recently and came across the feedback that we received on the 1981 meeting, which I had organized. My favorite was, "Next year ban all smoking from the plenary session hall." Another was, "Extend the meeting to two days." Things have changed for the better.

Getting an award like this from my professional family feels a bit like cheating—to get an award for a career that has been so much fun. It has been sufficient award just being able to do it. Albert Einstein said, "The value of achievement lies in the achieving." I would edit that to express my view: "The fulfillment and the fun of achievement is in the achieving." I hope all of you are having as much fun as I have been blessed to have had.

I am sure that many of you meet with students who want to know how you decided to take the path you took. Well, I'm usually honest with them. I tell them that it was a mistake. It's not like I planned it this way.

I often feel like the French general who was asked at a reception in Paris, "General, how did you get all those medals?" And the general responded, as he pointed to the medals on his chest, "Well, this one I got because I got this one. And this one I got because I got this one. And this one I got because I got this one. And this one was a mistake."

For me, that's the way it has been, a string of lucky accidents. Sure, it has been a lot of hard work, but I figure my career has been distinguished mostly by serendipity.

In college I met Anne and Herman Somers, two of the first scholars on access to care in this country. They introduced me to a field that I thought was really neat. Later I found out it is called health services research.

My next lucky accident was when I was in medical school and met a professor of medicine, Gerald Perkoff, who had made his first reputation in metabolism research but who was now studying a new kind of health care called health maintenance organizations. One day he asked if I would like to go with him to a lecture he was giving across town. I did and I

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Women's Health Education Interest Group Started

Rebecca S. Brienza, MD, MPH

The first meeting of the Women's Health Education Interest Group took place at the 24th Annual Meeting in San Diego, California, May 2–5, 2001. The objective of this interest group is to provide a forum for medical educators with interest and expertise in medical education about women's health to network and collaborate. Although many individuals, institutions, and organizations have invested increasing resources into development of women's health curricula, there has not been a national working group of internists focusing on this issue. The first meeting of the group was very productive, and all who attended were excited about sharing resources, collaborating on joint educational and research projects, and contributing towards working on a national curriculum and access to resources for teaching women's health in internal medicine.

Highlights and goals for the group from the first meeting included: 1) forming a national list serve of women's health educators; 2) sharing and evaluating existing curricula; 3) development of new curricula; 4) multi-institutional implementation and outcomes-based evaluation of new curricula; and 5) compilation of a national data bank of medical education resources on women's health to be used for the education of medical students, internal medicine residents, and faculty.

If you are interested in becoming involved with the Women's Health Education Interest Group or being placed on the list serve please e-mail Deborah Kwolek at **dskwol0@pop.uky.edu** or Rebecca Brienza at **rbrienza@wtbyhosp.chime.org**. *SGIM*

Research Funding Corner

American Cancer Society Offers Career Development Awards

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner highlights career development opportunities through the American Cancer Society. The American Cancer Society is the largest not-for-profit funding source for cancer research and is inviting applications to support training, research, and career development in primary care.

Cancer Control Career Development Awards

Cancer Control Career Development Awards (CCCDA) are intended to encourage and assist in the development of primary care physicians interested in academic careers with an emphasis in cancer control. The CCCDA provides opportunities for promising individuals to acquire skills in primary care practice, education, and research activities related to cancer control. Awards are made for three years with progressive funding of $50,000, $55,000, and $60,000 per year. The annual application deadline is October 1.

Clinical Research Training Grants for Junior Faculty

Clinical Research Training Grants for Junior Faculty support the training of junior faculty within the first four years of their independent faculty appointment to conduct mentored clinical, epidemiologic, or health policy and outcomes research. Awards are made for up to three years for up to $150,000 per year, including 25% indirect costs. These grants may be renewed once for a two-year period. Application deadlines are October 1 and March 1.

Research Scholar Grants for Beginning Investigators

Research Scholar Grants for Beginning Investigators support independent, self-directed researchers in the first eight years of their independent research careers to support basic, preclinical, clinical, or epidemiologic research projects. Initial awards are made for up to four years and for up to $250,000 per year. Annual application deadlines are October 15 and April 1.

Research Scholar Grants in Psychosocial and Behavioral Research for Beginning and Senior Investigators

Research Scholar Grants in Psychosocial and Behavioral Research for Beginning and Senior Investigators are awarded to independent investigators at any stage of their careers to support research centered on the psychosocial and behavioral aspects of cancer. Senior principal investigators are strongly encouraged to include an individual at an early career stage as co-principal investigator. Initial awards are made for up to five years and for up to $500,000 per year. Annual application deadlines are October 15 and April 1.

Research Scholar Grants In Health Services and Health Policy and Outcomes Research for Beginning and Senior Investigators

Research Scholar Grants In Health Services and Health Policy and Outcomes Research for Beginning and Senior Investigators are awarded to independent investigators at any stage of their careers to support research projects centered on health services and health policy and outcomes research. As with the Scholar Grants in Psychosocial and Behavioral Research, principal investigators are encouraged to include an individual at an early career stage as co-principal investigator.

Postdoctoral Fellowships

Postdoctoral Fellowships support the training of researchers who have just received their doctorate to enable them

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On Mentorship: A Minority Mentee's Perspective

M. Kathleen Figaro, MD

As difficult a subject as mentorship is, it deserves discussion and clarification. Young faculty in the clinician, educator, or investigator tracts rely on it, tenure requires recommendations nourished by it, and one's own sense of belonging at one's institution depends on its existence. Yet it is not often discussed because it is, at the heart of it, a relationship, and, as such, it shrinks under microscopic examination. The concept of mentorship has changed significantly from its origins when the goddess Athena assumed the shape of Mentor to guide Telemachus and give him prudent counsel. It is not necessarily one-on-one, cannot include all aspects of the life of the participants, and is often short-lived. Modern American life contains many benefits of individuality and freedom, but one risk is that relationships can suffer. In addition, the multicultural nature of our nation poses many challenges to all types of relationships. Since relationships breathe most comfortably in the air of similarity, issues of difference in race, ethnicity, or gender between mentor and mentee can influence this delicate association.

Many worthy books and articles discuss mentorship, but one particularly practical guide to mentorship is Linda Phillips-Jones' pamphlet, *75 Things to Do with Your Mentees*.[1] These suggestions are based on the assumption of mutuality and comfort in both members of the relationship. Phillips-Jones begins by setting out ideas that can enhance the relationship including, "Offer to tell your career story in some detail. Include high and low points and how these learning experiences helped you." In this section, Phillips-Jones pauses to remark that, if one is from a different background from that of one's mentee, one should "Read about your mentee's

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2001 ANNUAL MEETING

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On a scale of 1 (worst ever) to 10 (best attended), the overall meeting rating was 7.9, representing the highest rating since 1995.

mean rating of 3.9 on a scale of 1 to 5. I am currently performing a qualitative analysis of written comments, which should provide the planning committee with additional important feedback.

Members presented 21 precourses and 61 workshops, which were very well received. On an overall scale of 1 to 5, the mean participant rating was 4.4 for the precourses and 4.2 for the workshops. Several presenters deserve special recognition. Pamela Ganschow, Assistant Professor of Medicine, Cook County Hospital and Rush Medical College, and Jennifer E. Potter, Instructor in Medicine, Beth Israel Deaconess Medical Center and Harvard Medical School, received the Precourse Award for "Breast Health Across the Life Cycle," which had the highest overall rating. Three individuals received the David Rogers Education Award, given to junior faculty whose workshops receive the highest ratings (and at least a 60% evaluation response rate): Jeffrey Pickard, Assistant Professor of Medicine, Presbyterian/St. Luke's Medical Center and University of Colorado Health Science Center, for "Prescribing and Diagnostic Imaging in Pregnancy;" Jeffrey R. Jaeger, Assistant Professor of Medicine, University of Pennsylvania Health System, for "Teaching About Domestic Violence;" and Joshua Lee, Assistant Professor of Medicine, Dartmouth-Hitchcock Medical Center, for "Safespeak: Teaching an Orientation-Neutral Sexual History."

Other presenters of highly rated workshops, among those with a sufficient evaluation response rate, included:

- Erin E. Hartman, Managing Editor, Clinical Crossroads, JAMA, Beth Israel Deaconess Medical Center, "Medical Writing: What Editors Look for and How to Improve Your Manuscripts"
- Steven L. Cohn, Clinical Associate Professor of Medicine, SUNY Downstate Medical Center/ King's County Hospital, "Clinical Problem Solving: Patient Management Issues in Perioperative Cardiac Risk"
- Martha S. Grayson, Chief, Section of General Internal Medicine, St. Vincent's Hospital, New York Medical College, "Developing and Documenting Scholarship for Junior Clinician Educators"
- Robert Smith, Professor of Medicine, Michigan State University, "An Evidence-Based, Patient-Centered Interviewing Method"
- Lorna A. Lynn, Director of Recertification Development, ABIM, "Physicians and Power—From Coercion to Honor"
- Julie L. Mitchell, Women's Health Fellow, University of Wisconsin-Madison, "Phytoestrogens, Botanicals, Androgens, and Other Alternatives for Menopausal Symptoms: A Review of the Evidence"
- Gordon L. Noel, Professor and Vice Chairman of Medicine, Oregon Health Sciences University, "Measuring and Rewarding Faculty Teaching Productivity"
- Charles J. Hatem, Director of Medical Education, Mount Auburn Hospital, Harvard Medical School, "Renewal in the Practice of Medicine"
- Kristy F. Woods, Associate Professor of Medicine, Meharry Medical College, "Management Issues in Adult Sickle Cell Disease"
- Chad K. Brands, Assistant Professor of Pediatrics, Mayo Clinic, "Adolescent Medicine and Young Adult Care: New Dimensions for Internal Medicine"

Letters of commendation will be sent to these presenters and their department chairs.

A great challenge lies before the 2002 Annual Meeting Program Committee, should they aspire to top the 2001 meeting. Rest assured, I know its members are equal to the task. See you in Atlanta for SGIM's 25th Anniversary. **SGIM**

RESEARCH FUNDING CORNER

continued from previous page

to qualify for an independent career in cancer research (including basic, preclinical, clinical, psychosocial, behavioral, and epidemiologic research). Awards are made for one to three years with progressive stipends of $35,000, $37,000, and $40,000 per year, plus a $2,000 per year institutional allowance. Annual application deadlines are October 1 and March 1.

The American Cancer Society invites you submit your application electronically at **www.cancer.org**. For questions call or e-mail Virginia Krawiec, MPA at (404) 329-7612 or **ginger.krawiec@cancer.org**.

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

Calendar of Events

Annual Meeting Dates

25th Annual Meeting
May 2–4, 2002
Hyatt Regency Hotel
Atlanta, GA

26th Annual Meeting
May 1–5, 2003
Vancouver Convention and Exhibition Centre
Vancouver, BC, Canada

27th Annual Meeting
April 21–24, 2004
Sheraton Chicago Hotel and Towers
Chicago, Illinois

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mentor. More commonly, there is some compromise in which the give-and-take is not 50:50. The time, available resources, and scientific expertise of the mentor may require some channeling of the mentee's project. Seldom is an idea borrowed from another embraced with the same degree of passion as an idea that is entirely one's own.[6] However, one should at least find the area of research interesting. Lee Goldman suggested a litmus test for selecting a project: "Would you read it if someone else wrote it? Even better, would you quote the results on rounds?"[5]

Besides concordant research interests, four generic questions a mentee should consider in choosing a mentor include: (1) What is the mentor's personal success in scholarship, whether measured by grants, papers, new curricula or educational products, or institutional, regional, or national reputation? (2) What is the success of former mentees? An expert scientist is not invariably an expert mentor. (3) Does the mentor have the time? (4) Will the personalities of the mentor and mentee mesh (or at least not clash)?

Natural History

What is the natural history of mentorship? The attainment of independence in research and scholarship is a gradual process, typically unfolding over a minimum of 5 years. Two-year fellowships offer a good start, but seldom finish the process. Moreover, a number of fellows must leave the institution in which they formally trained and initiate new mentoring relationships as junior faculty elsewhere. For clinician-investigators, one common pathway is substantial protected time for the first two to three years following fellowship, with a priority being to apply for a career award (e.g., an NIH K23 or a VA or foundation career award) within the first 12 months. It is unrealistic for most fellowship graduates to be a principal investigator on an R01. Rather, career awards, small project grants (e.g., an R03), or co-investigator status on a mentor's grant is more feasible.

Weaning from mentorship is also a gradual process. Over a period of several or more years, the mentee publishes articles without the mentor as senior author, submits grants with the mentee (or another collaborator) as principal investigator, and follows independent lines of research that diverge in varying degrees from those of the mentor. Not uncommonly, individuals may have several mentors early in a career. Plural mentorship may be simultaneous (either co-mentors or a primary and secondary mentor) or sequential (transitioning from one mentor to another) because of changing institutions or redirection of one's research focus.

Expectations

Should mentoring be a win-win situation? Ideally yes. In practice it is usually somewhat asymmetric. It should not be win-lose. Sometimes, the mentor can be predominantly altruistic in terms of giving time and advice to a junior scientist pursuing a fairly independent theme. However, the best mentors often have very limited time, an obligation to complete their own funded projects, and other competing demands. For the most part, neither university monies nor external funding agencies reimburse mentorship. Moreover, the competencies and passions of mentors will be most demonstrable in projects with a reasonable connection to their own content or methodological expertise. Also, the senior investigator on a junior faculty member's career award or initial project grant must have credibility (i.e., a reputation) in the intended area of research. At the same time, the mentee must have ownership of a project or piece of a project, whether it is primary data collection, secondary data analysis, or literature synthesis. There is a middle road between autonomy and cloning. Finally, mentors may coax junior colleagues to take on occasional assignments, such as book chapters, manuscript reviews, or small projects with a short suspense date, but the time burden of ancillary requests should not pre-empt a mentee's primary research.

Levels

Are there levels of mentorship? We have been talking about the full model. There are also more circumscribed variants. Mentorship may be project-specific: advice from, or collaboration with, a senior investigator that begins and ends with a single project. Mentorship may be time-limited, involving a student or resident spending one or two months with a faculty investigator. In this case, the degrees of freedom allotted to the mentee may be considerably less, both because of time constraints and inexperience. Mentorship may be geographically distant—guidance from a senior academician at another institution who can dedicate limited amounts of time by telephone, e-mail, or one or two visits. Led by Preston Reynolds and others, SGIM has attempted to foster distant mentorship. One initiative has been the SGIM Research Mentorship Program, which provides seed money (primarily for travel) for distance mentoring. One generic constraint for distance mentoring, in the absence of grant support, is the need to provide mentoring at one's own institution. SGIM has also regularly offered one-on-one mentoring at both its national and regional meetings, although these brief encounters serve more as one-time opportunities for career advice, rather than ongoing guidance.

Processes and Outcomes

What are the processes and outcomes of mentorship? There is probably more consensus on the outcomes. Some are easily measured: projects completed; abstracts presented; papers published; grant proposals submitted and funded; new curricula; increasing responsibility and achievements in medical education or clinical research; institutional awards, leadership roles, and promotion;

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MENTORING

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involvement in regional and national professional organizations. Measurement continues to be more explicit for research careers than for clinician-educators; the latter is an area for which SGIM has promulgated guidelines but needs to continue its advocacy. There are also the softer but nonetheless invaluable outcomes of mentorship, such as career advice, networking with colleagues, nominations for committees or other positions, socialization into the academic profession, and fostering advancement.

The processes of mentorship are more variable. Regular meetings are important, ranging from weekly early on in the relationship, to once or twice a month in the later phases. Ad hoc meetings, curbside consultations, and e-mail availability for key questions or decisions also enhance the mentor's role. The mentor can help develop timelines; divide an intimidating project, proposal, or paper into manageable chunks; direct next steps; suggest resources; and offer advice on "when to hold them and when to fold them" (i.e., the decision on whether to persevere on a project, versus bailing out and cutting one's losses). The mentor and mentee should achieve explicit consensus on their short-, intermediate-, and long-term goals. In some cases, specifying the benchmarks in a table or timeline may help to formalize if not contractualize these expectations.

This discussion of mentorship is admittedly selective. While I have focused on formal scholarship and research, there is certainly a need (and somewhat different model) for mentorship of good clinical teaching, effective administration, and superb patient care. It is also likely that some mid-level and senior academicians receive (and many others would benefit from) periodic mentorship relevant to their stage of career. Members of SGIM have also written about the special mentorship needs of women and minority faculty.[9-11]

Mentorship is central to the mission of SGIM. It is also vital to each university, obligatory for senior faculty, and the incubator for the scholarship of the future. **SGIM**

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background" or read a book from that culture and discuss it with the mentee. After initially setting forth methods to develop goals with a mentee, Phillips-Jones suggests turning the tables and asking the mentee to take the teaching or leadership role in the relationship. One particularly harrowing piece of advice is, "Ask mentees to give you specific feedback—positive and corrective—on something you've written or on an action you took." As a mentee, I view this advice as fraught with potential danger; egalitarian ideals have not yet infiltrated medicine sufficiently to assure that the mentor will accept such advice. However, Phillips-Jones balances such difficult suggestions with other, easier ones, such as, "Take a course or workshop with them.... Do volunteer work together."

Currently, minority faculty make up just 5% of the US total.[2] It is, therefore, not surprising that the vast majority of young minority faculty have a mentor of a different race or ethnicity. This reality has many potential benefits and challenges.[3] Such differences force a junior faculty member to be resilient and to learn new relational skills. As a young faculty member, I've experienced both the depths and heights of mentorship, from mentors who have told me gravely to ignore my personal life and to pick a residency solely on its reputation, to those who have inspired me to achieve goals I did not think possible simply because they required them of me.

In another pamphlet, *Strategies for Getting the Mentoring You Need*,[4] Phillips-Jones identifies several useful ways to foster mentorship. I discuss these below, embellishing them a bit with my experiences as a minority mentee and my own attempts to understand the mentorship process.

First, be willing to ask for help. It is necessary to identify exactly what one requires to achieve one's goals and to be able to ask for the skills, knowledge, and opportunities to make these goals

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listened to his lecture and said to myself, "Wow, this is great. He is talking about health care delivery, but he is referring to all this research and quoting data like our basic science professors do." I didn't realize that medical school professors could do research on health care just like they did on biochemistry.

I had another lucky accident during my residency at Penn, where I had done a few research projects on trying to improve residents' use of laboratory tests. I really liked this health services research stuff, and read about it when I could. I had read some articles on measuring quality by a guy named Robert Brook and found out that he had worked at the National Center for Health Services Research (NCHSR), which was a predecessor agency to AHRQ. So I visited NCHSR, just outside Washington, and asked if I could sign up for a post-residency position. I was told they didn't need any more doctors. It didn't feel like it then, but that rejection was really a lucky break. Serendipity had struck again, if only I would be able to recognize it.

I went back to Penn with my tail between my legs, and another lucky accident fell my way. My medical clinic director, Helen Smits, suggested that I see a new guy on the faculty at Penn named Sam Martin, because she had heard that he was applying for some kind of fellowship grant. My residency director, Sam Their, and the chair of medicine, Arnold Relman, said that they would make the rest of the residency flexible, so that I could start the fellowship early if Penn got the grant. More serendipity.

So I went to Dr. Martin, and he told me that he was applying for funding from the Johnson Foundation for something called the Clinical Scholars Program. He asked if I would show up at the site visit to prove that Penn could get some internal applicants. Then he asked if there were any other residents who might be interested. I said, "Yes, there is the chief resident, Sankey Williams. I think he would come." The site visitors, including Suzanne Fletcher, showed up, I think sometime in the fall of 1974, and Penn got the Clinical Scholars grant. What a lucky accident!

We thought we were lucky, but some at Penn thought otherwise. I recall three subspecialty division chiefs at Penn who admonished me, "John, you are making a big mistake. You are throwing away your career with this academic general internal medicine stuff. You need a subspecialty fellowship." I realized that I was taking a chance, but this is what I wanted to do. And I was lucky enough to have a chance to do it—to do health services research and to practice and teach primary care internal medicine. I was so lucky!

A chemistry professor in college used to end each semester with a lecture that he titled "Great Discoveries, Lucky Accidents, and the Prepared Mind." I thought about keeping my mind prepared for those lucky accidents, and realized that the discovery I sought most was to learn what would make me happy professionally.

One of my luckiest accidents was being a young faculty member in academic general internal medicine in the late 1970's and being able to participate in the establishment of this Society. As a senior resident I attended a meeting on May 3, 1975, at the Annual Meeting of the American Federation for Clinical Research, chaired by Frank Davidoff, where Tom Delbanco, Bob Lawrence, and John Noble presented a proposal for a new organization. It was clear from the beginning that the new society would welcome teachers, researchers, and practitioners in primary care internal medicine.

Lucky accidents continued. I was invited to present the proposal for the new organization to the American College of Physicians (ACP) at a meeting on August 22, 1977. The Johnson Foundation had told us we would have a better chance of getting a grant to start the organization if we hooked up with the ACP. The ACP leaders insisted that the term "internal medicine" be in the new organization's title and urged that the title say "research *in* education," not "research *and* education in primary care internal medicine." Their intent was that we avoid doing research on controversial and politically charged topics like health care delivery. Well, we figured, let's take that chance, and it was to be the Society for Research *and* Education in Primary Care Internal Medicine, which we fondly called by an acronym that could stick in your throat, SREPCIM. Some suggested that the new organization be a chapter of the ACP. Others advocated independence of any existing organization.

Not too much later, on November 21, 1977, I received a letter from Bob Lawrence, asking me if I would be the Project Director on the grant from the Johnson Foundation to create the new organization. I am pretty sure that he asked because my office was within walking distance of the ACP offices in West Philadelphia.

By December 1977 we were negotiating with the Johnson Foundation. Vice-President Lee Cluff wanted to be sure we weren't just a pass-through in the ACP budget, but that there would be a serious acceptance of responsibility on the ACP's part to foster academic general internal medicine. Some in the ACP, we were told, feared that they had "spawned a monster." But there was also support in the ACP. Supporters like Ed Stemmler, Dan Federman, and Truman Schnabel urged that we incorporate separately but get help from the ACP administratively. The ACP lawyers helped us write bylaws and explore getting tax-exempt status.

The inaugural meeting of the new society, SREPCIM, the Society for Research *and* Education in Primary Care Internal Medicine, was held in April 1978 in San Francisco, and the

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SREPCIM Council first met in October 1978.

Bob Lawrence, SREPCIM's first President, and Sankey Williams, the first newsletter editor, were two of those who worked on the bylaws, which were presented to the membership at the second Annual Meeting, on May 4, 1979.

For 23 years we have had a family reunion in the spring, an opportunity to celebrate our common commitment to quality care of the entire adult, what is now called patient-centered care. Annually, we celebrate our dedication to the scholarship that is needed to promote that care—both scholarly research and scholarly teaching—as well as the thoughtful policy advocacy that is needed to promote high quality primary care research, education, and clinical practice

In 1983 I gave the SGIM President's Address, and I recently re-read that talk. I still believe what I said then, that the research of general internal medicine and other primary care disciplines is rooted in a different set of basic sciences than that of most other clinician-researchers. I said that, "Scholars in general internal medicine have added additional basic sciences—the basic social sciences and the basic quantitative sciences. The research of academic general medicine is rooted in fields such as sociology, psychology, and economics, in statistics, epidemiology, decision sciences, and operations research. In addition, much research in academic general internal medicine relies heavily upon fundamentals of the humanities…. The task of general internists is to be educated well and to apply these new basic sciences to topics of importance in health care."[1]

When Sankey called to tell me about this award, I was, of course, incredibly flattered and wondered if my research could have had enough impact to justify the award. My next thought was to think about a challenge we are facing at AHRQ, that is to demonstrate the impact that the research we sponsor has had on outcomes, costs, quality, or access. But sometimes it is hard to tell if there has been an impact, and sometimes the impact is surprising. I am reminded of my mother's first cousin, who won the Nobel Prize a couple of years ago. Years earlier, Robert had realized that a laboratory technician's mistake had serendipitously revealed the presence of an agent that Robert called endothelial releasing factor, which he later identified to be nitric oxide. But when he read the newspaper articles about his Nobel award, he read that he got it because his discovery had led to the development of Viagra. The papers made the case that the Nobel Prize was being given for Viagra, when Robert had been proud of his basic discovery of nitric oxide.

Impact is hard to come by in research, especially long-term impact. I learned that the hard way when I did a project as a resident that showed the protime not to be useful as an admission screening test.[2] I tried to reduce the use of screening protime testing for routine admissions to the Philadelphia VA Hospital. After an educational program, the residents did decrease their use of the admission protime from 78% all the way down to 55%, but after the educational program ended, the level of use bounced right back up to where it had been, up to 75% of admitted patients getting a protime.[3] I am grateful to John Murphy, chief of general internal medicine at the Philadelphia VA , who checked the rate of screening today, and it is now 72%. So, our research may have impact for a while… but impact, like fame, may be fleeting. I learned from that project and others, especially with Sankey Williams, how difficult it is to improve clinical practice, how education alone is rarely sufficient, how we need to use multiple interventions, how important clinical opinion leaders are, and how necessary repetition and continuation of the change process are for a lasting impact.[4, 5] The researchers, teachers, and practitioners assembled here—and many of you are all three—understand that the generation of knowledge alone is important, but it is especially important to translate research into practice.

As an academic discipline, I see general internal medicine as a bridge, a bridge between research and practice. It is our responsibility, as members and as an organization, to assure that the bridge is firmly planted at both ends… excellent clinical care and outstanding research, with a commitment to education that helps to bridge the gap between the quality of care that our nation can provide to all Americans and what is being provided.

So I guess you can see why I like our new name so much. The Agency for Healthcare Research and Quality is an "AHRQ," an arc that bridges the gap, or even the chasm, as the Institute of Medicine put it, "between the care we have and the care we could have."[6] And that is why I am proud to be called "John of AHRQ."

You know, when you bestow an award like this today on an individual, it is really an award for all those with whom he has worked—his mentors, his colleagues, and his students. And it is also an award for his family, who have influenced him and supported him in so many ways. So, on behalf on all my co-honorees… thank you!

I mentioned how hard it is to measure the impact of our research, but the impact that we have on each other is easier to recognize. I know that so many of you have had an important impact on me, and I thank you for it. I have been so lucky!

As I accept this award today, I want to thank you for being my academic and professional family. It has been and continues to be great fun. I hope that when you ask yourself, "Am I having fun?", you can answer every day with a definite "yes." And if you can say, "yes," I hope that you recognize how blessed you are. I am reminded so often of how lucky I have been, and how much our careers are made of hard work, but also

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of luck and serendipity.

Ours is such a wonderful field and such a fulfilling way to spend a career. For all of us, and especially for those entering academic general internal medicine, the research prospects are bright. The people of this country are asking about the quality of their care and its safety, about access to care, about disparities among races, where one lives—rural, inner city—and for those with disabilities, about the cost and the value of health care. The nation wants to know. And we are the ones who can find the answers to their questions.

So when then the next medical student comes to you for advice, tell her what the options are, but then say, "I have told you what choices you have. But let luck happen. Be ready, take chances, and do what you love to do."

I do love what I do, and I am confident that most of you can say the same. How fortunate we are, and how ironic it is to accept an award from you for just having had a few decades of fun. Thank you. **SGIM**

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possible. Developing a personal vision statement and writing a plan are excellent exercises. Books such as *The Seven Habits of Highly Effective People*[5] can help. Make bold and audacious goals. Then communicate these goals clearly. Minority mentees may also want to discuss such life goals with important people in their community, not only other physicians, but pastors or businesspersons, before presenting these goals to a mentor. The reinforcement and encouragement from those in one's own community may make it easier to articulate these goals to a mentor from another culture.

Second, a mentee will need to evaluate him- or herself as a mentee. A trusted member of one's family or community can give important feedback on one's general strengths and limitations, such as level of initiative, defensive behaviors, lack of listening skills, or reliance on less direct forms of communication to communicate one's needs. These strengths and limitations impact any relationship. They can be more crucial if one's communication style differs from that of one's mentor. I've found that getting feedback from an intuitive and articulate member of the majority community is very helpful. Young minority faculty do well to seek out feedback among majority peers to test for possible differences in interpretation of body language, verbal communication, and relational attitudes.

Lastly, but most importantly, choose a mentor, actually several, to be exact. No one person could hope to meet all the current professional needs of a clinician, educator, or investigator. Our roles are multi-dimensional. Such complex issues as overall goals and trajectory can be best handled by senior members in the faculty, while younger, more accessible members can act as informal mentors, especially on short notice or for very specific issues. Peers can be mentors as well; this emphasizes the point that the mentoring relationship, just like any, is best when it is reciprocal. This reciprocal balance is hard to achieve. While one can sometimes think that one's ethnic background contributes to the difficulty one encounters finding or relating to a mentor, the key is to remain resilient and to continue pursuing mentors. Mentorship is complex, not easily discussed, and like any relationship, takes tremendous work. However, understanding the process better can lead to remarkable opportunities for growth.

In addition to many informative published references, two useful websites on mentoring are **www.peer.ca/mentor.html** (lists many resources on mentoring and a test for mentors) and **www.mentoring-resources.com.** Currently, the AAMC sponsors Minority Faculty Career Development Seminars, which are targeted toward underrepresented junior faculty who wish to pursue positions of leadership in academic medicine. These seminars, among other opportunities, can improve one's skills and help in gaining desired mentoring. **SGIM**

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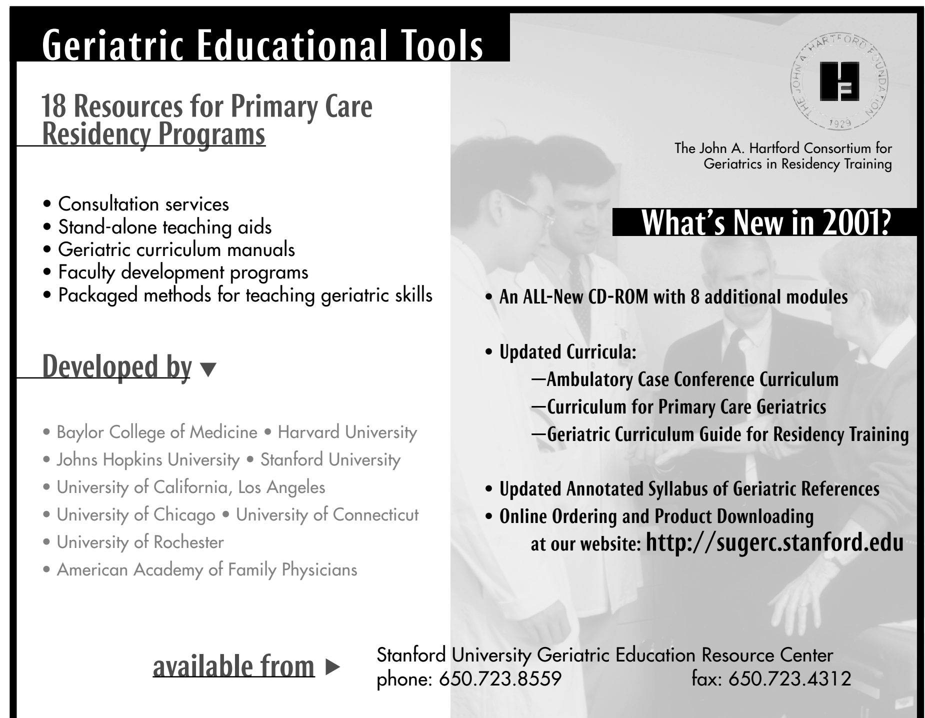

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