Society of General Internal Medicine

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

SGIM FORUM

Volume 24 • Number 12 • December 2001

# YOU CAN MAKE A DIFFERENCE

*Thomas Inui, ScM, MD*

In May 2002, the Society of General Internal Medicine will convene its 25th Annual Meeting. This anniversary will mark a quarter century of annual gatherings devoted to fellowship, scientific presentations, skill development in an amazing array of workshops, and exhibits bursting with new ideas and resources. When we reach this kind of milestone in our history, we should pause to reflect on our accomplishments, while we embrace the challenges and opportunities of our future.

Members describe SGIM as their professional home. I personally understand and subscribe to this notion. SGIM is a remarkable mosaic of diverse people, commitments, opportunities, and activities. Through this diversity, the Society fosters an environment in which members feel affirmed, enriched, challenged, and inspired. Under all circumstances, SGIM members exhibit unyielding respect and admiration for each other and are driven by a desire to be part of an organization with activities of significance to public health. We come together for many reasons; we may stay together because we also seek to integrate our personal and professional lives.

In the early days of our Society, the principal assurance of a robust future was no more than the glow in the eyes of those members who gathered together. We were relatively few in number, but we realized that this Society could become anything we wanted it to be. Prior to SGIM, we had found only a partial expression of our interests in other, pre-existing professional associations. This was a chance to forge, with the resources of our combined energy and vision, a Society that could encompass a dedication to education, research, health policy, and social action across the broad range of topics that are intrinsic to the domain of primary care. Amazingly, the Society thrived on such ambitions, in spite of the demand it placed on available resources. Like a snake that shed its skin as often as it needed to, while occasionally ingesting a big meal, we stretched and grew, adding members, meeting days, affiliations, regions, projects, publications, task forces, and interest groups.

Fifteen years ago, while SGIM President-Elect, I grew interested in learning more about how professional societies in medicine secured their financial well being. At the time, SGIM was living hand to mouth, supported solely by the annual dues and meeting registration fees of a growing membership. Our "reserves" were those funds that remained at the bottom line at the end of the year. There was a real risk that we wouldn't be able to make good on our commitments to ongoing activities (e.g., newsletter, council retreats, awards) if the meeting registration fell for any reason. Even planning to hold the Annual Meeting on the West Coast, for this reason, felt like taking a significant financial risk! When I conducted an admittedly unscientific poll of fellow medical society presidents, I was even more sobered. The smallest, youngest SGIM peer had reserves equal to twice

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# Christine Cassel Named Dean at OHSU

*David R. Calkins, MD, MPP*

Christine Cassel, MD, MACP, has been named Dean of the School of Medicine, Oregon Health & Science University (OHSU), effective January 1, 2002. She will be the school's 13th dean and the first woman to hold the position. Dr. Cassel is currently professor and chair of the Henry L. Schwartz Department of Geriatrics and Adult Development at Mount Sinai School of Medicine in New York City. She also directs the Geriatric Research, Education and Clinical Center at the Bronx Veterans Affairs Medical Center (VAMC).

Dr. Cassel has made important contributions in geriatrics, health policy, and medical ethics. She is a member of the Institute of the Medicine (IOM) of the National Academy of Sciences and serves on IOM committees related to quality of care and medical errors. She is past president of the American College of Physicians, past chair of the American Board of Internal Medicine, president-elect of the American Federation of Aging Re-

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# A Call for Papers: Community-Based Participatory Research

*Kaytura Felix Aaron, MD, and Eric B. Bass, MD, MPH*

In 2002, the *Journal of General Internal Medicine* (JGIM) will publish a special issue devoted to community-based participatory research (CBPR). This model of research emphasizes active involvement of community representatives and organizations in all stages and aspects of the research process as a means toward generating highly relevant findings in a manner that is ethical and beneficial to those involved. The special issue will highlight some of the outstanding work that is being done in this area and the role that it can play in improving the care and outcomes of populations at risk.

While participatory research has existed for some time in many fields, its role has been less accepted in clinical and health services research. Increasingly, however, researchers and policy makers are recognizing the value of meaningful involvement of patients, their relatives and neighbors, and local organizations.[1] The first-hand experiences and contextual understanding of community members complement the skills and knowledge of researchers and often enhance the relevance and usefulness of research findings.[2] Community members and patients often will be able to articulate priority areas and identify which questions should be

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# POLARITY MANAGEMENT

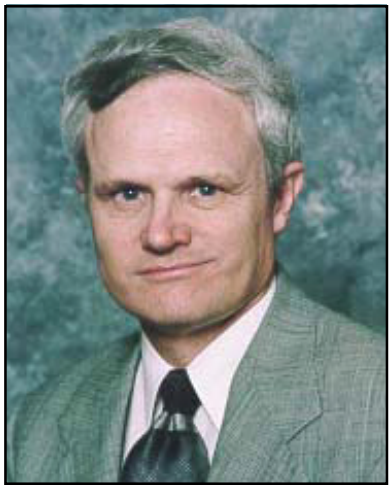
*Kurt Kroenke, MD*

***"Plurality which is not reduced to unity is confusion; unity which does not depend on plurality is tyranny." —Blaise Pascal***

In this quote, Pascal captures the tension between plurality and unity that characterizes complex deliberations in families, academic units, businesses, professional organizations, or any group whose members share at least some common aims. Complex deliberations often circle around two or more "right" answers, in contrast to simple decisions where obvious answers emerge efficiently as well as consensually. Although one choice may clearly be perceived as more "right" at the level of individual decision-makers, differences of opinion are divided enough at the corporate level to create rather intense debate. SGIM wrestled with one such issue for the past year and, in the process, discovered a lot about the equipoise between plurality and unity. I want to report briefly on the rationale underlying a recent Council decision and, in particular, share a few lessons I've personally learned about "polarity management."

## The ATRC Decision

In late 2000, SGIM received a one-year, industry-sponsored grant to support the initial development of the Anticoagulation-Thromboembolism Research Consortium (ATRC) and its Web-based data collection software. Arising as a grassroots initiative out of a long-standing SGIM interest group, the ATRC wished to develop a patient registry for observational studies that would involve multiple SGIM collaborators, including aspiring junior investigators with limited local resources or external funding. Subsequently, we have published a series of articles in the *Forum*, held a meeting with members at the 2001 Annual Meeting, solicited feedback from all members by e-mail in September, and held a special Council retreat in October. Much of the background is summarized on our Web site (**www.sgim.org/Publicweb/SGIMFeature0901.htm**).



The Council has decided to transfer ownership of the software as well as any remaining grant monies to an institution identified by the ATRC. SGIM is committed to serving as a facilitator for small group collaboration, but has not previously been involved in clinical research. That is why the Council approved SGIM administration of the developmental phase of ATRC but concluded that actual operation of the patient registry would best be done by ATRC independently of SGIM. Some of the research-related concerns include the growing complexity of regulatory and IRB issues, distraction from other SGIM core missions, and the possibility that research conducted within SGIM (even when done collaboratively) might compete with research done by individual members.

Why did the Council apparently change its mind? The ATRC did a remarkable job of responding to every request for policies, guidelines, operat-

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*.
*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 Preview

# Committee Expands Categories for Scientific Abstracts

*Judith M. E. Walsh, MD, MPH, and Robert M. Centor, MD*

We are very excited about the Annual Meeting in Atlanta, Georgia, May 2–4, 2002. As co-chairs of the Abstract Selection Committee, we invite all SGIM members as well as non-members to submit one or more abstracts. We are celebrating the 25th anniversary of SGIM, and this year's theme is "The Next 25 Years: Emerging Issues for Generalists."

We have expanded the number of categories this year. Categories include:

- Clinical Medicine
- Disease Prevention
- Clinical Epidemiology
- Disparities in Health
- Health Services Research
- Geriatrics
- Women's Health
- Medical Education
- Decision and Cost-effectiveness analysis
- Qualitative Research
- Ethics/Humanities/History of Medicine

The submission guidelines will be included in the Call for Abstracts and will describe each category in detail. Abstracts will be presented in either the Plenary Oral Session, which features six of the highest rated abstracts; a special Theme Plenary Oral session, featuring abstracts exemplifying emerging issues; or in several oral abstract and poster sessions.

One new innovation will be special sessions featuring the Lipkin and Hamolsky Award abstract presentations. These presentations will occur on Friday, May 3, 2002. Therefore, we will be able to present the awards for the best student presentation and best postgraduate presentation at our second plenary session.

As noted in the October issue of the *Forum*, the 2002 Annual Meeting will feature abstracts in qualitative research and studies in medical humanities and ethics. At both the 2000 and 2001 Annual Meetings, sessions featuring these topics attracted sizable audiences and generated stimulating discussion. These sessions have been greatly enhanced by the submission of a wide range of abstracts. So please submit them! Those labeled qualitative research should include abstracts in ethnography, anthropology, phenomenology, grounded theory, or case studies. Please direct any questions or suggestions to Jane Liebschutz (**jliebs@bu.edu**). Abstracts submitted in medical humanities and ethics should cover topics such as the history of medicine, literature, and non-quantitative ethics, such as work in philosophy or theology. Comments about these subjects should be addressed to Barron Lerner (**BHL5@columbia.edu**).

Submissions will again be done on line via computer submission. We have revised and refined the process and believe that this submission process offers great advantages. Detailed instructions about the computer submission will be included in the Call for Abstracts.

Submitted abstracts will be published in the *Journal of General Internal Medicine*. About 50% will be presented at the Annual Meeting. All abstracts must be received by 4:30 p.m. EST, January 9, 2002.

Past abstract presentations at SGIM have highlighted important issues that have advanced medical care. We hope that you will submit your best work to our meeting to enhance the scientific quality of the SGIM meeting. Questions about abstracts may be directed to Judith Walsh (**jwalsh@medicine.ucsf.edu**) or Robert Centor (**rcentor@uabmc.edu**). *SGIM*

# One-on-One Mentoring Program Offers Career Guidance

*JudyAnn Bigby, MD, and Marshall H. Chin, MD, MPH*

Very few successful individuals limit themselves to one mentor throughout their professional lives. It is better to build a personal mosaic of influences, experts, and guides, as one can learn different things from each mentor. Mentors can serve as coaches, counselors, sponsors, protectors, and role models and can provide friendship, validation, and opportunities for exposure.

The One-on-One Mentoring Program at the Annual Meeting gives individuals the opportunity to develop one of the many relationships that can help shape their careers. Mentors and mentees are matched based upon mutual interests and expectations. The mentor-mentee pair meets in-person during the Annual Meeting, with the option of continuing the relationship beyond that time. While mentoring is often viewed as an ongoing relationship with an individual in close proximity, past participants in SGIM's program have found this opportunity to be worthwhile and important in helping them sort out important career decisions and dilemmas. The program can help students, residents, fellows, junior faculty, or mid-life faculty looking for a new challenge or change in career.

Mentees should prepare for their meeting with their mentors by developing a clear agenda for the session. Clarity will enable mentees to avoid vague, general responses to their requests. Are you looking for someone to review your CV in a constructive way? Do you need help meeting key individuals in your field of interest? Do you need advice on a specific project or paper? Do you have a conflict in your current setting that an outsider can evaluate objectively? Are you at one of the natural transition points in your career and need some advice about

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# RESEARCH FUNDING CORNER

*Joseph Conigliaro, MD, MPH*

This month's Research Funding Corner highlights two requests for applications (RFAs) from the National Institutes of Health (NIH): one dealing with the placebo effect and the other with the prevention of obesity. Additional information about each RFA can be obtained at the Web sites provided.

## The Placebo Effect in Clinical Practice

On October 26, 2001, the National Center for Complementary and Alternative Medicine (NCCAM) released a new RFA, "The Placebo Effect in Clinical Practice" (RFA-AT-02-001). The deadline for letters of intent is March 1, 2002. Applications must be received by April 11, 2002.

Placebo effects are positive physiological or psychological changes associated with inert medications, sham procedures, or therapeutic measures in health care. They can also be active substances or real procedures that produce unexpected benefits. Placebo effects can also be mind-brain-body effects from religious beliefs and devotional practices; meditation; faith-based healing; hypnosis; and the effects of cultural, social, and economic systems on the prevalence and severity of specific diseases. Prior research has scientifically documented these effects. The purpose of this initiative is to stimulate research on how placebos and placebo effects impact on clinical practice and what factors are necessary to elicit a placebo effect in clinical practice so that the benefits of the therapeutic intervention can be enhanced to improve health and promote wellness.

Understanding how to enhance the therapeutic benefits of placebo effect in clinical practice has the potential to significantly improve health care. The objectives of this initiative are to encourage interdisciplinary studies involving social and behavioral sciences as well as other appropriate scientific disciplines to reveal those factors that are important for eliciting placebo effects in a clinical practice setting.

Research questions to be addressed by this RFA include the following: What are the tools that can be used to elicit the placebo effect? What is the role of cultural beliefs and social and economic systems in eliciting the placebo effect in clinical practice? What are the ethical questions to be considered when using placebos in clinical practice? How can different types of health care providers maximize the placebo effect, and thus potentiate the healing effects of interventions? Are complementary and alternative medicine practitioners better at eliciting placebo effects to enhance actual therapeutic interventions than conventional practitioners? NCCAM is particularly interested in systematic studies to determine what psychosocial factors in the patient/health care practitioner relationship and in the health care environment are important for eliciting placebo effect, such as shared beliefs, hope, expectancy, meaning response, and conditioning. Studies also can investigate the specificity, timing, and size of placebo effects in relation to different disease conditions, medical interventions, and social contexts.

Several NIH institutes and centers have joined NCCAM to support this initiative. Examples of specific topics of interest to individual NIH institutes and centers are listed in the complete RFA (**grants.nih.gov/grants/guide/rfa-files/RFA-AT-02-001.html**), along with contact information for each participating NIH institute and center.

This RFA uses the NIH R01 and R21 award mechanisms. NCCAM intends to commit approximately $1.13 million in total costs in FY 2002 and/or FY 2003 to fund four to six new grants. In addition, other institutes intend to contribute approximately $1.06 million in FY 2002 and/or FY 2003 to fund additional grants applications that respond to this RFA. Finally, NIAAA, NIAID, NIDDK, and NIMH may provide support to other meritorious applications that fit their program objectives.

## Environmental Approaches to the Prevention of Obesity

On October 26, 2001, several NIH institutes released another RFA, "Environmental Approaches to the Prevention of Obesity" (RFA-DK-02-021). The deadline for receipt of letters of intent is February 14, 2002. Applications are due March 14, 2002.

Obesity is the most common nutritional disorder in the U.S. Its prevalence is increasing in both children and adults.[1-3] It is particularly common among minority populations and women.[4] While genetic factors may account for a significant proportion of population variability in body weight, environmental factors may account for most variability in body weight between populations or over time.[5] Although genetic approaches may eventually lead to improved efforts in prevention and treatment, it is unlikely that addressing genetic factors alone will overcome environmental pressures for over-eating and sedentary behavior among Americans.[6]

This RFA responds to the need for research on environmental approaches, such as those that modify the external surroundings to effect behavioral changes. These include improvement in diet, increased physical activity, and decreased sedentary behaviors. There

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# THE INITIATIVE TO IMPROVE PALLIATIVE CARE FOR AFRICAN AMERICANS

*LaVera Crawley, MD*

African Americans suffer disproportionately from serious, chronic, and eventually fatal diseases—often presenting late with a higher degree of symptom burden. Yet, when many minorities do seek medical care, they may face race-based health disparities that further compound the problem. These disparities, ranging from lower referrals for appropriate diagnostic and therapeutic services to the inability to receive adequate treatment for pain, have been the subject of numerous studies in the last decade. For example, in studies on pain in nursing homes, emergency departments, and cancer centers, pain severity was more likely to be underestimated and effective analgesia less likely to be prescribed for blacks and Hispanics as compared to whites.[1-5] In addition, access to opioids for relief of pain may be limited for patients residing in some minority neighborhoods.[6]

The failure of the health care system to meet the needs of blacks and other minorities may explain, in part, the resistance of some African Americans to palliative and end-of-life care. In order to address barriers to the use of palliative care services by minorities, Dr. Richard Payne, Director of the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center in New York, recently established the Initiative to Improve Palliative Care for African Americans (IIPCA). The goal of IIPCA is a society where African Americans who are facing serious and potentially fatal illnesses have knowledge of and access to state-of-the-art palliative and hospice care. IIPCA seeks the elimination of racial and socioeconomic disparities that limit knowledge and access. IIPCA receives funding from the Open Society Institute's Project on Death in America. I serve as IIPCA's Executive Director.

The IIPCA agenda is to define and promote a research, education, and policy agenda and to build coalitions among organizations and stakeholders in the African-American community with other palliative care groups. To date, the activities of IIPCA have included presentations and networking with the NAACP, the Congressional Black Caucus Health Brain Trust, the National Medical Association, and the National Black Nurses Association.

**IIPCA seeks the elimination of racial and socioeconomic disparities that limit knowledge and access.**

Publications have included commentaries for the *Journal of the American Medical Association*,[7] and a special issue of the on-line journal, *Innovations in End-of-Life Care*.[8]

In January 2002, IIPCA will hold its first annual forum to identify historical, cultural, clinical, and health policy barriers to palliative care for African Americans. The theme of the forum, "Heritage, Health, and Hope," acknowledges the positive strengths and hopes derived from a rich African-American heritage and the desire to employ those strengths toward improving the health of the community. The event will be moderated by Juan Williams, former host of Nation Public Radio's "Talk of the Nation" and award-winning author of *Eyes on the Prize: America's Civil Rights Years, 1954-1965*. Speakers include Harold Freeman, Director, Center to Reduce Cancer Health Disparities, National Cancer Institute; M. Brownell Anderson, Senior Associate Vice President for Medical Education, Association of American Medical Colleges; and Joanne Lynn, Director, RAND Center to Improve Care for the Dying.

The invited speakers and participants for this national forum were chosen for their strategic ability to leverage change through their respective organizations. They represent leaders, stakeholders, and constituents who are either from the African-American community or in positions to influence that community. The forum will enable organizations and individuals that desire to foster change in this area to network with these leaders and other organizations. The meeting will complement other events to be held later in the year by the Tuskegee Bioethics Center. Further information is available on the IIPCA Web site (**www.iipca.org**) or through the IIPCA national office (address: North General Hospital, 1979 Madison Avenue, New York, NY 10035; telephone: 212-423-1595). *SGIM*

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## *MAKE A DIFFERENCE*

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their annual operating budget, and one society had reserves that exceeded seventeen times their annual budget.

All SGIM members know that our present situation isn't as precarious as it was in those days of yore. It is still the case, however, that the growing appetites of our members for innovation exceed the Society's capacity to generate new sources of revenue. Complicating the situation is the realization that not all types of revenue are equal in our eyes. SGIM learned—in its recent, intense, and important discussion regarding the pros and cons of accepting industry support for SGIM programs—that we have a built-in "values compass" that makes the development of necessary resources especially challenging.

One critical approach to meeting this challenge is securing personal, voluntary financial support directly from SGIM members. Regardless of where you stand on the issue of external funding via foundations, government grants, or corporate donations, it is safe to assume that no SGIM member wants the Society to become radically dependent on non-member revenue. SGIM should be able to support itself through dues, Annual Meeting registration fees, and member contributions, with supplemental outside funding under appropriate circumstances.

SGIM is responding to the challenge of developing a balanced slate of resources by launching the "Make a Difference" Campaign: SGIM's first-ever organized effort to solicit personal contributions from members. If you haven't already received a mailing describing the effort, you will soon be getting a brochure that explains the purpose and principles of the Campaign.

The "Make a Difference" Campaign is broad in scope, aiming to provide a foundation of support for SGIM programs that benefit senior faculty, junior faculty, fellows, and residents. When you make your contribution, you can direct your funds to one of the following programs:

- John M. Eisenberg National Award for Career Achievement in Research
- Research and Education Mentorship Program
- Resident Presentation of the Year Award
- Associate Annual Meeting Scholarship Program
- Mary O'Flaherty Horn Scholars in General Internal Medicine Program
- General Support (allows SGIM to use your contribution where it is needed most)

For more information about the programs that will benefit from the "Make a Difference" Campaign, please visit the SGIM Web site (**www.sgim.org**).

Making a personal contribution is your opportunity to solidify your commitment to SGIM, in return for the many ways in which the Society has helped you to develop professionally while advancing your career. Do this because the Society expresses your professional values and will continue to create opportunities for you and for those who follow in our lineage: our fellows, residents, and students. Do this because we work for the health of the public, not a narrow disciplinary constituency. Do this because your personal investment confirms your commitment to SGIM – an organization that has provided so much to its members over the years. Make a donation, make a difference!

SGIM is a 501(c)(3) nonprofit organization. Your contribution is tax deductible. Contributions are accepted via check, money order, or credit card. For information on donating stock and the tax benefits of stock donations, please get in touch with Bradley Houseton, SGIM Development Director. ***SGIM***

***Editor's Note***—*Dr. Inui is Chair of SGIM's "Make a Difference" Campaign.*

## *CASSEL NAMED DEAN*

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search, and is chair of the board of the Greenwall Foundation, which supports work in bioethics. In addition, she serves on the Advisory Committee to the Director, National Institutes of Health, and was a member of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. In 1999 she delivered the Malcolm Peterson Honor Lecture at SGIM's Annual Meeting (*Forum*, August 1999).

Dr. Cassel received her bachelor's degree from the University of Chicago and her MD from the University of Massachusetts Medical School. She did postdoctoral training at Children's Hospital of San Francisco, the University of California-San Francisco, OHSU, and the Portland VAMC. Before joining Mount Sinai she taught at the University of Chicago. ***SGIM***

## *PALLIATIVE CARE*

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ing procedures, and legal opinions. The Council was unanimous in its praise for the diligence and innovation of the ATRC. Indeed, the ATRC serves as a model of what SGIM interest groups can accomplish given a common passion and strong leadership. What ultimately emerged from Council deliberations is the yet-to-be-resolved issue of whether SGIM's role is to be an incubator for new research projects or a permanent home for them. In particular, there is not yet consensus on the issue of whether human subjects research should be conducted under the auspices of SGIM, even purely observational studies using patient registries with identifiers removed and approved by the IRBs of collaborating investigators. One reason is the continuously changing and uncertain landscape of regulations governing clinical research.

Council also considered whether the pharmaceutical funding for this project met SGIM's explicit policies that guide acceptance of external funding from a variety of sources (including industry) for programs aligned with our core missions. An External Funds Task Force is currently reviewing these policies and preparing recommendations for Council deliberation in February. The Council's decisions will be published in the *Forum* for feedback from members and discussed at a meeting with members at the 2002 Annual Meeting in Atlanta. SGIM continues to look at pharmaceutical funding as one source of external funds for initiatives that stay within our current guidelines.

## Principles of Polarity Management

What we learned is that on certain key issues (e.g., SGIM's role in coordinating clinical research and acceptable sources of funding), our organization has a diversity of viewpoints. There is not a single voice but rather a plurality of opinions. I addressed this briefly in a July *Forum* article entitled "Yin and Yang." Tony Suchman and Rich Frankel—SGIM members and facilitators at the October retreat—introduced Council members to the principles of polarity management, developed by Barry Johnson (© Copyright, Polarity Management Associates, 1998). I'd like to share a few highlights of Johnson's writings (for more detail, go to **www.polaritymanagement.com**), because his principles apply not only to a professional society like SGIM but also to many of the organizations, groups, and other "social contracts" in which we are all engaged.

Johnson estimates that 95–99% of the problems we are asked to solve in formal education are "either/or" problems with a single right answer. Examples include:

- Language: How do you spell _____?
- Mathematics: 4+4 = _____?
- History: The first president of the United States was _____?
- Science: Why do apples fall down from trees rather than up? _____
- Morals: According to the Ten Commandments, murder is right ___wrong ___?

In contrast to either/or problems, polarities have two or more right answers that are interdependent. Johnson uses, as one example, how parents teach their children to share. The process of sharing is a polarity issue because it involves two interdependent, right answers to the problem: "In my relationship with this childhood friend, should I be concerned about her, or should I be concerned about myself?" If I just take care of her and neglect myself, it won't be a very satisfactory relationship. If I just take care of myself and neglect her, it won't be a very satisfactory relationship. Sharing is a response to a polarity. In a relationship we need to pay attention to our own needs, and we need to pay attention to the other's needs.

Figure 1 provides one example of what Johnson calls a "polarity map." While SGIM members might see this as a variant of the familiar two-by-two table, there are in fact eight pieces to the "map." There are two "neutral" boxes at either end of the central, horizontal axis (in this case, Caring for Others vs. Caring for Self). There are two "upside" boxes above the neutral names in which you put the positive results of focusing on each of the poles. There are two "downside" boxes below the neutral names in which you put the negative results of over-focusing on one pole to the neglect of the other. The box on top is for the Higher Purpose. This contains the answer to the question, "Why invest in managing this polarity?" The answer goes beyond getting the upside of each pole. Instead, balancing Caring for Others and Caring for Self might hopefully lead to a Life Well Lived. The box on the bottom is for the Deeper Fear. This is usually the opposite of the Higher Purpose and represents the worst-case situation if the problem is not managed and one pole is emphasized to the detriment of the other. Finally, the two diagonal arrows illustrate that successful polarity management requires that the organization recognize when it has drifted toward the lower left or right hand corners of the diagram. This usually results from over-focusing on one pole to the neglect of the other. When this happens, the organization should "re-equilibrate" by trying to navigate a path toward either the upper right corner or the upper left corner.

## Polarity Management in SGIM

The proper role of external funding in support of SGIM activities is an example of a polarity within SGIM. SGIM has explicit policies guiding acceptance of external funds. Modest industry support has been received in the past decade for various educational programs, awards, the Annual Meeting, and other activities. Unlike many other professional organizations, SGIM relies on external sources for only a small proportion of its revenues and, instead, depends upon members' dues and meeting fees for over 80% of its annual budget.

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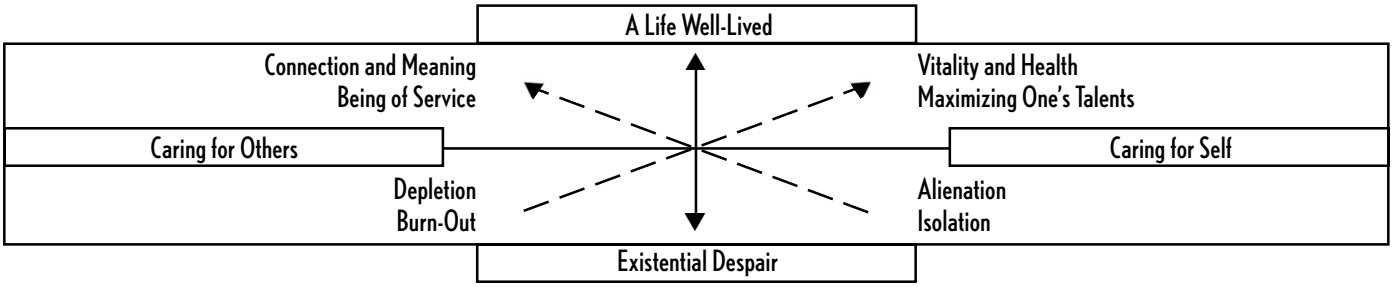


***Figure 1. Example of a polarity map (prepared with the assistance of Tony Suchman).***

Figure 2 illustrates the tension between maximizing external funding resources (particularly those that may come from industry) and maintaining cohesiveness among our members. There are upsides and downsides to a predominant focus on either pole. In a polarity management approach, SGIM would navigate the two polarities judiciously—gauging and respecting the diversity of viewpoints held by its 3,000 members.

The principles of polarity management extend well beyond a particular group decision or even a particular group. Wherever there is a complex decision and an "n greater than one," polarities readily surface. Polarities should not paralyze a group from making a given decision nor fracture the group. However, because each pole typically represents an acceptable answer for a certain portion of the group, polarities seldom evaporate after a decision. Indeed, their persistence coupled with collaborative management empowers rather than weakens the group. Ideally, the group does not dwell exclusively in either the upper right or upper left box, but instead maintains an intentional and dynamic equilibrium between the poles. In the words of Johnson: "It is possible to manage a polarity well. When you do, you maximize both upsides while minimizing both downsides. This helps you attain and sustain your higher purpose."

I recently heard Walt McDonald, President of ACP-ASIM, say that only two of the top 100 businesses from a century ago are still in the top 100, and they are in a different product line! Indeed, Barry Johnson describes a series of studies documenting that "organizations that tap the power of polarities out perform those that don't." One example he cites is *Managing on the Edge* by Richard Tanner Pascale. In this book, Pascale reports his five-year follow-up study of 43 companies identified in *In Search of Excellence*. He discovered that 14 companies retained their "Excellent" rating, while 29 did not. The key factor that distinguished the 14 persistently excellent companies was that they managed seven polarities better. Pascale calls it "managing contention."

SGIM will strive to be one of those organizations that successfully manages polarities. Progress and sustainability are the outcome of decision making that relies on dialogue that is not black *or* white, but rather black *and* white. No one person can ever see the whole picture. So, in speaking to the upsides of one pole, we also will listen in a spirit of curiosity and open-mindedness to others who articulate the upsides of the opposite pole. If we use them well, our differences and diversity are our most valuable resource—a source of innovation and growth. The balancing of divergent poles may not always provide the simplest and clearest line of sight, but it can provide the wisest course of action. ***SGIM***

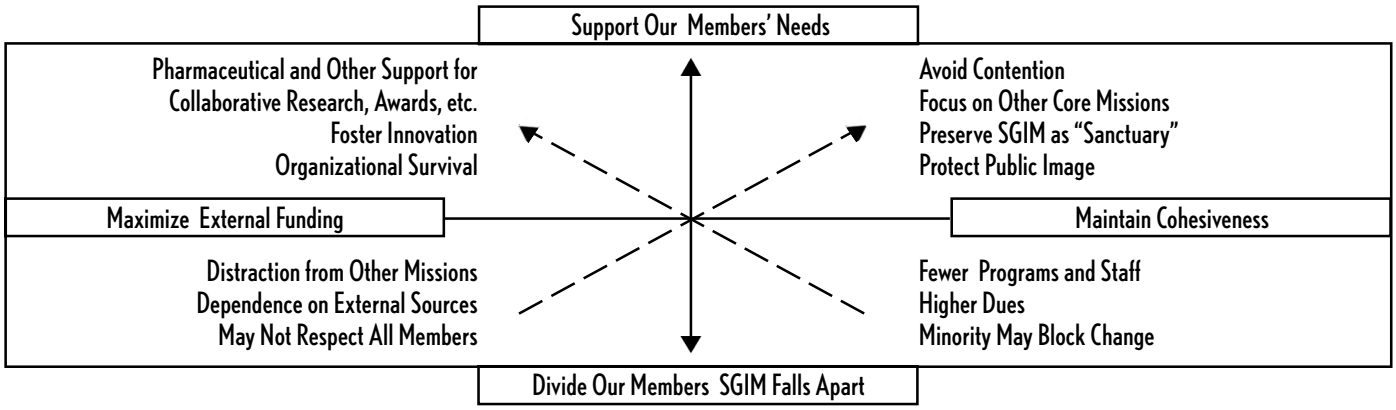


***Figure 2. Example of a polarity within SGIM (adapted from a "map" developed by Council).***

## *RESEARCH FUNDING CORNER*

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have been few studies showing that changing these factors prevents weight gain. The goal of such external interventions is to prevent inappropriate weight gain, without relying heavily on an individual's knowledge or motivation. Behavioral and/or educational interventions (self-monitoring, motivational interviewing, skills training) may be included in combination with environmental changes; however, the primary focus should be on environmental modification. Studies of weight management programs or the use of medications or dietary supplements to prevent weight gain are not appropriate. Applications should address: the content of the intervention (e.g., relative focus on aspects of diet, physical activity, sedentary behaviors, combinations of these, or other factors), the setting of the intervention (e.g., health care setting, worksite, community center, neighborhood, recreation facility, home, or school), and the method of delivery of the intervention (e.g., individual, family, group, or community). Environmental changes that reinforce factors supporting healthy lifestyles and reduce barriers to healthy lifestyles may also serve to diminish health disparities, as barriers may be more prevalent in disadvantaged and ethnic minority communities.[7] Therefore, applications targeting high-risk populations are encouraged. Novel or innovative aspects of study design and the rationale for their use should be highlighted.

Investigators responding to this RFA should propose to collaborate with organizations or institutions such as schools, supermarkets, restaurants, religious organizations, recreation facilities, industry, governmental, public health, or community groups, worksites, and so forth, to develop approaches that, if successful, could potentially be translated into larger scale interventions.

Appropriate study topics include the impact of changes in food advertising, promotion, or packaging on dietary choices; the impact of economic factors, such as pricing, on food choice or physical activity; the efficacy of establishing or reinforcing policies for environments supportive of physical activity and or healthy diet; the influence of neighborhood characteristics on physical activity and nutrition; the impact of culturally appropriate interventions to enhance physical activity and improve nutrition, implemented in collaboration with community-based organizations; race and gender differences in response to environmental interventions to prevent obesity; and the impact of environmental interventions to prevent obesity in underserved populations, including racial and ethnic minority populations and rural women.

This RFA uses the NIH R01 and R21 award mechanisms. Approximately $4 million will be committed in the first year to fund five to 12 applications. The complete RFA can be found at **grants.nih.gov/grants/guide/rfa-files/RFA-DK-02-021.html**.

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

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## *MENTORING PROGRAM*

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which path to explore? What further training and skills do you need for your career path? How can you negotiate for the time and opportunity to pursue your interests? How can you be more efficient? What academic goals should you establish as a clinician-educator? How can one raise a family and achieve one's professional goals? As a person of color, how do you motivate your institution to address some of your unique concerns? When is it time to consider changing institutions? These are the types of questions you can bring to the One-on-One Mentoring Program.

Don't be shy. Almost all of us can benefit from mentoring. Look for the One-on-One Mentoring application in the preliminary program for the Annual Meeting. Many enthusiastic, generous mentors are eager to get to know you! *SGIM*

## *CALL FOR PAPERS*

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asked and how they should be answered. Their perspectives and insights into the social and cultural dynamics of a community can inform researchers' future work. In addition, community members often can make substantial contributions to study implementation, analysis and interpretation of results, and dissemination of findings, such that involvement directly benefits participants and others. CBPR has been identified as a key strategy in efforts to reduce disparities, whether they are racial, ethnic, socioeconomic, or geographic.[3] Participation of community members can narrow the linguistic and cultural gaps that exist between many underserved groups and researchers.

Substantial community involvement also promises indirect benefits. These include the development of new skills, capacity, and empowerment for community members. Community involvement can reduce the distrust that many communities have developed for researchers because of prior studies resulting in direct harm (such as Tuskeegee), stigmatization associated with public reporting of unfavorable data, and use of findings for financial or professional profit without benefit to the subjects that were involved.[4]

This special issue on CBPR builds on efforts of SGIM, the Agency for Healthcare Research and Quality, and the W.K. Kellogg Foundation to help CBPR fulfill its potential as an important influence on health care policies and practices. We encourage authors to submit original research articles and brief reports as well as manuscripts that would fit *JGIM*'s sections for Innovations in Education and Clinical Practice, Populations at Risk, and Health Policy. These submitted manuscripts will be considered for publication along with several commissioned papers focused on the unique role that CBPR plays in the spectrum of health services research. The commissioned papers will address some of the major challenges facing CBPR and steps that can be taken to alleviate them. These include how incentives to participate can be enhanced for both communities and academics, how additional capacity can be developed for both communities and academics, and how opportunities for funding this type of work can be expanded. The deadline for submission of papers is March 1, 2002. Please direct any questions to the *JGIM* office (telephone: 410-955-9868; e-mail: **jgim@jhmi.edu**). ***SGIM***

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## CLASSIFIED ADS

Positions Available and Announcements are $50 per 50 words for SGIM members and $100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and appearance on the SGIM Website at http://www.sgim.org. Send your ad, along with the name of the SGIM member sponsor, to SGIM Forum, Administrative Office, 2501 M Street, NW, Suite 575, Washington, DC 20037. It is assumed that all ads are placed by equal opportunity employers.

ACADEMIC GENERAL INTERNISTS. Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks academic general internists with interest in clinical epidemiology and health services research. These positions will be structured to provide 50-80% protected time to conduct research. Academic rank and salary will be commensurate with qualifications. Review of applications will begin immediately and continue until positions are filled. Send letter of interest and CV to David Bates, MD, Division of General Internal Medicine, PBB-A3, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115. Brigham and Women's Hospital is an affirmative action, equal opportunity employer.

CLINICAL EDUCATOR, SOUTH CENTRAL PA. Dynamic, community & hospital based IM residency program seeks full time teaching partner in York, PA. The position is divided between 50% teaching and 50% providing care for one's own patient. Outpatient practice is located in a state-of-the art outpatient medical center; inpatient care is provided at York Hospital, rated by HCIA as a "100 Best Hospital". Call coverage 1:7 in a group that describes their chemistry as "outstanding". No grant funding or research required for the position. Full benefits with guaranteed salary. Community of 400,000 is an excellent place to raise a family with superb schools and only 45 minutes from Baltimore. Available 2002. Send CV to Carol Stowell FAX 717.851.2968 cstowell@wellspan.org, Phone 717.851.6585.

FELLOWSHIP, PALLIATIVE CARE. The Palliative Care Service at Massachusetts General Hospital offers BE/BC physicians a one-year NCI-sponsored fellowship in palliative medicine with options for additional research years. Positions available beginning July 2002. Contact: Eric Krakauer, MD, PhD, c/o Nan Lawless, Palliative Care Service, MGH/Founders 600, Boston, MA, 02114-2696. Telephone: 617-724-9197. Fax: 617-724-8693. E-mail: nalawless@partners.org.

FELLOWSHIP PROGRAM, GENERAL INTERNAL MEDICINE at Boston University(BU). BU offers 2 year fellowships in preparation for an academic career, focusing on research and/or education. Optional track in Preventive Medicine leading to board eligibility. Also, tracks in Substance Abuse, Women's Health, Informatics. Fellowship can qualify for National Health Service Corps payback or for medical school loan repayment. Fellows complete a Masters degree at BU School of Public Health. Inquiries to Drs. Jane Liebschutz, jliebs@bu.edu, or Robert Friedman rfriedma@bu.edu. Requests for application to Ms.Barbara Pekenia, barbara.pekenia@bmc.org, 617/638-8030.

FELLOWSHIP, WOMEN'S HEALTH, BOSTON UNIVERSITY GENERAL INTERNAL MEDICINE. Fellowship Program offers a special track to

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## Classified Ads

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prepare internists for academic careers in Women's Health. Fellows collaborate with nationally recognized faculty at Boston University's Center of Excellence in Women's Health to conduct independent research, gain specialized clinical expertise and strengthen teaching skills. Fellows also complete a Masters degree at Boston University School of Public Health. Send request for application materials to Mrs. Barbara Pekenia, 720 Harrison Ave. #1108, Boston MA 02118, barbara.pekenia@bmc.org, 617/638-8030; inquiries can be sent to Susan Frayne MD MPH (sfrayne@bu.edu) and Karen Freund MD MPH (karen.freund@bmc.org).

GENERAL INTERNIST INVESTIGATOR. INSTRUCTOR/ASSISTANT PROFESSOR, RHODE ISLAND HOSPITAL. Rhode Island Hospital seeks a general internist. Candidates must be eligible for license to practice medicine in Rhode Island and have completed fellowship in General Medicine or Geriatrics, or have five years experience in general medicine including funded research. Candidate is expected to establish a program of independent investigation, and will have significant protected time. Candidates must qualify for appointment as Instructor or Assistant Professor of Medicine at Brown University contingent on criteria. Assistant Professor rank will have documented qualities as a teacher and a documented ability to conduct research. Interest in health services research and chronic diseases specifically substance abuse or oncology preferred. Review of applications will begin immediately and continue until the position is filled or the search is closed. Rhode Island Hospital EEO/AA employer, actively solicits applications women, minority and protected persons. Please send a curriculum vitae to: Michael D. Stein, MD, Associate Professor of Medicine, Division of General Internal Medicine, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903.

INTERNAL MEDICINE PHYSICIAN, MADISON WISCONSIN. Excellent opportunity with the University of Wisconsin Medical Foundation. We are seeking a full-time Internal Medicine physician to join four others at our Madison East Towne Clinic. Teaching opportunities with medical students and residents. Madison is the state capitol and recognized as one of the top cities in which to live and work. Competitive salary and comprehensive benefits package. Contact Laura Schowalter, Director of Physician Recruitment; call toll free (888) 267-7764 or local (608) 287-2651 FAX (608) 287-2199. E-mail: Laura.schowalter@uwmf.wisc.edu. The UW Madison is an EE/AA employer and has an open records law. Women and minorities are encouraged to apply. Wisconsin caregiver law applies.

INTERNISTS—GENERAL INTERNAL MEDICINE. The Department of Internal Medicine at the University of New Mexico, Department of Internal Medicine and the New Mexico Veterans Administration Health Care System (NMVAHCS) is seeking Internists for the General Internal Medicine Section. Must be Board Certified in General Internal Medicine. These faculty positions are based at the NMVAHCS. Full and part-time work available. Must have clinical, administrative and teaching experience. Salary and academic rank based on training and experience. Preference will be given to candidates with advanced general internal medicine training and research experience. Opportunities exist for research and collaboration with members of this active, dynamic division. Position open until filled. Not a J-1 opportunity. Applicant selected is subject to random drug testing. Send signed letter of interest and CV to Robert E. White, MD, MPH, Chief, General Internal Medicine Section (111GIM), 1501 San Pedro SE, Albuquerque, NM 87108. The University of New Mexico and the NMVAHCS are EEO/AA employers.

RESEARCH POSITIONS, GIM OUTCOMES. The University of Cincinnati Medical Center and the Cincinnati Veterans Affairs Hospital seek general internists with clinical research training in outcomes research, health decision sciences, quality of life assessment, clinical epidemiology, health services research, or clinical practice improvement to conduct collaborative outcomes research with both intramural and extramural grant funding. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Send CV and cover letter to: Joel Tsevat, MD, MPH, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH 45267-0535, e-mail: Joel.Tsevat@UC.Edu. UCMC and the VA are AA/EOEs.

FELLOWSHIP—HEALTH SERVICES RESEARCH/CLINICAL EPIDEMIOLOGY/HEALTH POLICY. Weill Medical College of Cornell University seeks candidates for a two-year fellowship program for physicians interested in an academic career in health services research, clinical epidemiology, or health policy. It's designed to give physicians the skills necessary to conduct methodologically rigorous health services research that will enable them to develop and implement solutions to the nation's pressing health care problems. RESEARCH PROJECT: With the active support of faculty mentors, fellows will design, perform, and present an independent research project. Possibilities include: Behavioral Science, Health Promotion and Disease Prevention, Biostatistics, Clinical Epidemiology, Geriatrics and Gerontology, Health Policy, Economics and Health Services Research, Health Education, Health Services Research, Management and Finance, Medical Informatics and Decision Analysis. Fellows will attend at least one national conference per year pertaining to their project area, and will be given multiple opportunities to present their work during their fellowship. MASTER'S DEGREE: Fellows will be enrolled in the Weill-Cornell Graduate School to obtain a Master of Science Degree in Clinical Epidemiology and Health Services Research. Contact Mary Charlson, MD or Carol Mancuso, MD: Weill Medical College of Cornell University, 525 East 68th Street, Box 46, New York, NY 10021; 212-746-1608; ssamuel@mail.med.cornell.edu.