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2002 ANNUAL MEETING: A PREVIEW

CELEBRATE SPRINGTIME IN ATLANTA!

Donald Brady, MD

Spring is an exciting and wonderful time to visit Atlanta, the site of this year's Annual Meeting, May 2–4. Temperatures averaging in the 70s, flowers blooming all around, and just general spring fever infuse the city that time of year.

When I think of May in Atlanta, I think of the outdoors. Just a few blocks from the Hyatt Regency Hotel, where the meeting is to be held, is Centennial Olympic Park, where the Olympic Rings Fountain and the open green spaces provide children a place to play and adults a chance to relax from the business of the meeting. Less than two miles from the hotel is Piedmont Park, one of the city's most popular recreational areas—it was designed by the same man who designed New York's Central Park. Also a short drive from the hotel is Grant Park, home to the Atlanta Zoo and the Cyclorama, a Civil War museum and interactive learning center. If you have a car, Stone Mountain Park, with its mountain carvings and laser light shows, is approximately 30 minutes away.

For history buffs, there are several sites to highlight. Within walking distance or a short cab ride of the hotel are the historic Sweet Auburn District and the Martin Luther King, Jr. Center for Non-Violent Social Change, both important to the history of the civil rights movement in this country and particularly in

the South. The Carter Center and the Jimmy Carter Presidential Library are approximately three miles east of the hotel. And, as mentioned above, the Cyclorama presents a unique perspective on Civil War history. The CNN Center, with guided tours available, is also within walking distance.

At night, the city comes alive! In addition to the many downtown restaurants, great dining can be found in many Atlanta neighborhoods—Buckhead, Virginia-Highland, Midtown, and many others. These same areas offer outlets for dancing, live music, comedy, and other nightlife. Unfortunately, the Braves are in St. Louis during the Annual Meeting. Instead of attending a baseball game, however, you might want to take the time to see a local theater production or visit one of the many museums available: the High Museum for fine arts enthusiasts, the Fernbank Museum of Natural History, or SciTrek, an interactive science museum for children of all ages. Don't forget about the Coca-Cola Museum and its special tasting rooms featuring flavors bottled in different corners of the world!

Whatever you decide to do, don't stay inside—take advantage of what Atlanta has to offer. Stop someone in the hotel or on the street, or find an SGIM member who is wearing an Emory or Morehouse badge. Let us show you some Southern hospitality! Enjoy your stay here. **SGIM**

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Remembering Mark

Karen M. Freund, MD, Barbara F. Pekenia, and Noreen R. Clifford

The SGIM community and Boston University Medical Center lost a trusted colleague and friend when Mark A. Moskowitz, MD, died on September 1, 2001. In November of 2000, weeks after his 50th birthday, Mark was diagnosed with a sarcoma. He immediately entered treatment and, in spite of the rigorous therapies, continued to perform all of his non-clinical responsibilities up until two days before being admitted to intensive care.

Dr. Moskowitz was Professor of Medicine and Public Health at Boston University Schools of Medicine and Public Health and Vice Chairman, Department of Medicine for Health Care Policy. Mark earned his bachelor's degree in economics from the University of Pennsylvania and his MD at Albert Einstein College of Medicine, where he was elected to Alpha Omega Alpha in 1976. He completed his residency and rheumatology fellowship at the Beth Israel Hospital in Boston. It was there that he also completed the Henry J. Kaiser Fellowship in General Internal Medicine and developed his interest and focus in general internal medicine and health services research. He joined the faculty at Boston University in 1981. He quickly was appointed to leadership positions at the institution, initially as Chief of the Health Care Research Unit, then as Section Chief in General Internal Medicine at University Hospital. He was named Chief of the combined General Internal Medicine Section following the merger of University Hospital and Boston City

Hospital into Boston Medical Center. Over the past five years, Mark successfully led the Section of 65 full-time faculty members.

Mark was a pioneer and leader in the use of administrative databases to answer important questions about how we deliver care to our patients. He

contributed his expertise not only to his own work but also in consultation to so many others. In Mark's 10 years as Chair of the Veterans Administration Health Services Research and Development Program's National Scientific Review and Evaluation Board, he fostered improved reviewing and, ultimately, better health

services research studies. During the most recent five years, he directed the Health Care Financing Administration (now CMS) Boston University-based Research Data Center, whose mission is to train researchers to use Medicare and Medicaid data for policy studies.

In addition to his role in health services research, Mark maintained a busy clinical practice in general medicine. He is sorely missed by his patients, many of whom he had cared for throughout his 20 years in practice. Mark exemplified the model of the doctor-patient relationship. As one of his patients recalled, "When you were with him, you had his full attention. I felt encouraged to talk fully about all my concerns, not rushed."

One of Mark's greatest legacies is the growth of the General Internal

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STARLING CURVES

Kurt Kroenke, MD

I was one of those students who was not particularly interested in the basic science courses in medical school, but was instead eager to get on to more direct patient care and clinical experiences. For example, if you were to ask me now about even the basics of the Krebs cycle, I would fail, having not drawn upon this biochemical pathway for some decades. However, one concept that I have found to be of recurring value is the Starling curve. Strictly speaking, this is the physiologic principle that increased filling of the heart leads to increased cardiac output up to a certain level after which decompensation occurs and output declines. The Starling curve, however, transcends medicine. What is true of the heart applies to many other things in life. Mies van de Rohe coined a tenet of modern architecture—“less is more.” The Starling curve describes a critical threshold where this rule is reversed, and “more is less.”

One too many syndromes

The irony of the Starling curve is that there is a very fine line distinguishing optimal filling pressure from diastolic dysfunction. A busy waiting room characterizes a successful practice. Multiple grants define a fully funded investigator. Numerous and interesting patients are required to provide a valuable learning experience for residents and students. There comes a point, however, when there is one too many patients scheduled, one too many projects, one too many admissions. Or one too many unwritten papers, one too many committee meetings, one too many hats to wear. In short, the proverbial straw that breaks the camel's back. Most of us have played the children's game of stacking blocks, anxiously waiting to see if the next block will topple the pyramid, holding

our breath because of the tenuous balance. For each of us, the ascent up the slope may be gradual, but we find ourselves on a precipitous cliff. While preload accumulates imperceptibly, pulmonary edema has an abrupt onset.

Signs and symptoms

There are clues that the downslope of the curve is approaching or upon us. Irritability is one. Resenting the patient we are about to interview or examine. Impatience with the learner. A short fuse with our office staff, colleagues, or



family. Pressing the button repeatedly in an attempt to hasten the elevator to our floor, or to close the door once we have boarded. Muttering in exasperation at the avalanche of e-mail that awaits us if we miss a day or two of checking our electronic inbox.

Feeling overwhelmed is a more advanced symptom. Shifting from one stack of papers on our desk to another, randomly chipping away at unfinished tasks. Forgetting where we put our notes from rounds, or that form we need to complete, or what it was we had started to do. Housestaff who are on-call can experience this in the waning hours before dawn, as they

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SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

The SGIM World-Wide Website is located at <http://www.sgim.org>

2002 ANNUAL MEETING: A PREVIEW

Encouraging the Next Generation: Students, Residents, and Fellows at the Annual Meeting

Donald Brady, MD, and Lisa Inouye, MD

This year we have several new plans for students, residents, and fellows to complement all the traditional offerings at the Annual Meeting. We strongly believe that for SGIM to retain its vibrant, growing flavor we need to reach out to the next generation of general internists graduating from our medical schools and training programs.

In keeping with this commitment, we have designed a “track” at the meeting that will highlight activities we believe may be of particular interest to residents and students. Included in this track are SGIM 101, the Clinical Vignette Unknown Session, and some specially designated workshops, in addition to a 90-minute Career Development Workshop discussing general medicine career options and job search issues. More specific information on the various workshops will be in the on-site program. One may choose to attend as much or as little of the track as he or she wants; we are simply offering what we believe will be helpful suggestions for students and residents. On Friday evening, May 3, Frieda Millhouse and Andrew DeFillipis of Emory University will convene the first meeting of the Resident and Student Interest Group. Organized by and for residents and students, this interest group will provide a forum for associate members to discuss their training needs, to have an organized voice within SGIM, and to create a listserv through which they can share their ideas throughout the year.

New this year is the SRF Lounge! Hyatt Executive Conference Suite 223 will be available throughout the meeting strictly for students, residents, and fellows to network, visit with friends, or simply relax. There will be tables and displays announcing job and fellowship opportunities in general internal medicine. Enjoy this special area set aside for SGIM’s associate

members. Also, don’t forget the popular, traditional outlets, such as the Students, Residents, Fellows, and First-Time Attendees Reception and the One-on-One Mentoring Program.

Less widely known, but equally important, are the discounts available to students and residents. The first 25 medical student associate members to register for the meeting are eligible for scholarship support for the registration fee. We encourage division chiefs and medical schools to sponsor students and help them pay for transportation and lodging. Just down the street from the Hyatt Regency, we have reserved a special block of rooms for students and

residents at the greatly discounted price of \$89.00 per night for single, double, triple, or quadruple occupancy. These rooms are restricted for student and resident use only. Call the SGIM office for details.

This meeting promises to highlight one of the crucial emerging issues for general internal medicine—the recruitment and retention of bright, creative young people into this career path. We hope that the above efforts, along with the usual nurturing presence of seasoned members, will make this a memorable meeting for our students, residents, and fellows. **SGIM**

Cluster Discusses EBM Web Site

Sharon E. Straus, MD, FRCPC, and Eduardo Ortiz, MD, MPH

In the January 2002 issue of the *Forum*, Martha Gerrity described the activities of the SGIM Evidence-Based Medicine (EBM) Task Force and outlined the development of several subcommittees to expand the capability to achieve the goals of the Task Force. One of these subcommittees, the Web-Based Resources Cluster, recently held a retreat to discuss the creation of an SGIM EBM Web site. This article provides a brief review of the progress achieved during that meeting.

The EBM Task Force established the Web-Based Resources Cluster because of the need for an online resource to help SGIM members learn about, practice, and teach EBM. The cluster was launched at the 2001 Annual Meeting. Members include clinicians from a variety of practice settings.

The purpose of the recent retreat was to discuss the creation of the SGIM EBM Web site and the development of resources for personal digital assistants

(PDAs), to evaluate potential sources of funding, and to determine the strategic direction of the cluster. Foremost among the goals of the cluster is to develop an EBM Web site that is available to all SGIM members. One of the challenges will be to create a Web site that provides high-quality resources for learning about, practising, and teaching EBM without simply reproducing other currently available EBM Web sites. Contents ultimately will include electronic resources for use on personal computers or PDAs. Clinicians active in practising and teaching EBM will rate all resources on the Web site. We will evaluate resources based on predetermined methodological criteria, with specific emphasis placed on their clinical and/or teaching usefulness. We will outline how learners and teachers could use these resources and describe explicitly the intended audience for their use. For Web resources, additional requirements for inclusion on the SGIM

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PRIMARY CARE PRACTICE-BASED RESEARCH NETWORKS

Joseph Conigliaro, MD, MPH

On February 6, 2002, the Agency for Healthcare Research and Quality (AHRQ) released a request for applications (RFA) for developmental/exploratory grants to assist new or established primary care practice-based research networks (PBRNs) to enhance their capacity to conduct research and translate research findings into practice (RFA-HS-02-003). Letters of intent must be received by April 15, 2002. Applications must be received by May 14, 2002.

A PBRN is a group of ambulatory practices devoted to primary care and joined together to investigate questions related to community-based practice. PBRNs have been in existence in the U.S. since the late 1970s. The major goal of these networks has been to involve busy clinicians and their staffs in studies by investigators in clinical and health services research. Much of the research conducted in PBRNs has been small descriptive or observational studies, but several networks have been successful in competing for larger grants to conduct more advanced research. These studies are often generalizable and lend themselves easily to the translation of research into practice. Finally, PBRNs provide a means of engaging practitioners in the development of research questions about practice that lead to practice improvement.

To increase practice-based research and the translation of findings into practice, AHRQ is seeking to fund developmental grants to assist new or established (PBRNs). PBRNs are invited to apply for these funds so they can plan, develop, or enhance their infrastructure. AHRQ is particularly interested in studies that focus on priority populations, such as racial and ethnic minorities; practice-based information technology; and preventive services, including the promotion of healthy

behaviors in primary care settings.

There are two categories of funding available. Applicants can apply for one or both categories. The two categories are support for the development or enhancement of network infrastructure (Category I) and support for exploratory or pilot research projects (Category II). For Category I, priority will be given to networks that propose building infrastructure that will develop or test computer-based data-collection or information systems, improve the translation of research into practice and measure its impact within the network, and/or expand the number or types of practices in the network so that the health care of priority populations can be studied. In Category II, priority will be given to networks studying the feasibility and development of projects investigating community-based primary care. AHRQ has a particular interest in methods of delivering preventive services in primary care; innovative uses of information technology in primary

care; methods for improving patient safety and identifying/responding to medical errors in primary care practices; and elucidation of primary care practice-based strategies for diminishing disparities in health care delivery and health outcomes for priority populations, including minority, rural and underserved patients.

AHRQ expects to award \$2 million in total costs to support the first year of projects using the R21 award mechanism, with 25 to 30 awards for infrastructure planning and development, not to exceed \$50,000 annually, and five to seven awards for pilot projects of up to \$100,000 annually. The total period for applications may not exceed two years. The RFA is available on AHRQ's Web site (www.ahrq.gov) under "Funding Opportunities" and through the InstantFAX at (301) 594-2800.

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

Steve Fihn Receives VA Award

David R. Calkins, MD, MPP

On February 14, 2002, SGIM Past-President Stephan D. Fihn, MD, MPH, received the Under Secretary's Award for Outstanding Achievement in Health Services Research from the Veterans Health Administration, Department of Veterans Affairs (VA). Dr. Fihn is Professor of Medicine and Health Services and Head, Division of General Internal Medicine, University of Washington. He is also Director, Northwest Health Services Research



and Development (HSR&D) Field Program, VA Puget Sound Health Care System (VAPSHCS) and Co-Director, Ambulatory Care and HSR&D Fellowship Program, VAPSHCS. The award includes a \$5,000 honorarium and an additional \$50,000 per year for three years to support Dr. Fihn's research. The award was presented at the VA HSR&D Annual Meeting in Washington, DC. **SGIM**

STARLING CURVES*continued from page 3*

vacillate between finding the x-rays, completing write-ups, starting IV's, or checking up on earlier admissions. Prioritizing becomes more difficult. An orderly sequence of task completion gives way to a desultory pattern of starting and stopping. Or not knowing where to begin. Researchers may experience this in the last days before a grant deadline. That desperate undergraduate feeling of final exams.

An even later symptom is ennui. What once provided joy and satisfaction becomes tedious. Attending rounds are a duty. Getting a grant funded is a mixed blessing. Invitations to serve in a leadership capacity feel more like a burden than a privilege. Burnout is a term commonly applied to the terminal stages.

There are other signs. Over scheduling so you are always 5 to 10 minutes late for the next person waiting to meet with you. Interrupting conversations with the person in your office to

answer a page or make a quick phone call. Promising to review a paper or grant for a colleague but doing so with either an unreasonable delay or a hurried, almost token effort. Agreeing to one too many invitations for lectures or teaching assignments with the result being old slides, minimal updating, and scanty preparation. Being chronically delinquent in completing student evaluations, in submitting research progress reports, in signing medical records—and needing repeated reminders.

Etiology

Why is there a tendency to skate so near the edge? Don't forget—a large portion of the Starling curve is a good thing. We like to be productive. We want to maximize our potential as physicians, teachers, and investigators. Training is long, life is short, the time to make substantial contributions seems evanescent. This is true of our personal

life as well. Kids grow up too fast. The number of books we desire to read always exceeds our grasp. Additional time for recreation, community involvement, and personal restoration are asymptotic goals, always just beyond our reach. Thus, the Starling curve is not simply optimizing our achievements in one particular sphere but rather maximizing the "area under the curve" in all domains of our life. It is that utopian vision of personal-professional balance.

There are other factors. We hate to say "no." We are honored to be asked. We know how hard it is for those making the request to find someone else (we have been in their position). We are pressured to say "yes"—by patients, collaborators, department chairs, professional organizations. Being overly busy is worn as a badge of importance. Free time can make that Type A portion of our personality feel guilty or unproductive.

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REMEMBERING MARK

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Medicine Fellowship at Boston University. Robert Friedman, MD, Director of the Fellowship Program, in a letter to the program's graduates, commented, "Teaching fellows was probably the most enjoyable thing Mark did in his career, and he did a lot of great and exciting things. He was gifted at understanding what each fellow wanted to do with his own career and in helping each [fellow] get there." The 60 graduates of the fellowship program over the past 21 years, who are leaders across the United States and Canada in general internal medicine, attest to his gift at teaching others. One graduate wrote, "I'll really miss Mark. He taught me or helped me learn just about everything I know academically, and a lot of what I know about life in general... really an incredible role model and wonderful person to have known." For many years, Mark taught a course on health services research methods at the School of Public Health and several times was awarded the "Best Teacher" award for his dedication.

Mark was a compassionate physician, an outstanding educator, a revered mentor, a brilliant health services researcher, and a valued leader. But all these accomplishments do not sum up who Mark was as a person, a colleague, and a friend. Each day, Mark would enter the office with a booming, "Good Morning." He would antagonistically sing "Good Morning" to us if his beloved Yankees had beaten the Red Sox the previous night. Mark always saw the best in people. He always took the time out of his busy schedule to listen. He wanted to be informed about joyous occasions, like the birth of a child, or sadder ones, like the death of a parent, so he could personally make a phone call or pay a visit, in addition to insisting that the Section send flowers or make a donation. He was always optimistic. He never complained. In fact, in July, following an especially difficult round of chemotherapy, he sat in his office and said, "If it were not for this pain in my leg, and for my shortness

of breath, and for my fatigue, I would feel fine!" Mark was the eternal optimist.

Mark is survived by his wife of 27 years, Deborah, his three children, Elliot, Rachel, and Philip, and a granddaughter, Rivka, who was born three weeks after his death.

A memorial was held for Mark at Boston University Medical Center on

October 16, 2001. The Department of Medicine has established a lectureship in his name, to honor his work in general internal medicine. Contributions in Mark's memory may be sent to the Mark A. Moskowitz, MD, Memorial Lectureship, Department of Medicine, Boston Medical Center, 88 East Newton Street, Boston, MA 02118. **SGIM**

EBM WEB SITE

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EBM Web site are a description of the developers/creators of the resource, a declaration of competing interests of the creators of the resource, and evidence that the Web site is updated frequently and regularly.

There are several resources that the cluster hopes to make available on the Web site. For example, we will provide access to the upcoming series of articles in the *Journal of General Internal Medicine* entitled "Teaching Tips for EBM" and to an interactive, online version. We also hope to offer the recently published "Users' Guide to the Medical Literature" and the accompanying online version. Other Web site content will include an annotated bibliography of useful EBM resources, tools to calculate key statistics (e.g., number needed to treat, likelihood ratio), critical appraisal worksheets, evidence-based clinical prediction rules, cases to be used in teaching EBM, evaluation tools, and tools for profes-

sional development.

We are developing the Web site to meet the needs of SGIM members who are interested in learning about and teaching EBM. To help us learn more about what those needs are and how we can make the Web site useful for members, we have prepared a brief online survey to be distributed by e-mail in March. We understand how busy all of you are, but we hope you will take a few minutes to complete the survey. Your responses will help us develop a resource that will be useful in your daily activities.

If you wish to join the Web-Based Resources Cluster, comment on the Web site, or nominate a resource for inclusion on the Web site, please contact Karen Lencoski (LencoskiK@sgim.org). We hope that many members will join us in working on this exciting project. **SGIM**

STARLING CURVES

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Prevention

To reiterate, a large portion of the Starling curve is good. It is that last 10–20% we need to avoid, the extra gasp of air that bursts the balloon. Many of the ways we might avoid the downslope of the curve have already been alluded to. Recognizing the signs and symptoms and understanding the etiology are

cornerstones of prevention. I would like to conclude with three other strategies. One is accommodation. The gradual accretion of tasks and responsibilities is better tolerated than sudden overload. Muscles can strengthen over time rather than suffer acute injury. If we must say "yes" to multiple competing demands,

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STARLING CURVES

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sequential acceptance is better than simultaneous acquiescence. A second strategy is substitution. Even with accommodation, only so many balls can be juggled in the air before one is mishandled or dropped entirely. Deciding what to relinquish and when is a lifelong process and a skill we should impart to all professionals. A third strategy is the ability to accept boundaries. Eternity and infinity are intoxicating concepts. While rationally we understand our temporal and finite nature, we are enticed by the urgings of "one more." Whenever we have achieved "N" in some important area of our life, it is tempting to desire "N + 1." Preempting this process of inexhaustible addition demonstrates good stewardship of our Starling curve.

Starling curves are like snowflakes: there are as many sizes and shapes as there are individuals in the world. Managing our own curve is a highly personal and idiosyncratic process. The only universal characteristic is that every curve has an elbow. Recognizing that juncture and stopping just short is both the greatest challenge and the ultimate reward of our vocation. It is what makes our job a calling. **SGIM**

Chief of General Internal Medicine

VA Connecticut Healthcare System

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