

Contents

- 1 Ten Reasons to Attend the 25th Anniversary Meeting**
- 2 SGIM Leaders Make a Difference!**
- 2 Members Urged to Complete EBM Web Site Survey**
- 3 President's Column**
- 4 External Funds Task Force Seeks Member Comments**
- 4 Draft Policy on Acceptance and Disclosure of External Funds—March 3, 2002**
- 5 President's Budget Cuts Funding for AHRQ and Title VII**
- 5 Health Policy Addition to SGIM Web Site Debuts**
- 6 SGIM's Women's Caucus: Looking Ahead as SGIM Turns 25**
- 6 IOM Tackles Health Disparities**
- 7 Research Funding Corner**
- 7 Practice-Based Research Networks: Growing the Evidence for Primary Care**
- 16 Classified Ads**

2002 ANNUAL MEETING: A PREVIEW

TEN REASONS TO ATTEND THE 25TH ANNIVERSARY MEETING

Jeff Jackson, MD, MPH, and Ellen F.T. Yee, MD, MPH

Our first meeting was held in 1978. At that time SGIM was known as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM). All 178 attendees were given membership in the new society. The next year, the meeting received 38 submissions and had eight oral presentations. Now SGIM celebrates its 25th anniversary meeting in Atlanta, May 2–4, 2002. This milestone commemorates a quarter century of dedication to patient care, teaching, and research in general internal medicine. Over the years SGIM has grown. We now have 2,743 members, and 1,500 attendees are expected at the meeting. This year, a record 1,206 scientific abstracts, clinical vignettes, and innovations in education and practice management were submitted, in addition to 134 workshops and 44 precourses. By meeting's end, over 1,000 of our members will have presented in some venue. More than any other professional gathering, SGIM's Annual Meeting is by and for its members.

Come celebrate with us. This year's theme is "The Next 25 Years: Emerging Issues for Generalists." Highlights of this landmark meeting follow.

♦ **Peterson Lecture** — This year's Peterson Lecture will be given by Deborah Prothrow-Stith, MD, Professor of Public Health Practice and As-

sociate Dean for Faculty Development, Harvard School of Public Health. Her topic will be "Violence Prevention: A Public Health Mandate." Dr. Stith is a nationally recognized public health leader, with applied and academic experience as a practicing physician in neighborhood clinics and inner city hospitals, a state commissioner of health, and now Director of the Division of Public Health Practice at the Harvard School of Public Health. In her address, she will describe the problem of youth violence in the United States as a major public health epidemic. She will promote understanding of the factors leading to violence, the context in which policies have been framed, and public health strategies for society and communities to quell the epidemic. We are honored that she will share her vision and passion with us.

♦ **Theme Plenary Session** — A special theme plenary session, entitled "Looking Back, Moving Forward," will feature the best four scientific abstracts on emerging issues in general internal medicine. This session also will include a presentation by Robert Centor, MD, Director, Division of General Internal Medicine, and Associate Dean, University of Alabama, and President, Association of Chiefs of General Internal

continued on page 8

SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

PRESIDENT

Kurt Kroenke, MD • Indianapolis, IN
KKroenke@regenstrief.org • (317) 630-7447

PRESIDENT-ELECT

Martin F. Shapiro, MD, PhD • Los Angeles, CA
mshapiro@mednet.ucla.edu • (310) 794-2284

IMMEDIATE PAST-PRESIDENT

Sankey V. Williams, MD • Philadelphia, PA
sankey@wharton.upenn.edu • (215) 662-3795

TREASURER

Brent G. Petty, MD • Baltimore, MD
bpetty@welchlink.welch.jhu.edu • (410) 955-8181

TREASURER-ELECT

Eliseo Pérez-Stable, MD • San Francisco, CA
eliseops@medicine.ucsf.edu • (415) 476-5369

SECRETARY

Ann B. Nattinger, MD, MPH • Milwaukee, WI
anattng@mcw.edu • (414) 456-6860

COUNCIL

Michael J. Barry, MD • Boston, MA
mbarry@partners.org • (617) 726-4106

Pamela Charney, MD, FACP • New York, NY
charney@aecom.yu.edu • (718) 918-7463

Susana R. Morales, MD • New York, NY
srm2001@mail.med.cornell.edu • (212) 746-2909

Eileen E. Reynolds, MD • Boston, MA
ereynold@caregroup.harvard.edu • (617) 667-3001

Gary E. Rosenthal, MD • Iowa City, IA
gary_rosenthal@uiowa.edu • (319) 356-4241

Harry P. Selker, MD, MSPH • Boston, MA
hselker@lifespans.org • (617) 636-5009

EX OFFICIO

Regional Coordinator

Jane M. Geraci, MD, MPH • Houston, TX
jmggeraci@mdanderson.org • (713) 745-3084

Editor, *Journal of General Internal Medicine*

Eric B. Bass, MD • Baltimore, MD
ebass@jhmi.edu • (410) 955-9868

Editor, *SGIM Forum*

David R. Calkins, MD, MPP • Boston, MA
david_calkins@hms.harvard.edu • (617) 432-3666

HEALTH POLICY CONSULTANT

Robert E. Blaser • Washington, DC
rblaser@mail.acponline.org • (202) 261-4551

EXECUTIVE DIRECTOR

David Karlson, PhD
 2501 M Street, NW, Suite 575
 Washington, DC 20037
KarlsonD@sgim.org
 (800) 822-3060
 (202) 887-5150, 887-5405 FAX

SGIM Leaders Make a Difference!

Tom Inui, MD

Bradley Houseton and I hope that you saw our update on the SGIM “Make a Difference!” Campaign in the February issue of *Forum*, acknowledging the generosity of the members who had already made a personal contribution to the campaign. Since that update, more of you have responded with contributions to the Campaign. On behalf of SGIM, I want to extend my sincere appreciation to those who have given and to those who are planning to give.

What is especially impressive to us is how quickly the SGIM Council responded to this campaign. Less than three months after launch, 87% of the current Council had already made personal contributions. This high-level participation is symbolic of the Council’s commitment to support the continued growth and development of the Society’s goals and strategic values. During their tenure as SGIM leaders, they have seen SGIM grow in size, organizational complexity, scope of activities, and vision. Because of evolving philosophies on external funding, Council understands how important this campaign is to our Society, as it seeks to diversify its resources for support of special programs.

At the end of February, nearly four months into the Campaign, a total of 59 SGIM members, two foundations, and one geriatrics/GIM division have contributed a total of \$63,310. One of the goals of the Campaign—to endow the Eisenberg Award for Career Achievement in Research—has been attained, but we are far from finished overall.

Speaking frankly, this is a small number of participants for an organization of our size. In spite of their modest numbers, these contributors have mobilized significant funds. In part, they

have taken the Campaign to a higher level by leveraging their own support from a variety of non-member sources. One member secured a \$25,000 contribution from a family foundation to jump-start the endowment for the Eisenberg Award. Another member took advantage of his institution’s “matching gift” program and increased his personal contribution by 75%. Finally, a third member arranged for his geriatrics/GIM division to make a \$5,000 contribution to this campaign in the name of the founding director of his division.

At last year’s Annual Meeting some members passionately articulated opposition to accepting pharmaceutical funding. In the Council town meeting, they expressed a concern that the sources of such financing—however laudable SGIM’s goals for the use of the funds—did not fully share members’ values. Receipt of these funds ran the risk of incorporating conflicts of interest

continued on page 15

Members Urged to Complete EBM Web Site Survey

Karen Lencoski

The Evidence-Based Medicine (EBM) Task Force is developing a Web site to meet the needs of members who are interested in learning and teaching about EBM. To learn more about those needs and how the Web site might address them, the EBM Task Force has prepared a brief, online survey (www.insitefulsurveys.com/index.asp?a=s_1052-14). Members who respond by April 30, 2002, will be entered into a drawing for a Palm Pilot. Please complete the EBM Web site survey as soon as possible. We need your input! **SGIM**

VALEDICTORY

Kurt Kroenke, MD

In my final column as President, I would like to focus on SGIM as an organization and, specifically, in a forward direction. This year marks the 25th anniversary of our Society. Indeed, I prefer the term society in describing SGIM to the more bland word organization. The dictionary defines society as “a group of human beings broadly distinguished from other groups by mutual interests, participation in characteristic relationships, shared institutions, and a common culture.” More than half of the words in this definition conjure up in me powerful sentiments regarding SGIM. Terms like mutual interests, participation, relationships, shared institutions, and common culture ring true. Life has many organizations but few societies.

So what does a silver anniversary signify? While in marriage it represents a substantial milestone, 25 years is simply the first stage in an organization's life history. SGIM has survived its adolescence, a grace period of limited responsibilities and modest expectations. Maturation now raises the ante. What might the next quarter century bring? No soothsayer, I offer instead a personal vision, or rather a “wish list,” for the next two and half decades. It is a balance between future and past, since embracing one at the expense of the other may sacrifice the unique value of each.

Encourage partnerships to flourish

SGIM's census is deceptive. Our influence exceeds what a simple head count might suggest. Members provide a disproportionate share of direct patient care and medical education in academic institutions. They provide leadership in interdisciplinary research, not only in health services but also encompassing clinical investigation that includes as well as transcends organ systems.

Additionally, SGIM's roster contributes substantially to the national think tank in areas like health policy, biomedical ethics, doctor-patient communication, geriatrics, medical decision-making and numerous other domains. To leverage its impact in all of these areas, SGIM must partner with other organizations whenever there is a common agenda. This does not mean compromising our position on an issue but rather joining together with others when joint advocacy is a win-win situation.



Keep the Annual Meeting flame burning

The Annual Meeting is our Olympic torch, differentiating SGIM's meeting from that of many other organizations. Many attendees want more than simply feeding at the CME trough. They also desire to participate actively in

presenting abstracts, posters, vignettes, workshops, or precourses. Even when one is a passive recipient of education at the SGIM meeting, there is a Disney World quality: so many attractions and so little time. One “ride” competes with many others. The energy at the Annual Meeting is palpable, attendees frenetically moving among options in a type of

continued on page 9

SGIM FORUM

EDITOR

David R. Calkins, MD, MPP • Boston, MA
david_calkins@hms.harvard.edu • (617) 432-3666

EDITORIAL COORDINATOR

Stacy A. McGrath • Boston, MA
stacy_mcgrath@hms.harvard.edu • (617) 432-3667
(617) 432-3635 FAX

ASSOCIATE EDITORS

James C. Byrd, MD, MPH • Greenville, NC
byrdja@mail.ecu.edu • (252) 816-4633

Joseph Conigliaro, MD, MPH • Pittsburgh, PA
joseph.conigliaro@med.va.gov • (412) 688-6477

Giselle Corbie-Smith, MD • Chapel Hill, NC
gcorbie@med.unc.edu • (919) 962-1136

David Lee, MD • Boise, ID
lee.david@boise.va.gov • (208) 422-1102

Mark Liebow, MD, MPH • Rochester, MN
mliebow@mayo.edu • (507) 284-1551

P. Preston Reynolds, MD, PhD, FACP • Baltimore, MD
preynold@welch.jhu.edu • (410) 283-0927

Valerie Stone, MD, MPH • Providence, RI
Valerie_Stone@mhri.org • (401) 729-2395

Brent Williams, MD • Ann Arbor, MI
bwilliam@umich.edu • (734) 936-5222

Ellen F. Yee, MD, MPH • Los Angeles, CA
efyee@ucla.edu • (818) 891-7711 Ext. 5275

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>

External Funds Task Force Seeks Member Comments

Michael J. Barry, MD

Since last year's Annual Meeting, an External Funds Task Force, appointed by SGIM President, Kurt Kroenke, has been working on a revision and consolidation of the Society's documents related to the acceptance and disclosure of external funding. Perhaps no issue has engendered more debate in SGIM in recent years than the issue of external funding, particularly from the pharmaceutical industry. The draft policy that follows represents the Task Force's attempt to balance the "benefits and harms" of external funding for worthwhile endeavors, particularly educational and research projects. Simplistically, a more liberal external funding policy would mean that SGIM could support a greater variety of worthwhile programs and maintain lower annual dues and meeting fees. However, concern about potential conflicts of interest and dependence, among other things, would be greater. A more conservative policy on accepting external funding probably would mean that SGIM could support fewer worthwhile programs, and dues and meeting fees would be higher. On the other hand, there would be less concern about conflicts of interest or dependence. Currently, about 80% of SGIM's operating budget comes from its membership (primarily through dues and meeting registration fees). Some professional organizations derive a much smaller proportion of revenues from their members. Our relative dependence on funding from members has led to substantial increases in membership dues and meeting registration fees over the past five years.

The Task Force welcomes feedback from members on any and all aspects of the draft policy. However, we especially would like feedback about those questions that engendered the most debate:

- ◆ What are the percentages of the Society's operating budget derived from all external funding sources and from any one for-profit source that would engender concern about excessive dependence on those funding sources?
- ◆ Given that SGIM cannot do everything, what are the types of research and educational projects that SGIM is particularly well suited to conduct?
- ◆ When does SGIM conducting a research or educational project requiring external funding create "undue" competition with the efforts of individual members to obtain funding for their own work?

We really need your input at this juncture! Comments may be sent to the Task Force at **ExternalFundsTF@SGIM.org**. Members also may offer comments in person at a special open session with the Task Force and the Council at the upcoming Annual Meeting in Atlanta. The Task Force will submit its final recommendations to Council shortly after the Annual Meeting. The Council hopes to adopt a final policy statement at its summer retreat.

Editor's Note—Additional information about the Task Force is in the July 2001 issue of Forum.

Draft Policy on Acceptance and Disclosure of External Funds—March 3, 2002

Introduction

The primary goal of the Society of General Internal Medicine is to support its members in their efforts to promote improved patient care, teaching, and research in general internal medicine. The SGIM Council may promote these goals by accepting external funds, such as grants, sponsorships, or gifts, in support of activities. This policy provides guidance for the negotiation and acceptance of all external funding and is not limited to commercial relationships. Individuals and groups who solicit funds on behalf of SGIM should be familiar with this document. This policy has evolved from the original SGIM Policy Regarding Acceptance of External Funds, which was approved on January 6, 1994, and amended on December 3, 2000. It also subsumes two previous appendices to that document adopted February 10, 2000, and March 3, 2000.

Background

External funds may help SGIM pursue its mission in several ways. Examples include:

- ◆ Helping SGIM undertake initiatives to promote patient care, teaching, and research in general internal medicine;
- ◆ Improving the quality of SGIM meetings by allowing the Society to reimburse speakers, provide honoraria, furnish amenities, give scholarships and awards, or offer general programming that might otherwise be unavailable; and
- ◆ Helping SGIM provide services of value to members that advance the goals of the Society, such as the SGIM Web site, e-mail, and listserv systems.

In short, external funds potentially allow SGIM to pursue worthwhile activities that it might otherwise have to forgo.

continued on page 10

PRESIDENT'S BUDGET CUTS FUNDING FOR AHRQ AND TITLE VII

Jennifer Jenkins

President Bush released his fiscal year (FY) 2003 budget on February 4, 2002, starting what already appears to be a contentious budget process. The environment is unprecedented: the United States is at war and is defending homeland security; it is an election year; the government is facing deficit spending rather than surpluses; and the House of Representatives and the White House are controlled by Republicans, while the Democrats hold a one-seat majority in the Senate.

The Administration's budget decreases funding to several programs of great importance to SGIM, including the Agency for Healthcare Research and Quality (AHRQ) and the Title VII health professions education programs of the Health Resources and Services Administration (HRSA). Securing stable funding for AHRQ and Title VII is a top priority for SGIM's Health Policy Committee and government affairs staff. We are working independently and through relevant coalitions to assure continued support for these programs.

SGIM supports a \$390 million funding level for AHRQ in FY 2003, an increase of \$91 million. The Administration, however, proposes \$251 million for AHRQ, a \$48 million (16%) decrease from AHRQ's 2002 budget of \$299 million. Under this plan, AHRQ would not be able to fund any new research or training grants, and funding for current unprotected grants would be reduced by 46%. (Patient safety grants are protected.)

SGIM supports \$550 million for the Title VII and VIII health professions programs for FY 2003, including \$40 million for grants in general internal medicine and general pediatrics. The President's proposal cuts Title VII and VIII programs by 75%, eliminating all

programs except the Scholarships for Disadvantaged Students and the Title VIII nursing programs. The President's budget offers the following rationale for these cuts.

Despite 40 years of funding, most of the health professions grants have not proven to be effective, because they do not accurately address current health professions problems. For example, since 1993, the number of residents enrolled in primary specialties has grown, but the demand for primary care physicians is still acute in health professional shortage areas. Over the last two decades, almost \$7 billion has been invested in health professions training grants, and during this time the population of areas with shortages of primary care health professionals has increased by 140 percent.

The President's budget is a guide to Congress and is not binding. SGIM has joined other organizations in asking Congress to increase support for AHRQ and Title VII. SGIM leaders and government affairs staff have met with key staff on Capitol Hill. SGIM's advocacy efforts will be more effective, however, if they are reinforced by personal messages from SGIM members. Accordingly, the Health Policy Committee encourages all SGIM members, especially AHRQ and Title VII grantees, to contact members of Congress to support the proposed funding levels for AHRQ and Title VII. SGIM members can use our new, Web-based Advocacy Action Center, launched earlier this year, to e-mail members of Congress. The Advocacy Action Center allows members to view SGIM Legislative Alerts, identify members of Congress, and review the status of key legislative issues. It also provides tips on communicating with legislators. The Advocacy

continued on page 8

Health Policy Addition to SGIM Web Site Debuts

Mark Liebow, MD, MPH

The long-awaited (at least by Health Policy Committee members) health policy addition to the SGIM Web site debuted in January, as part of the new SGIM Web site. It can be reached by going to www.sgim.org and clicking on Advocacy. We hope the addition will be helpful to policy novices as well as policy wonks.

The site has five sections. The first section is the Advocacy Action Center. The Advocacy Action Center allows you to identify your elected federal officials and important legislative issues of interest to SGIM. It includes legislative alerts and updates, the status of current legislation, how your legislators have voted on important issues, and instructions on how to communicate with members of the House or Senate. It also has schedules for the House, the Senate, and Congressional committees. We hope that this will make communication by SGIM members to government officials on policy issues much simpler. SGIM may post legislative alerts, asking you to be in touch with an elected official on an issue. When this happens, sample messages will be available to send. These will usually be e-mailed, though they will sometimes be faxed to members of Congress or to the White House. You can download these and send the message on your own stationery as well. Of course, these can be modified and personalized as needed. In the future this section of the Web site will be password-protected and available only to SGIM members.

The second section is Health Policy Clusters. This section describes the nine clusters of SGIM's Health Policy Committee. It identifies the chair of each cluster and provides a brief summary of each cluster's purpose.

The third section is Where We Stand. Currently, this section has two

continued on page 14

SGIM's Women's Caucus: Looking Ahead as SGIM Turns 25

Anuradha Paranjape, MD, MPH, and Rowena J. Dolor, MD, MHS

The SGIM Women's Caucus was founded in 1987, the product of a breakfast discussion at the Annual Meeting the year before. In the early years of SGIM, women formed a small proportion of SGIM members. Senior women colleagues report that the Caucus was an important voice for issues of interest to women within SGIM and a forum for sharing ideas, networking, mentoring, and collaboration. Over the last 15 years, the Caucus has indeed met that need effectively. The Caucus has sponsored several workshops and precourses, typically on issues dealing with women's health or faculty development. These sessions have been well received and have contributed positively to the content of the Annual Meeting as a whole. Networking and collaboration at the Caucus' annual Interest Group meetings have resulted in the formation of two other Interest Groups, namely Physicians Against Violence and Women's Health Education. Like the SGIM Women's Caucus, both Interest Groups collaborate on educational workshops at the Annual Meeting.

As SGIM meets in Atlanta for its 25th Annual Meeting, it is evident that SGIM and the Women's Caucus have grown significantly. Women are no longer an invisible presence within SGIM. The efforts of the Women's Caucus have heightened the involvement of women members within educational, research, and leadership components of SGIM. Now newer members wonder why the Women's Caucus exists and are surprised to learn about how invaluable the Caucus has been to the growth of several senior women leaders in SGIM.

While many of the challenges that confront women in academic medicine have evolved over the last decade, some remain unaltered. To better understand

the needs of women members of SGIM and help guide the Caucus in continuing to be an effective forum for their growth and promotion, we mailed a survey to all 1,050 women members of SGIM identified by the National Office in 2000. A total of 121 surveys were returned. Among respondents, 55% were current members of the Women's Caucus, 12% were former members, and 17% had never been Caucus members. Over half of the respondents (52%) classified themselves as clinician-educators, 16% were in training (students, residents, and fellows), 17% were clinician-researchers, and 9% were clinician-administrators.

The survey assessed involvement in the Annual Meeting (including planning committee member, mentor in the One-on-One Mentoring Program, or professor in a Meet-the-Professor session), preferences for the agenda of the annual Interest Group meeting, ideas for speaker presentations, and communication. Respondents were active in submitting abstracts to the Annual Meeting: 79% had submitted at least one abstract, 64% had made poster presentations, and 48% had made oral presentations. Participation in precourses and workshops also was high: 32% and 49% respectively. Of note, while 18% of respondents had served on an abstract selection committee, only 5% had served as a mentor, 6% had spoken at a Meet-the-Professor session, 6% had served on the program committee, 7% on a precourse committee, and 7% on a workshop committee. Agenda preferences for the annual Caucus Interest Group meeting included time for networking (59%); identification of collaborative groups in research, clinical practice, or education (58%); speaker presentation (54%); mentoring (50%); exchanging or updating address lists

continued on page 14

IOM Tackles Health Disparities

Joseph R. Betancourt, MD, MPH

The prestigious Institute of Medicine (IOM) of the National Academy of Sciences, chartered by Congress to advise the federal government on issues of medical care, research, and education, has taken on health disparities as part of its recent charge. Two studies will be released this year that directly address key aspects of this national crisis.

Since the President's Initiative on Race was set forth in 1998—of which the elimination of racial and ethnic disparities in health was a major cornerstone—the federal government has been actively engaged in fostering efforts to understand better the root causes of disparities, while also trying to develop interventions to eliminate them. Examples have included the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED), funded by the Agency for Healthcare Research and Quality (AHRQ), and the Racial and Ethnic Approaches to Community Health (REACH) projects, supported by the Centers for Disease Control and Prevention (CDC).

Although progress is being made and researchers are digging deeper, more questions seem to arise and the complexities underlying health disparities are being revealed. As a result, in early 2000 the Office of Minority Health of the U.S. Department of Health and Human Services commissioned the first IOM study on disparities, entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. A committee of academicians, medical educators (including SGIM members), health services researchers, health policy makers, economists, social psychologists, social scientists, lawyers, practicing physicians, and nurses was assembled to tackle the issue of health disparities. The charge to the committee

continued on page 14

RESEARCH FUNDING CORNER

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner highlights the Translating Research into Practice program of the Agency for Healthcare Research and Quality (AHRQ) and the Health Services Research and Development Service (HSR&D), Department of Veterans Affairs (VA), and career development awards in patient safety offered by AHRQ.

Translating Research into Practice

On February 19, 2002, AHRQ and HSR&D issued a new program announcement (PA), Translating Research into Practice (TRIP) (PA-02-066). This PA will use the R01 award mechanism for applicants applying to AHRQ. The PA expires on July 24, 2004 (for R01s).

The TRIP program will support innovative and rigorous research and evaluation projects that deal with the translation of research findings into measurable improvements in quality, patient safety, health care outcomes, cost, use, and access. Two categories of applications are eligible for consideration: 1) comparative studies, conducted concurrently in VA and other settings, and 2) translation studies, which may be done in either VA or non-VA settings. If a VA setting is included in an application, the investigator must meet the eligibility requirements of the VA to receive VA funding for the VA site. To be eligible for studies in the VA, principal investigators (PIs) and co-PIs must have a VA appointment (minimum of 5/8ths time). Non-PI investigators who collaborate on the project do not need a VA appointment.

AHRQ and HSR&D are especially interested in recommendations, tools, and strategies that can be used to implement research findings across multiple levels of health care delivery and multiple types of health care-

related systems. This PA will support research that not only identifies and tests new methods for translating research into practice, but also expands the use of tested methods of translating evidence-based information across larger populations, different health care systems, or different clinical situations.

This PA is available at grants.nih.gov/grants/guide/pa-files/PA-02-066.htm. Further information about eligibility to be a VA investigator is available at www.va.gov/publ/direct/health/direct/195036.htm and www.va.gov/resdev/directive/VHA_Handbook_1200.15_Eligibility.doc.

Career Development Grants in Patient Safety

On December 20, 2001, AHRQ released a notice (NOT-HS-02-001) announcing its intention to fund career development (K) awards for investigators who want to develop research careers in areas related to patient safety. Applications for these awards must

include projects that will address key unanswered questions about how errors occur and provide science-based information on what patients, providers, hospitals, policymakers, and others can do to make the health care system safer. Research should identify strategies that work in hospitals, doctors' offices, nursing homes, and other health care settings across the nation.

This notice is available at grants.nih.gov/grants/guide/notice-files/NOT-HS-02-001.html. Additional information about AHRQ's research agenda in patient safety may be found at www.ahrq.gov/qual/errorsix.htm. Additional information about AHRQ-sponsored career development grants is available at www.ahrq.gov/fund/training/trainix.htm##.

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

Practice-Based Research Networks: Growing the Evidence for Primary Care

John G. Ryan, DrPH

Pprimary care practices and patients presenting to these practices represent a genuine conundrum for researchers. They are a potential goldmine of data with which to examine the structure, processes, and outcomes of primary care, the level at which people interact most often with the U.S. health care system. It is in primary care practices that evidence can potentially be acquired with which to address important health care issues that cause significant morbidity: asthma, diabetes, back pain, headache, and the common cold. It is in primary

care practices that we can potentially translate research into practice, bridge the performance gap, answer "real-world" research questions, improve the quality of health care in America, and prevent avoidable hospitalizations. However, it is in primary care practices that researchers are less able to control for confounders, standardize patients, and acquire statistically rigorous sample sizes in reasonable timeframes.

The untapped potential of primary care practices has been recognized by the giants in our field: Will Pickles,

continued on page 13

TEN REASONS TO ATTEND
continued from page 1

- Medicine. Dr. Centor will discuss briefly the history of academic general internal medicine in the United States. Though general internal medicine is now an established discipline, it was not until the 1970's that separate divisions were started anew. We look forward to hearing Dr. Centor discuss the forces that have and will shape modern general internal medicine as we look towards the future.
- ◆ **Award Abstract Sessions** — New this year are special abstract sessions for finalists for the Hamolsky Junior Faculty and Lipkin Associate Member Research Awards. These sessions will include the 12 top-rated abstracts submitted by junior faculty and Associate Members. Come and root for your favorite finalist. See if you agree when the winners are announced at the Saturday morning plenary.
 - ◆ **Pre-Meeting Reception** — A pre-meeting reception will be held in the lobby of Grady Memorial Hospital on Wednesday, May 1, 2002. We invite all members to join us for this open reception. The history of this previously segregated public hospital and its role in the integration of medicine in the South will be discussed and refreshments provided. Van transportation will be available for those who do not wish to walk or take public transportation. Though the meeting precourses will not start until Thursday, we welcome all those in Atlanta on Wednesday to come on by and enjoy this unique event. Please be sure to register for this free event, so we'll know how many to count on!
 - ◆ **Evidence-Based Updates** — As in the past, there will be evidence-based updates on General Internal Medicine, Women's Health, Geriatrics, HIV/AIDS, and the work of the U.S. Preventive Services Task Force. In addition, there will be new updates on Minority Health and Community-Based Preventive Services. The Clinical Crossroads will feature Dr Harold G. Koenig, MD, MHSc, who will discuss how patients' spirituality can interface with their medical care.
 - ◆ **5K Run** — Put on your running shoes and crawl out of bed early Saturday morning for a 5K run. It's for a good cause, and we'll give you a nice shirt. Even if you wind up running one block and walking the rest, it'll be a great way to start the day. Ellen and Jeff promise that no one runs slower than they do!
 - ◆ **New traditions** — We will continue popular features introduced at recent Annual Meetings, such as an Unknown Clinical Vignette session led by eminent generalists and sessions on Innovations in Medical Education and Practice Management.
 - ◆ **Old traditions** — The meeting will include 23 stellar precourses, 65 interesting workshops, and 726 exciting abstract presentations. Several sessions will be devoted to our theme.
 - ◆ **Other special programs and features** — Other offerings include Meet-the Professor sessions, One-on-One Mentoring, Interest Groups, and a new Student/Resident/Fellow (SRF) program. The SRF program is designed to encourage careers in general internal medicine, and enrich learning experiences at the meeting. In addition to a First-Time Attendees Reception, there are specially designated learning/activity tracks, and a SRF lounge for networking, visiting, or relaxing.
 - ◆ **Music** — We are recruiting some of our more talented members to provide music at the breaks and prior to our meals. If you are blessed with musical talent and/or lack of inhibitions about sharing your talents, please contact Linda Pinsky, MD (lpinsky@u.washington.edu), Eric Whittaker, MD (whittaker@cchil.org), Jeff Jackson, MD, MPH (jejjackson@usuhs.mil), or Ellen Yee, MD, MPH (efyee@ucla.edu).
- On behalf of our President, Kurt Kroenke, the Program Committee, and over 245 dedicated SGIM members that have worked to bring you this program, we invite you to join us in Atlanta. We plan to showcase the best that our diverse Society members have to offer. Whatever your interest, be it clinical medicine, administration, education, or research, we believe you will find something in our program that appeals to the passion in your heart! We look forward to seeing you in Atlanta. **SGIM**

BUDGET CUTS
continued from page 5

Action Center is described in more detail by Mark Liebow in another article in this issue of *Forum*. SGIM members can access the Advocacy Action Center at www.capwiz.com/sgim/home/ or through the Advocacy link on the SGIM Web site (www.sgim.org).

SGIM will hold a "Hill Day" on May 15, 2002. On this day SGIM members will meet with key legislators and their staff to discuss funding for AHRQ and Title VII. Members who wish to participate in Hill Day should contact David Calkins, Chair, Title VII Cluster, Health Policy Committee

(David_Calkins@hms.harvard.edu), or Jenn Jenkins, SGIM Government Affairs Representative (jjenkins@mail.acponline.org). SGIM members also may contact Ms. Jenkins if they would like to meet with a legislator during a visit to Washington, DC, or if they would like to set up a visit at home during a Congressional recess. SGIM members who want to hone their advocacy skills are encouraged to participate in the precourse "Health Policy Advocacy in the 21st Century" at the Annual Meeting. **SGIM**

VALEDICTORY

continued from page 3

Brownian motion. In short, active involvement and frenzied education are two characteristics of an SGIM meeting. A third is the contagious nature of the meeting for newcomers. I remember my first Annual Meeting in 1984. Coming from a small teaching hospital that was not affiliated with a medical school, I felt a little like an immigrant checking into Ellis Island. By the time the meeting ended, however, I felt connected to others who were committed to generalist practice, teaching of students and residents, and atypical but exciting types of clinical research. In short order, I had become a first-generation SGIM-er. Thus, I am convinced the Annual Meeting is one place we must always make the newcomer feel welcome and the established member feel wanted. SGIM is of course much more than its Annual Meeting. But the Annual Meeting must remain a mountaintop experience for first-time attendees and rejuvenating for those who return.

We need not look like our childhood picture

In just over a decade, general internists have experienced the wide temperature swings of the primary care movement, which has gone from cold to hot to lukewarm. They have experienced competition from medical subspecialists as well as other generalists, including family physicians, nurse practitioners, and physician assistants. New movements continue to emerge, such as hospitalism and medicine-pediatrics. There have been struggles with managed care. Who knows where the pendulum will swing next? We must regularly reinvent ourselves, rather than reactively respond in a sporadic or erratic fashion. Adaptation is a continuous process akin to quality improvement. Our individual and organizational identity must be redefined periodically and open-mindedly. While holding fast to nonnegotiable values, we must be nimble enough to let go of ballast that may be dated and holding us back.

Focus in moderation

Prioritize, but not obsessively. Accept the two-edged sword of generalism. The values of breadth, holism, expansiveness, comprehensiveness, and eclecticism are usually the blessing but occasionally the bane of general internal medicine. Both as individuals and as an organization, we must avoid the excesses of generalism that tries to be all things to all people. As academic physicians we deal with the paradox of needing to specialize within GIM, be it in education, a clinical area, or a type of research. Some of us must become specialists-generalists or, to borrow a phrase coined some years ago in an SGIM President's column, "specialoids." Likewise, SGIM must pick its targets selectively, so it has adequate resources to accomplish some things exceptionally well.

At the same time, we are generalists and SGIM is a generalist organization. We chose this career and consequently this Society because we preferred the broad and meandering trail to the straight and narrow highway. The big picture captivates us, with its panoramic view. I think of that type of photograph in which objects of varying distances are all part of the print. No one image is in perfect focus, yet multiple depths are exposed, developed, and framed together.

Don't retreat from complex issues

Accept the fact that tough decisions may sometimes be polarizing. Whatever the outcome on a particular issue, continue to welcome a loyalist opposition. A family is strengthened by working through disagreements and even at times by accepting that alternative but valid viewpoints might need to coexist peacefully. Just as heterogeneity in the gene pools strengthens the species, so too does dialogue, deliberation, debate, and honest differences enrich a society. SGIM needs to remain interdisciplinary, multigenerational, demographically diverse, and a melting pot of ideas, attitudes, and pathways.

There is a phrase, "all on the same page." Although this is often something desirable to strive for, I would also argue that a variety of different pages can likewise make an interesting chapter.

More is more

One of my favorite quotations is "less is more" by the minimalist modern architect, Mies van de Rohe. It is sage advice for teachers preparing lectures and handouts, fellows preparing posters or 10-minute talks for scientific meetings, or researchers simplifying their hypotheses or study designs. However, in terms of member involvement in SGIM, I believe "more is more." The Annual and Regional Meetings are one venue. Another is a proliferation in the number and the size of our Interest Groups. Service on an SGIM Committee or Task Force is yet a third way members can become actively engaged in the Society. Thus, the architectural metaphor I prefer here is not modern but baroque: a style exuberant, prolific in variety and details, busy. SGIM should continue to be not only its members' primary organization but also one in which they actively engage in a way salient to their career. An identified niche for each member coupled with enhanced electronic communication capabilities will accelerate SGIM's aim of meeting members "where they are" on a year-around basis.

Heraclitus, the ancient Greek philosopher, said: "You can never step into the same river twice." The paradox is that although the river as a whole is one, each time you step in the river the former water has moved on and your feet are surrounded by new eddies. I predict that this metaphor, which has characterized SGIM since its inception in 1977, will continue to be a portrait of our Society as we move forward in the 21st century. **SGIM**

ACCEPTANCE AND DISCLOSURE OF EXTERNAL FUNDS

continued from page 4

Notably, any financial relationship with an external funder may create a potential conflict of interest for SGIM. Conflicts of interest are common and not by themselves unethical. Regardless of whether the conflict of interest results in inappropriate action, the appearance of a conflict of interest may be damaging to SGIM’s reputation. Concerns that the acceptance of external funds creates an inappropriate conflict of interest, with the greatest potential for inappropriate action, are particularly acute in two situations: when external funding is from for-profit companies (or not-for-profit entities funded largely by for-profit companies); and when the amount of external funding, particularly from a single source, becomes large enough to create dependence.

With these observations of the benefits and risks of external funding in mind, SGIM has established the following guidelines for the acceptance of external funds.

Guidelines for the Acceptance of External Funds

Projects in General. SGIM should accept external funds only for high quality projects that are:

- ♦ consistent with the SGIM mission, “To promote improved patient care, teaching and research in primary care and general internal medicine”;
- ♦ judged to be particularly well suited to be carried out by SGIM as an organization (especially in contradistinction to individual Society members or groups of members working through their own institutions), especially if SGIM is to be the primary recipient of external funds for the proposed project; and
- ♦ judged to be unlikely to create undue competition with individual SGIM members’ pursuits of funding for their own research or educational projects.

The authors of this policy acknowledge that there will be subjectivity in decisions regarding which projects are particularly well suited to be carried out

by SGIM (particularly as primary recipient of external funding) and which projects are unlikely to cause undue competition with its members for funding. In general, projects for which SGIM is particularly well suited create the opportunity for participation of large numbers of SGIM members in ways that would be difficult or impossible to arrange through standard mechanisms of funding to hospitals and universities. Undue competition is more likely to be a problem when SGIM responds to requests for proposals and applications from funders which are also likely to attract proposals and applications from individual members or groups of members. When more than one SGIM member independently approaches the organization regarding obtaining funding for a project of a similar nature, and particularly when SGIM’s participation would be mutually exclusive, every effort should be made to foster collaboration among the interested individuals so that a single project proposal results. If, despite these efforts, more than one proposal is submitted for a similar project, and SGIM’s participation is mutually exclusive, these projects would be reviewed in parallel, with heightened concern about undue competition.

In addition, SGIM should not accept external funds, either directly or indirectly as a subcontractor to another entity, from for-profit companies (or not-for-profit entities funded largely by for-profit companies) for research or educational projects related to specific pharmaceuticals, medical devices, diagnostics, or any other product purported to have direct health benefits to patients (regardless of whether the products are sold by that particular external funder). In addition, SGIM shall not accept external funds from companies that make or sell tobacco products.

Finally, dependence is potentially created when SGIM’s core operations become too reliant on external funding. External funds that “pass through”

SGIM to other individuals and groups for the accomplishment of specific projects or for awards do not create dependence, nor do funds that are saved by SGIM for future disbursement for these purposes. The SGIM operating budget best reflects expenses for core activities; it is the proportion of external funds that comprises the operating budget that, if too high, raises concerns about dependence. In this context, “internal” funds are considered revenues from dues, meeting and course registrations, serial publications, sales of products and services to members, and member donations. “External” funds are revenues from all other sources. External funds used specifically for the Society’s operations and included in the annual operating budget should not comprise more than approximately 25% of the Society’s annual operating budget, and no more than approximately 5% of the Society’s operating budget should be derived from any single for-profit source of external funding (see Appendix 1 for details on this calculation).

Educational Projects. SGIM must retain ultimate control over educational content, selection of speakers, review of educational materials, selection of research for presentation, or other activities with scientific content that are financed with external funds.

Research Projects. SGIM will retain control of the selection of project personnel and other activities for the conduct of research activities for which the Society accepts external funding.

Use of Human Subjects. If an externally funded research or educational project involving SGIM requires use of human subjects in any way, it is the responsibility of the project’s proponents to obtain appropriate IRB approval(s). SGIM will not maintain a central IRB.

Freedom to Publish Results. The proponents of any externally funded research or educational project involving SGIM shall have the right to

continued on next page

ACCEPTANCE AND DISCLOSURE OF EXTERNAL FUNDS

continued from previous page

publish their findings without interference from the external funder. Only nonbinding, expeditious review and comment on written results by the external funder is acceptable. The Society encourages but neither requires nor commits to publication of the results of these projects in the *Journal of General Internal Medicine*.

Intellectual Property. When SGIM serves as the primary entity accepting external funds for a research or educational project, SGIM reserves the right to all intellectual properties resulting from the project. When SGIM collaborates with another entity that is the primary recipient of funds for the project, that entity, usually the project proponent's academic institution, will generally have the right to all intellectual properties resulting from the project. In the latter case, an agreement regarding intellectual property must be documented in writing between the concerned institutions and SGIM and approved by Council.

Budgets. When externally funded research or educational projects require using SGIM resources at the National Office, a budget for those activities should be negotiated between the Executive Director and the SGIM members responsible for the project to cover the direct costs of SGIM's participation. In general, to cover SGIM's indirect costs, an additional percentage reflecting the Society's overhead costs as negotiated with the Federal government (currently 30%) will be added to the budgeted direct costs (but not to other funds that "pass through" SGIM to other parties for completion of the project). The final budget for each project, including any deviations from the usual overhead rate, must be approved by the SGIM Treasurer. External funds for awards or prizes which reflect acknowledgment for completed work (rather than grants for new work), and which require minimal use of resources at the SGIM central office, as judged by the Executive Director, do not require a specific

budget. Rather, a reduced overhead rate of 10% will be added to the total amount of the award to account for the Society's costs for publicizing, selecting, and administrating the award.

Competitive Projects. When SGIM accepts external funds for research or educational projects that involve a selection process with submitted proposals, the external funder can have limited input in the selection criteria for which proposals will receive funding, and will receive information about which proposals did and did not receive funding. However, final funding decisions will be made by a group designated by SGIM, independent from the external funder. This group may include both SGIM and non-SGIM members.

Awards. When SGIM accepts external funds for awards that reflect acknowledgment for work already completed, awardees will be selected based on criterias, established by SGIM. The sponsor may have limited input in the selection criteria, but SGIM retains ultimate control over selection of the award recipient. The sponsor can impose no obligations on the recipient of an award.

Access to SGIM Members. Access to SGIM members or to recipients of external funds shall not be a condition of support from an external funder, including access through talks by representatives of the external funder at regional or national meetings.

Disclosure. SGIM should disclose all sponsored activities that are partially or completely financed by external funds, including but not limited to research grants, presentations and publications, and support of policy efforts (see subsequent section of procedures for disclosure).

Business Relationships. SGIM may establish a business relationship with an individual, group, or organization to endorse, develop, distribute, or sell products or services, for example, journals, books, software, or other educational products. However, accep-

tance of any funds that come to SGIM from these relationships will be governed by these guidelines for external funding of projects. For example, SGIM shall not receive funding to endorse, develop, distribute, or sell products such as pharmaceuticals, medical devices, diagnostics, or other products purported to have a direct health benefit to patients. In addition, SGIM shall not enter business relationships with companies that make or sell tobacco products.

Acknowledgments. Tasteful acknowledgment of external funders may be made in the Society's publications, meeting materials, or reports of project results, as appropriate. These acknowledgments should not advertise any products or services of the funder. Ultimate decisions about the tastefulness and appropriateness of any acknowledgments of external funding rests with the Society.

Advertising. The *Journal of General Internal Medicine* may accept advertisements for medically related products and services. Final judgment regarding the appropriateness and acceptability of advertisements rests with the *Journal's* editorial staff. Advertising (except for classified advertising of positions available and announcements) will not be accepted for the Society's other publications, including the *SGIM Forum* and Web site.

Because the opportunities for external funding for valuable projects are varied and to some extent unpredictable, exceptions to these guidelines may be appropriate in some circumstances. Any exceptions, however, must be approved by the SGIM Council. As circumstances may also change over time, this policy should be reviewed at least every three years by Council and amended if necessary.

Procedures for Reviewing External Funding

All SGIM members, staff, or consultants involved in negotiations with

continued on next page

ACCEPTANCE AND DISCLOSURE OF EXTERNAL FUNDS

continued from previous page

external funders should be familiar with this policy. The initiation of the approval process should begin early in any quest for external funding, ideally when an SGIM member or group of members first conceives of a project requiring SGIM's participation and external funding, or when an SGIM member or group of members is first approached by an external funder about a potential project requiring SGIM's participation.

General contributions, including contributions for awards, will be handled directly by the Development Committee. All general contributions, except unrestricted educational grants less than \$5,000, will also be reviewed by the chair of the Ethics Committee. Any general contribution that raises concerns will undergo a full Ethics Committee review (see below).

Proposals for research or educational projects requiring external funding and for which the applicant(s) request SGIM's involvement should come from an SGIM member or groups of members (with one member designated as the main point of contact).

At minimum, proposals for research or educational projects should include a standard cover page and a three- to four-page abstract describing the project's objectives, methodology, timetable, the estimated budget and proposed source of external funding, human subjects/IRB issues, and how it satisfies the SGIM guidelines for the acceptance of external funds. A biographical sketch of each key participant should be included. Additional supporting materials may be included. A template for proposals for externally funded research or educational projects is included as Appendix 2 of this policy.

Proposals for research or educational projects should be submitted to the SGIM Development Director, who will triage them as follows:

- ♦ Research projects will go to the Chair of the Research Committee.
- ♦ Educational projects will go to the Chair of the Education Committee.

The Chairs of these committees will preliminarily review the proposal (in consultation with the Executive Director), focusing on compliance with the external funding guidelines and feasibility of the project, and either reject the proposal, return the proposal to the applicant(s) for revision, or forward the proposal for a full review. Full review would be undertaken by a subcommittee of each committee consisting of three members, with approval to move the project forward required from at least two of the three members. Reviewers would be asked to declare any potential conflicts of interest in their evaluation of assigned proposals; occasionally, such a declaration may lead the committee chair to replace a reviewer.

Each proposal for external funding for research or educational projects forwarded for a full review by the Research or Education Committee will also be reviewed in parallel by the Chair of the Ethics Committee. If any concerns are raised, the Chair of the Ethics Committee will appoint three Ethics Committee members to perform a full ethics review. Once again, approval to move the project forward would be required from at least two out of the three members.

During the period of full review, the proposal would be posted on the SGIM Web site, and all SGIM members with active e-mail addresses in the Society's membership database would receive a brief message about the nature of the project under review, referring them to the full proposal. Any concerns of individual members, especially regarding competition with their own efforts, should be communicated to the Chair of the Research or Education Committee within two weeks of the posting. These messages would in turn be forwarded to the committee members performing the full review, and considered in the deliberations regarding project approval.

In parallel with the committee reviews described above, the proposal

would be reviewed by the SGIM Treasurer to determine whether the new funding would bring the total amount of external funding above acceptable thresholds for the year(s) when the project would be conducted. Projects approved to move forward by either the Education or Research Committee and the Ethics Committee, with assurance by the SGIM Treasurer that the new funding does not violate the acceptable external funding limits, would be forwarded to the SGIM Council for final approval at a monthly conference call or meeting. The goal of the entire review process should be to accept or reject proposals within 60 days of submission.

SGIM acknowledges that occasionally opportunities for externally funded research or educational projects may be time-limited. If a decision on SGIM's participation must be made in less than 60 days, a letter requesting an expedited review can accompany the proposal. Decisions regarding the desirability, practicality, and mechanisms of an expedited review will be made by the Executive Director, in consultation with the chairs of the appropriate committees (Research or Education and Ethics).

If a proposal is not recommended for further consideration at any stage of the process, the proponents may appeal the decision in writing to the SGIM Executive Committee. The Executive Committee may confirm or override the original decision; in the latter case, the proposal would proceed to (but not circumvent) the next step in the review process.

Procedures for Disclosure of External Funding

When external funding supports presentations or awards at regional or annual meetings, the program for the meeting should indicate the sources and nature of external support. Speakers should disclose whether any part of their presentation resulted from external funding and whether they have any personal financial interest in the

continued on next page

ACCEPTANCE AND DISCLOSURE OF EXTERNAL FUNDS

continued from previous page

subject matter of the presentation.

All externally funded research and educational projects will be posted on the SGIM Web site by leaving the project descriptions, originally posted for member review and comment, on the site with an indication that funding was ultimately accepted for the project.

The SGIM Treasurer will prepare an annual report on the sources and amounts of external funding at the end of each fiscal year, along with a calculation of the proportion of the operating budget for the fiscal year derived from external funding. The report, when accepted by Council, will also be posted on the SGIM Web site.

Appendix 1. Calculation of the proportion of the SGIM operating budget attributable to external funding

The denominator of this calculation will be the total operating budget for the fiscal year, including contract offsets (deducted from expenses). The numerator of this calculation will be the amount of the total actual operating budget derived from all external sources (and, separately, from any one for-profit source), other than membership dues, membership list sales, member contributions, interest income, submission and registration fees for the Annual Meeting, newsletter income, JGIM income (including Editor's Office revenues and royalties), and funds transferred from reserves.

Example

The actual operating budget for SGIM for a given fiscal year is \$1,900,000 (including contract offsets deducted from expenses). Of this amount, a total of \$275,000 (14.5% of the actual operating budget) is derived from contributions and income from external funders, including royalties, contributions, exhibit fees, and contract offsets. The largest source of revenue, a for-profit entity, contributed \$65,000 (3.4% of the actual operating budget) in royalties. Neither percentage is high

enough to raise concerns about dependence (see guidelines).

Appendix 2. Template for proposals

RESEARCH NETWORKS

continued from page 7

John Fry, Curtis Hames, Paul Nutting and Larry Green, to name a few. The dilemma has always been how to harvest the rich data that are available while overcoming the difficulties of pursuing scientific endeavors in primary care medicine. In the 1980's, Larry Green, Paul Nutting, and others became vocal advocates for a concept that would overcome some of the difficulties of investigating health care issues in general outpatient practices. They recommended that primary care physicians emulate the methods long applied in Europe, whereby general, community-based, primary care practices formed *de facto* national or regional networks of practices by virtue of their information infrastructure. For example, the British have a rich history of examining large health care data sets describing patients presenting to numerous primary care practices. Based on this model, the Ambulatory Sentinel Practice Network (ASPN) was established as a means of bringing together primary care physicians, mostly family physicians, from the United States and Canada in the form of a network of physicians interested in doing something different in their practices. Their common bond was their commitment to proactively ask and discern the answers to questions that could help them provide better medical care to their patients.

In recent years, the concept of practice-based research networks (PBRNs) has grown significantly, propelled forward in large part by the Committee on the Future of Primary Care, convened by the Institute of Medicine. The Committee's 1996 report is considered seminal because of its updated definition of primary care and its endorsement of PBRNs. The

to SGIM for research or educational projects requiring SGIM's participation and external funding.

(To be developed) **SGIM**

Committee described PBRNs as "the most promising infrastructural development that [the Committee] could find to support better science in primary care." Many academic primary care departments, particularly in family medicine, successfully developed regional or statewide PBRNs as platforms upon which to build a research infrastructure. Today, regional and national PBRNs are offering critical contributions to the evidence base of family practice, general pediatrics, and general internal medicine.

In 1995, a core group of network directors affiliated themselves in an umbrella organization, the Federation of Practice-Based Research Networks (FPBRN). The mission of FPBRN is to expand the number of PBRNs in the U.S., provide technical assistance to new networks, promote network-to-network collaboration, and foster greater appreciation of the unique capabilities and infrastructure needs of networks among government and private funding agencies.

The seeds planted through the advocacy efforts of numerous primary care researchers, organizations representing primary care physicians, and the FPBRN appear to be bearing fruit. Through a Request for Applications (RFA) published in early 2000, the Agency for Healthcare Research and Quality (AHRQ) provided competitive funding to support the infrastructure needs of 19 PBRNs. AHRQ released a second RFA in 2001 to provide AHRQ-supported networks with funding for research in bioterrorism. More recently, other sponsors have endorsed PBRNs, including the National Cancer Institute and the Robert Wood Johnson Founda-

continued on page 15

HEALTH POLICY ADDITION*continued from page 5*

components: Health Policy News and Issue Briefs. In Health Policy News you will find legislative updates on topics of interest to SGIM, as well as a summary of SGIM's advocacy activities on these topics. In Issue Briefs you will find background material on the topics that are the focus of the Health Policy Committee's nine clusters. In the future Where We Stand will add two additional components: Letters to Congress and Administration, and Position Papers. Letters to Congress and Administration will include letters sent by SGIM as well as letters sent by other organizations in which SGIM participates (e.g., Friends of the Agency for Healthcare Research and Quality, Health Professions and Nursing Education Coalition). Position Papers will provide access to documents outlining SGIM policy on specific issues (e.g., access to care).

The fourth section, Health Policy Discussion Group, has not been completed yet. When it is functional (in a few months), it will be a bulletin board for health policy topics of interest to SGIM members. The Health Policy Committee will monitor the bulletin board from time to time and will try to answer questions as well as contribute to the discussion. The Health Policy Discussion Group will not be a chat room and so will be available at any time for asynchronous discussion. This section also will be password-protected.

The fifth section, SGIM Government Affairs Staff, identifies SGIM's health policy consultants at Medical Advocacy Services, Inc. (MASI).

The Health Policy Committee began work on this Web site addition in 1999. Jenn Jenkins from MASI and staff in the SGIM National Office, especially Kay Ovington, have been extremely helpful in making it a reality. We welcome comments on and questions about the addition. There will be a formal evaluation available online and through the *Forum* within the next few months. **SGIM**

SGIM'S WOMEN'S CAUCUS*continued from page 6*

(26%); and identification of meeting leaders (23%). Respondents most often requested speaker presentations on faculty development (85%), women's health education (43%), and gender issues/sexual discrimination in medicine (36%). To continue communication between Annual Meetings, most respondents preferred quarterly updates via electronic mail.

Reviewing the survey results and past accomplishments of the Caucus calls attention to a few issues. The Women's Caucus remains an invaluable resource for collaboration and mentorship for SGIM's women members. In addition, while women are a more visible group within SGIM, promotion and leadership are still important issues for most women in academic medicine.

We encourage all members to view information about the Women's Caucus on the SGIM Web site (www.sgim.org). The Web site includes the article, "The First Decade of the SGIM Women's Caucus," that was originally published in the November 1996 issue of the *Forum*. It lists important milestones in the work of the Caucus since its inception. It also allows members to join the Caucus listserv or pay annual dues. (Note: The annual dues letter on the Web site replaces the annual dues letter that was previously sent by mail.)

We also invite members to attend the Women's Caucus Interest Group meeting at the Annual Meeting in Atlanta. The Interest Group meeting is Friday, May 3, from 7:00 to 8:30 p.m. A panel of Caucus members will share their views on issues for women in leadership positions in academic medicine. Participants will include Fran Brokaw, Sandra Fryhofer, Katherine Kahn, Ann Nattinger, and Judith Walsh.

We hope that during the next 25 years SGIM will continue to have an active Women's Caucus with programs that appeal to the unique career development needs of women within SGIM. **SGIM**

HEALTH DISPARITIES*continued from page 6*

tee was three-fold: to determine the presence and extent of racial/ethnic disparities in health care, to identify potential root causes other than access to care, and to provide recommendations for strategies to eliminate disparities. Given that the charge was limited to disparities in health care (versus the larger issue of health outcomes) once access had been achieved, specific areas of exploration included health system factors (e.g., financial and institutional arrangements, structural processes of care) and provider level factors (e.g., communication in the medical encounter, the effect of race/ethnicity on clinical decision making). To carry out its responsibilities over the 18 months of the study, the committee reviewed a significant amount of evidence, including a literature review of over 600 manuscripts, commissioned papers (on topics ranging from an exploration of health disparities to the economic, ethical, and legal ramifications of disparities in health), and expert testimony. In addition, the IOM commissioned focus groups of patients and providers, and sponsored a public workshop on the issue of health disparities. The report was released on March 20.

A second IOM study dealing with disparities was commissioned in late 2001. The goal of the Committee on Developing a National Health Care Disparities Report is to advise AHRQ on the format and content of an annual report to be submitted to Congress on prevailing disparities in the quality of health care based on access (uninsured versus underinsured versus insured), race/ethnicity, geography (rural versus urban versus suburban), and socioeconomic status. This annual report will be an adjunct to the *National Health Care Quality Report* and will serve as a barometer by which to gauge progress in improving the performance of the health care delivery system in consistently providing high-quality health care. Similar tools are used in other

continued on next page

HEALTH DISPARITIES

continued from previous page

areas to track the state of the economy and to help shape economic policies (e.g., the Consumer Price Index and other economic indicators issued by the Bureau of Labor Statistics).

The Committee on Developing a National Health Care Disparities Report is also composed of experts (including SGIM members) in health services research and health policy, who will be reviewing evidence such as commissioned papers, expert testimony, and the findings of a public workshop. They will focus on measures that span preventive care, acute care, chronic care, and long-term care, all grounded within the principles of effectiveness, safety, patient-centeredness, timeliness, efficiency, and equity—the pillars of quality proposed by an earlier IOM report, entitled *Crossing the Quality Chasm*.

What does this mean for academic generalists? Clearly, both IOM reports will have a great impact on how we devise our health care delivery system (including, for example, data collection and quality improvement) and how we practice medicine. Having a greater understanding of the root causes of disparities should allow us to intervene accordingly, whether in our roles as opinion leaders, administrators, teachers, or caregivers. The IOM reports will provide a well thought out blueprint for determining where we've been, where we are, and where we need to go as it relates to health disparities. They will help in designing interventions to reduce disparities.

Needless to say, disentangling the multifactorial and complex causes underlying racial and ethnic disparities is extremely challenging. The literature is expansive, yet, as one might expect, imperfect, given how difficult it is to study these issues in a clear and simple fashion. Actors within the health care system hold steadfast to their specific perspectives on the causes of disparities and strategies to eliminate them, yet all agree that something must be done to address this national problem. Measure-

ment of our progress to eliminate disparities is equally difficult and challenging, yet absolutely required if we are to chart our movement and document our successes. The two IOM committees have taken their collective responsibilities to address these important tasks very seriously. Their reports should help guide future efforts to eliminate racial and ethnic disparities in health care. **SGIM**

RESEARCH NETWORKS

continued from page 13

tion. On February 6, 2002, AHRQ released a new RFA to develop or enhance PBRNs (RFA-HS-02-003, described in the March 2002 issue of *Forum*). Applications are due May 14, 2002. On February 19, 2002, AHRQ and the Health Services Research and Development Service (HSR&D), Department of Veterans Affairs (VA), issued a new program announcement (PA), Translating Research into Practice (TRIP) (PA-02-066, described elsewhere in this issue of *Forum*). TRIP is also network-friendly.

More information about the resource needs for developing and managing a regional PBRN may be obtained from FPBRN (www.aafp.org/research/fpbrn/) or from the author (johngryan@miami.edu). FPBRN

Editor's Note—Joseph Betancourt and Thomas Inui, members of the IOM Committee on Understanding and Eliminating Racial/Ethnic Disparities in Health Care, will join other experts in minority health in leading a workshop entitled “The IOM Report on Racial/Ethnic Disparities: Findings, Recommendations, and Concrete Next Steps” at the SGIM Annual Meeting, Saturday, May 4, 2002, 10:00–11:30 a.m.

also sponsors preconference workshops at annual meetings of the North American Primary Care Research Group (NAPCRG). The 2002 NAPCRG Annual Meeting will be in New Orleans, Louisiana, November 17–20. Meeting information is available on NAPCRG's Web site www.napcrg.org. **SGIM**

Editor's Note—Dr. Ryan is Assistant Professor and Director, Division of Primary Care/Health Services Research and Development, Department of Family Medicine and Community Health, University of Miami School of Medicine. He is also Vice-Chair, FPBRN.

LEADERS MAKE A DIFFERENCE

continued from page 2

into SGIM's operations. I don't want to re-open that dialogue in this report; there will be another town meeting at the upcoming Annual Meeting in Atlanta to continue the discussion. I do want to remind us all that campaign contributions to SGIM are revenues that, without question, reflect our shared values and interest in SGIM's future. This campaign will strengthen the relationship between the Society

and its members. It is a substantial opportunity to shift from potential conflicts of interest to a confluence of interest. I encourage you to join your colleagues who have already made a contribution and “Make a Difference!” **SGIM**

Editor's Note—Tom Inui is a Past-President of SGIM and Chair of the “Make a Difference!” Campaign.

SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037

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 PHYSICIAN TO DIRECT HOSPITALIST PROGRAM. Assistant Professor (CHS): Extraordinary opportunity for a physician 2–3 years into their career to head up our established hospital-based program at the University of Wisconsin, Department of Medicine. Position includes 30–40% protected scholarly time (first two years) in the areas of patient safety/quality improvement, informatics and administrative responsibilities as Director of the Program; 4–5 months of inpatient responsibilities; 1–2 half-days/week of outpatient work; educational opportunities to teach medical students and residents; and, ongoing involvement in career development of other Hospitalist Program faculty. The UW-Madison is building a culturally diverse faculty and strongly encourages applications from minority candidates. The UW Madison is an EEO/AA employer. Please send letters of interest and CV to Dr. Juanita Halls, University of Wisconsin-Madison, Clinical Services Chief, Section of General Internal Medicine, 2828 Marshall Ct., Suite 100, MC 9054, Madison, WI 53705.

GENERAL INTERNAL MEDICINE FELLOWSHIP AT NEW YORK UNIVERSITY/BELLEVUE: NYU's recently funded Division of Primary Care's 2-year Fellowship Program has openings for candidates for academic year 2002–2003. Fellows prepare for academic general internal medicine careers through formal training and practical,

mentored experience in clinical research and medical education, including courses on research methods, clinical epidemiology, health policy, clinical teaching, curriculum design, leadership, psychosocial medicine, cross-cultural medicine/immigrant health and quality improvement. Masters degrees are optional. For inquiries, Dr. Mark Schwartz, Mark.Schwartz@nyu.edu. For applications, Jennifer.Rockfeld@med.nyu.edu or 212-263-8895.

TRAINING IN FACULTY DEVELOPMENT. The Stanford Faculty Development Center (<http://sfdc.stanford.edu>) is accepting applications for three, month-long, facilitator-training programs. The training prepares faculty to conduct a faculty development course in one of three content areas

for faculty and residents at their home institutions. (1) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. (2) The End-of-Life Care course is designed to increase physicians' competence in the delivery and teaching of end-of-life care. (3) The Geriatrics in Primary Care course enhances primary care physicians' ability to care for older patients and teach geriatrics to medical trainees. 2002 program dates: End-of-Life Care (September 3–27), Geriatrics in Primary Care (September 3–27), Clinical Teaching (September 30–October 25). Application deadline: June 15, 2002. Please contact: Georgette Stratos, PhD, Co-Director, Stanford Faculty Development Center, 700 Welch Rd., Suite 310B, Palo Alto, CA 94304-1809. Telephone (650) 725-8802; E-mail gstratos@stanford.edu.

Geriatric Educational Tools

18 Resources for Primary Care Residency Programs ▼

- Consultation services
- Stand-alone teaching aids
- Geriatric curriculum manuals
- Faculty development programs
- Packaged methods for teaching geriatric skills

Developed by ▼

- Baylor College of Medicine • Harvard University
- Johns Hopkins University • Stanford University
- University of California, Los Angeles
- University of Chicago • University of Connecticut
- University of Rochester
- American Academy of Family Physicians

Now Available
<http://sugerc.stanford.edu>

**Online Ordering
and
Digital Distribution**

order from ►

Stanford University Geriatric Education Resource Center
phone: 650.723.8559 fax: 650.723.4312