The celebration of our Society’s 25th anniversary at the 2002 Annual Meeting in Atlanta was a spectacular opportunity to recognize the work of past, present, and future pioneers in general internal medicine. For three days in May, members came from all across the country and the world to share ideas, gain knowledge, meet old friends, and make new ones. The contributions and work of the founding pioneers of SGIM have shaped the landscape of general internal medicine, and their work continues through the efforts of present and future leaders. The theme of the meeting, “The Next 25 Years: Emerging Issues for Generalists,” offered us the chance to reflect on the impact of past events on the future. Multiple venues highlighted the theme and promoted values embraced by SGIM: excellence in patient care, research, and education, as well as diversity, social responsibility, collegiality, collaboration, mentorship, innovation, and creativity.

Though the Annual Meeting itself made history, with new records set for attendance (1,612) and submissions (1,266), the real story came from the members and the events of the meeting. SGIM reflects the passion and dedication of its members. The Annual Meeting was a wonderful reminder of what can be accomplished with a dream and an opportunity. From the first Annual Meeting in San Francisco in 1978, SGIM, formerly the Society for Research and Education in Primary Care Internal Medicine (SREPCIM), has experienced tremendous growth. A retrospective published in JGIM in 1994 noted that SREPCIM, an organization with “no board, no mailing list, no tradition, and almost no money,” drew 178 physicians, “including several department chairs,” to its first meeting.³ The one-day meeting included workshops, plenary papers, and a meal. For the second meeting, Paul Griner’s call for abstracts drew 38 submissions with 13 accepted for presentation. By contrast, this year there were 1,226 submissions, 44 precourses, 134 workshops, 675 scientific abstracts, 68 innovations in medical education, 22 innovations in practice management, and 266 clinical vignettes. With only a handful of exceptions (the clinical updates and two workshops), all presentations at this year’s meeting were selected by committees of volunteers through a largely blinded process. More than any other national meeting, the SGIM Annual Meeting is by and for its members.

A Wednesday evening, pre-meeting reception at Grady Hospital featured a poignant presentation by Jordan Messler on the history of this once-segregated public hospital. Though change has occurred in the form of integration, emerging issues from the early 1900’s still remain: concerns about staffing...
Southern Region Meets in New Orleans (Again!)

Jane M. Geraci, MD, MPH

It is universally acknowledged that SGIM’s Southern Region meets in New Orleans for the food and atmosphere. Yet this year there was still abundant scholarly activity available for periodic relief from the more basic overindulgence. The 2002 meeting was held at the Hyatt New Orleans from Thursday, February 21, to Saturday, February 23. It began on Thursday afternoon with a workshop entitled “Resource and renewal: recognizing physician burnout, promoting physician wellness.” This workshop was sponsored jointly by SGIM’s Southern Region and the Southern Section, American Federation for Medical Research (AFMR). Don Brady led the workshop with assistance from Susan Ray (AFMR), Elisha Brownfield, and Erica Brownfield.

Friday’s activities included concurrent workshops and oral scientific abstract and clinical vignette presentations throughout the day. The Plenary Scientific Abstract Session was held Saturday morning. Two abstracts tied for the Best Abstract Award: “Resident smoking cessation therapy” by Amanda Green and colleagues from Duke and “Health profile of an urban, low-income clinic” by Keith Winfrey and colleagues from Tulane. Dr. Winfrey also received the Southern Region’s award for Resident Presentation of the Year, which included presentation of his work at the SGIM Annual Meeting in Atlanta and financial support to attend that meeting. At the Business Meeting Don Brady of Emory hit a double, winning the position of President-Elect and the Southern Region’s Clinician-Educator Award for 2002. Also announced was the winner of the Best Clinical Vignette Award, Anupama Kewalramani of Tulane for “Diabetes, thyromegaly, and acute weakness.”

The meeting closed Saturday afternoon with the final clinical vignette and workshop presentations. There was a general sense of pleasure and satisfaction with the meeting overall. Registration reached 129, a gain of more than 10% over 2001. Fifteen institutions from eleven southern states were represented by attendees and/or presenters.

I would like to take this opportunity to thank the many individuals who made this meeting possible: Sam Cykert, Program Chair; Carlos Estrada, incoming President; Terry Shanefeldt, Treasurer; Ron Shorr, Abstract Selection Chair; Mark Parkulo, Abstract Selection Co-Chair; Erica Brownfield, Workshop Chair; Nathan Facher, Workshop Co-Chair; Karen DeSalvo, continued on page 14

EBM Task Force Seeks Member Input

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 survey that we invite you to complete. We understand how busy all of you are, but we would appreciate it if you could take a few minutes to complete the survey. Your input will help us develop a resource that will be useful in your daily activities. For your convenience, we are mailing the survey with this issue of the Forum. Members who complete and return the survey by August 31, 2002, will be entered into a drawing for a Palm Pilot. Thanks for your help!
We live four score summers or so. That is about 5,000 days of Julys and Augusts. As a kid, those were the best days. Summers seemed endless. After the middle of August, of course, there was the aura of impending doom associated with the irreversible slide towards the start of the school year. Prior to that, it was a time in which a kid could have a lot more control over his or her life—for a while.

In high school and college, summer meant summer jobs for many of us, but the labor was a new experience and was a lot of fun. As a relatively newly licensed driver, I drove a pick-up truck and delivered auto parts at 18, and really got to know my hometown of Winnipeg. At 19, I was a taxi driver. (On my first day, one customer asked where to find a prostitute; another wanted to make an illegal alcohol purchase. I had little expert advice to proffer.)

In medical school, summer fun can be attenuated by growing involvement in things medical. For me, one summer was consumed by a health policy job, and another with beginning my fourth-year clinical rotations. The break between medical school and residency was rather short for my cohort. Those weeks were filled with nervous anticipations of what lay ahead. To the house officer, of course, the first months of internship and the similar period at the start of each subsequent training year bear little resemblance to the summers of youth. They are a time of immense professional challenges. When I was an intern, hours were long, even on days off. Wandering out into the humid Montreal summer night felt a bit other worldly, given my lack of sleep and need to be up early the next morning. I don’t think that I ever considered summer to be a carefree time when I was a resident.

I moved to California for my fellowship and was determined to experience the joys of the season. For a while, I went down to Malibu Beach every Sunday and sat on the beach, reading. I finally concluded that that was rather boring and have rarely been back to a beach since.

I joined the faculty and was encouraged to do inpatient rotations early in July when you could have the greatest impact on the new interns. I loved it. The interns ranged from the brash to the terrified, but it was pretty much impossible to predict which one would overlook the potentially lethal low potassium value. It was great to get to know the trainees and feel that you had helped them towards independence as doctors. It was gratifying to realize that you were making a difference in quality of care at a time when patients are rather vulnerable. But it sure was a long way from the summers of my youth.

I decided to start taking summer vacations again a few years later. Of course, long summer vacations were not even on the table. A week or two or two and a half was the limit, often following a grueling ward rotation with new interns.

Those vacations afforded an opportunity to catch up on the reading of fiction. Doctors tend to read a lot, continued on page 14
Talking with Tom Inui a few months ago, I remarked that not since my eighth grade graduation speech have I delivered a talk more personally important to me. Now, 37 years later, it’s a real privilege giving a valedictory address to my closest colleagues. I will be speaking about something past, something present, and something future. This seems particularly relevant given our theme for this Annual Meeting. “The Next 25 Years” implies we have witnessed a past 25 years, and “Emerging” suggests that things are just beginning to percolate to the surface, faintly present now but ready to burst onto our landscape.

Regarding past, present, and future, I have picked three verbs that, if not strictly failings for me, neither are they strengths. With respect to remembrance, my family background is pretty stoical. In terms of welcome, I am not by nature very outgoing. And as to anticipating the future, I’ve always had to ward off a slightly pessimistic streak. However, our advice is sometimes best informed by those things that inadequacy has taught us.

Not surprisingly, there is an Osler story that illustrates this point. When arriving as Chair at Johns Hopkins, Osler was already an acclaimed diagnostician. One afternoon, he examined a new patient who had a large, suprapubic mass. He proceeded to counsel both the patient and family about the grave prognosis, preparing them to accept what was obviously a terminal condition. The next day, a surgeon was consulted to evaluate potential palliative options, and he proceeded to insert a urinary catheter, drain a distended bladder, and “cure” what Osler had misdiagnosed as probable cancer. For years afterwards, Osler openly shared this story with his students. Indeed, medical educators tell us that acknowledging our own limitations is a powerful means of enhancing the learning climate. This is true also in research and patient care. After all, why is science often advanced through “trial and error”? And in clinical practice, medical errors are not simply a phenomenon of an Institute of Medicine report or the funding this has triggered.

Remember

Of my three themes, I will talk most on remembrance, touching first on individuals, and then on the significance of names, as reflected in the following few photographs. John Eisenberg and Mark Moskowitz were well known to many here today. Sarah Stone and Steve Glidden were a University of Massachusetts faculty member and an SGIM member’s son, respectively. September 11th needs no recounting. These were a few of our great losses this past year. I also know that a number of you have experienced other losses as well. These may have been inside or outside of SGIM, professional sorrows or personal ones. During the next 15 seconds, I would like us to silently remember and mourn those represented by these empty circles.

A predecessor is not always someone older than us. It literally means “pre-deceasor.” Our predecessors have simply departed first, sometimes too soon. They are part of our lives as family or friends or, in the few photographs I’ve shown, our SGIM community. This community is cumulative.

If you visit Barcelona, there is a fascinating museum, built around an excavation site. At the street level, you are surrounded by 16th century architecture. Inside the museum, you take an elevator down one floor, and, when the doors open, you enter the remains of a medieval city. After visiting this 1,000-year-old site, you re-enter the elevator and descend one more floor to visit the ruins of a Roman village from the first century AD. Each higher level is built upon the lower one, and even incorporates remnants of ancient walls into the new city. At the street level, you would have never guessed this history. You had to enter the museum and push the down button. In the same way, we build on top of. While our predecessors may have physically left us, they surround us in every wall. Because of the John Eisenbergs and the Mark Moskowitz, the Sarah Stones, Steve Gliddens, and those circles we silently honored, we continue to build a new city. Remembering these predecessors is our cornerstone.

What’s in a Name?

Think of medicine a century or two ago. Physical findings, diseases, basic mechanisms were often prefaced by a person’s name: Babinski reflex, Parkinson’s disease, the Starling curve. This linkage of a person’s name with a thing or place is called an eponym. Like many societies, SGIM honors individuals through its own eponyms, linked to awards, lectures, or endowments.

Acronyms are another type of label—formed from the initial letters of words. For example, WACs belonged to...
Before I start, I think it's very important that I give you some caveats to prevent too many attacks afterwards. These are my personal opinions. I got to choose what issues I included and excluded. My goal is to stimulate discussion throughout the meeting and throughout the years. I hope to emphasize the hypothesis that general internists desire complexity. We don't often have time to address this in our outpatient practice. This leads to a lot of discontent. And if we could go back to focusing on complexity, perhaps we could better define ourselves.

I'd like to acknowledge the following, among many other people, who have helped me develop my thoughts about general internal medicine. Tom Huddle is a medical historian in our division who has tried to put the history in some context for me and who seems to include my thoughts on a regular basis. I've had ongoing, long discussions with Gustavo Heudebert at my institution, and this presentation is really the result of probably five to eight years of wrangling about what general internal medicine really is. Jim Byrd is a long-time colleague and friend at East Carolina, and most of our discussions occur on golf courses. Karen DeSalvo, the Division Chief at Tulane, shared some very interesting things about how she redefined her division at Tulane, which really got me thinking about some of the fine points of this talk. And Jack Peirce. For those of you who don't know Jack Peirce very well, try to find him, talk to him. He will make you think.

What I'm going to do is review what academic general internal medicine was prior to the 1970's, when I started medical school; how it emerged during the 1970's, while I was in residency; how we expanded our responsibilities in the 1980's and 1990's; and then what I see as some challenges for this century.

In the early stages of the 20th century, all internists were general internists (or, as they were often known, “academic consultants”). The leading internists of the time were strong believers in the value of generalism. William Osler once said, “There are, in truth, no specialties in medicine, since to know fully many of the most important diseases, a man must be familiar with their manifestations in many organs.” And Tinsley Harrison, the founder of the Department of Medicine at the University of Alabama at Birmingham, and our local hero, noted, “The true physician has a Shakespearean breadth of interest in the wise and the foolish, the proud and the humble, the stoic hero and the whining rogue. He cares for people.”

How did general internal medicine first wane? How did subspecialty medicine grow? And then, how did we re-emerge? Well, this is a very short story of a complex set of societal issues. The 1950's and 1960's marked the first boom in federal research support. Departments of medicine over that period of time slowly reorganized along subspecialty lines. This trend was echoed in community practice, with growth in the number of board-certified subspecialists. And the Accreditation Council for Graduate Medical Education (ACGME) gave all this even more standing.

By the 1970's many departments of medicine had no general internists. This was the situation at my own medical school. When I was a medical student, it was impossible for me to have a role model.

However, during the 1970's, things began to change. The key events will be familiar to those who were in medical school or residency during that era.

Several prominent institutions started divisions of general internal medicine. This stimulated other institutions to take similar actions.

The Residency Review Committee (RRC) for Internal Medicine added a requirement for a continuity clinic for all internal medicine residents. When I was a resident, I did not have to have a continuity clinic. RRC requirements changed in about 1977 or 1978, if I recall correctly. Once there was a requirement for a continuity clinic, someone had to run those clinics. The chairs got a little nervous, because they knew they couldn't run it, and they didn't have anybody else who could run it. So they had to hire some general internists.

The Health Resources and Services Administration (HRSA) began to offer funding for training in primary care. The new divisions of general internal medicine grabbed on and said, “This is a way for us to build our divisions.” Chairs weren't so sure about this primary care thing that was going on, but it was money, and chairs never turn down money.

We started to develop academic leaders through The Robert Wood Johnson Foundation’s (RWJF) Clinical Scholars Program, the Kaiser Fellowship, and other training programs for generalist physicians with an academic focus.

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Glaser Award Goes to Lee Goldman

David R. Calkins, MD, MPP

At the recent Annual Meeting in Atlanta, the Robert J. Glaser Award was presented to Lee Goldman, MD, MPH, Professor and Chair, Department of Medicine, and Associate Dean, Clinical Affairs, School of Medicine, University of California, San Francisco. The Glaser Award is SGIM's highest award. It is given to an individual for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

Lee was nominated by a group of colleagues from UCSF, who noted his many contributions to generalism, to academic medicine, and to SGIM. They wrote in part:

"Lee is one of the best-known generalist physician-investigators in the world. Beginning as a resident, when he developed the cardiac risk index for assessing perioperative risk, he has had a remarkable knack for identifying essential clinical questions, conceiving a creative research plan, executing and analyzing the study with skill, and presenting the results in a lucid and compelling manner. Lee's contributions to the medical literature are extraordinary: he has first-authored 13 articles in the New England Journal of Medicine, JAMA, or the Annals of Internal Medicine, and he has senior-authored another 25 articles in these journals with his trainees or junior colleagues. In addition to his research in non-cardiac surgery, he has made unique contributions about the triage of patients with chest pain, the usefulness of autopsies, the roles of observation units and hospitalists, health policy for coronary heart disease, and physician-patient communication....

"Lee's contributions to academic general internal medicine as a teacher perhaps have been greater than his accomplishments as an investigator. In building the General Internal Medicine Fellowship program at the Brigham and Women's Hospital, serving as its Director and Co-Director of Harvard's Program in Clinical Effectiveness for over a decade, Lee developed a generation of academic generalists.... As a mentor, Lee has always been known for his instant availability. He still has a remarkably short "turn-around" time for manuscript drafts; within a few days, and sometimes even sooner, he provides a detailed list of helpful suggestions and comments....

"Lee is a leader in American medicine. He served SGIM as Program Director of the National Meeting, Secretary-Treasurer, and President, and he has been elected to the Institute of Medicine, the American Society for... continued on page 19

Jack Feussner Receives Eisenberg Award

Russell S. Phillips, MD

I was pleased to serve this year as Chairperson of the Selection Committee for the John M. Eisenberg National Award for Career Achievement in Research. This award was named for John M. Eisenberg, MD, MBA, because of his unique role as a researcher and mentor and because of his national role as Director of the Agency for Healthcare Research and Quality (AHRQ). As Director of AHRQ, John was a strong advocate for research in general medicine. With John's passing, this award becomes a part of his legacy. The Eisenberg Award will help us to recognize those among us who share some of John's inspiring qualities as a researcher.

The Eisenberg Award is given to a member of SGIM who has made major contributions conducting research that had an important impact on how we do research, on how we care for patients, on how we teach, or on health policy. Although not required for this award, successful candidates also may have had... continued on page 19
EDUCATION AWARD GOES TO
ROBERT C. SMITH

Catherine R. Lucey, MD

SGIM established the National Award for Career Achievements in Medical Education in 1996 to recognize individuals whose lifetime work has had a major impact on medical education. This year’s award recognizes the outstanding contributions of Robert C. Smith, MD, from Michigan State University. Randall Barker noted that Dr. Smith has “studied, conceptualized, operationalized, and disseminated methods that are of fundamental value to medical educators involved in teaching interviewing skills and the provider-patient relationship.” His book, The Patient’s Story, uses a stepwise, prioritized, behavioral approach to guide new students of basic communication and doctor-patient relationship skills. Additionally, Dr. Smith has developed a teaching monograph and illustrative videotapes to facilitate the work of faculty charged with teaching about interviewing. He is known for being an approachable expert—willingly taking calls from faculty dealing with this tremendously important subject. Dr. Smith’s randomized controlled trial of the methods outlined in his book led not only to publications in the medical literature but to a second book, appropriately titled Patient-Centered Interviewing: An Evidence-Based Method.

On a parallel track, Dr. Smith has used his skills in the medical interview to identify and recommend strategies for dealing with patients with somatization disorders in primary care practices. At this meeting, he is presenting innovative work on a new syndrome of patients who rely on the health care system for evaluation of multiple simple symptoms.

Dr. Smith has been recognized in the past by the Association of American Medical Colleges with the Thomas Hale Ham Award and by the American College on Physician and Patient with the George Engel Research Award for Distinguished Research in Doctor-Patient Relationships. He has presented award-winning workshops at the Association of Program Directors in Internal Medicine and SGIM and is recognized as an outstanding teacher and mentor at his home institution. SGIM is delighted to add its voice in recognition of Dr. Smith’s major contributions to the field of medical education with the National Award for Career Achievements in Medical Education.

The Elnora M. Rhodes SGIM Service Award was established in 1997 to honor Elnora Rhodes’ tremendous contributions to the Society during her 10 years as Executive Director. The award is given to individuals for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine. The award is supported by contributions from SGIM members and from friends and family of Elnora Rhodes. Previous Rhodes Awardees include Elnora Rhodes (1997), Annie Lea Shuster (1998), Oliver Fein (1999), Shirley Meehan (2000), and Mark Linzer (2001).

Before reviewing nominations, this year’s Rhodes Award Committee first brought to mind some of the strong attributes that Elnora brought to SGIM, including love, commitment, zest, support for members, vision, connectedness, good cheer, expertise, wisdom, perseverance, joy and optimism, generosity, and a “can-do” attitude—with Elnora, anything was possible!

This year’s Rhodes awardee is Carole M. Warde. In making the award, the Committee noted that Carole...
Nickens Award Goes to David Satcher

Valerie E. Stone, MD, MPH

SGIM’s Herbert W. Nickens Award was established in 2000 to honor an individual who has demonstrated exceptional commitment to cultural diversity in medicine or to improving minority health. The award is named in memory of the late Herbert W. Nickens, MD, the former director of the Office of Minority Health of the Department of Health and Human Services and the first Vice President of the Division of Community and Minority Programs, Association of American Medical Colleges (AAMC). During his tenure at the AAMC, Dr. Nickens established groundbreaking programs designed to address the critical need to train more minority physicians and to improve minority health status, including Project 3000 by 2000 and the Minority Health Services Research Institute. Dr. Nickens died suddenly and unexpectedly in 1999. This award was established to honor his memory and his groundbreaking work in increasing diversity in medicine and improving minority health. The members of this year’s Nickens Award Selection Committee were Giselle Corbie-Smith, JudyAnn Bigby, Eric Whitaker, Olveen Carrasquillo, David Campa, and myself as Chairperson.

We are very honored and incredibly excited to present this year’s Herbert W. Nickens award to David Satcher, MD, PhD, who until February 2002 was the Surgeon General of the United States and until February 2001 was the Assistant Secretary of Health of the Department of Health and Human Services. We are honoring Dr. Satcher for his enormous contributions in the area of improving minority health.

Upon being appointed Surgeon General and Assistant Secretary of Health, Dr. Satcher immediately began to bring attention to disparities in health status, health care, and quality of care by race/ethnicity via numerous speeches, conferences, and targeted programmatic initiatives. In 1998, with substantial input from Dr. Satcher, President Clinton set forth the goal of eliminating racial and ethnic disparities in seven major clinical areas by the year 2010. This resulted in several new initiatives, including the Racial and Ethnic Approaches to Community Health Reach (REACH) grant program of the Centers for Disease Control and Prevention (CDC) and the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) grant program.

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Passing the Torch

David R. Calkins, MD, MPP

For the past three years and 36 issues, I have had the pleasure of serving as Editor of the Forum. With the completion of this issue, my term as Editor will end. Missy McNeil, University of Pittsburgh, will begin her three-year term as Editor with publication of the August 2002 issue of the Forum.

From my perspective, the position of Editor of the Forum is one of the most enjoyable roles one can have in SGIM. It offers regular interaction with members throughout the country, who contribute to the production of each issue. It provides frequent contact with staff in the SGIM National Office, a great bunch of folks! And it includes a position on the Council as an ex officio member, an honor and a privilege.

My job as Editor has been made easier by the enthusiastic work of Associate Editors and other SGIM members who have written nearly 300 articles over the past three years. While space does not permit me to list all of these individuals, I would like to thank a few.

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SGIM Inaugurates Electronic Bulletin

Lorraine Tracton

Did you receive the inaugural edition of SGIM E-News? Volume 1, Issue 1 of this new, biweekly electronic bulletin was sent directly to members on June 11. If you did not receive the transmission, the SGIM National Office probably does not have a current, accurate e-mail address for you. Please contact Katrese Phelps, Director of Member Services (e-mail: PhelpsK@sgim.org, telephone: 800-822-3060), to update your records.
Members gather for a group photo outside the original Grady Memorial Hospital building. (L.TRACTON)

Past-President Stephan Fihn (second from left) offers advice on the transition from fellow to faculty during the precourse “A General Internal Medicine Fellowship Survival Course.” (L.TRACTON)

Members network at the opening poster session. (L.TRACTON)

Council member Susana Morales (top) joins the crowd at the Students, Residents, Fellows, and First-Time Attendees Reception. (L.TRACTON)

Session Coordinator Carole Warde (second from right) listens attentively to a discussion at the Personal-Professional Balance Interest Group meeting. (L.TRACTON)
Opening Plenary Session, Award Presentations Highlight Second Day

JGIM Editor Eric Bass sits atop copies of the Annual Meeting Supplement at the publisher’s booth. (L.TRACTON)

Past-Presidents gather to celebrate the 25th Annual Meeting. Left to right are Eric Larson, Kurt Kroenke, Wishwa Kapoor (back), Bill Tierney, Stephan Fihn (back), Wendy Levinson, Sankey Williams (back), Lee Goldman, Sheldon Greenfield, and Seth Landefeld. (L.TRACTON)

Jim Sosman (left) congratulates Lawrence S. Linn Award recipients Gwen Davies and Shawn Fultz, who were recognized during the Update in HIV Care. (FOSTER ASSOC.)

Eric Holmboe (left) describes his Innovations in Medical Education project to Lisa Rubenstein (right), one of the leaders of the 1998 SGIM Innovations Task Force. (L.TRACTON)

Julie Machulsky, Director of Regional Services (left), joins Jane Geraci, Regional Coordinator (second from right), in celebrating Regional Resident Presenters of the Year Award winners Eleanor Binla Schwarz, Samer Sader, Judy Zerzan, Varalakshmi Venkatachalam, and Keith Winfrey, who were recognized during the Opening Plenary Session. (L.TRACTON)

Wit playwright Margaret Edson (left) and Selection Committee Chair Anderson Spickard, III (center), join winners of the National Clinician-Educator Award for Innovation in Medical Education Karl Lorenz, Kenneth Rosenfeld, and Eric Holmboe. M. Jillisa Steckart and Nancy Rigotti (not pictured) also received this award. (L.TRACTON)
Theme Plenary Session Opens Final Day

Gregg Rouan, Chair, Communications Committee (left), chats with Past-Presidents Bill Tierney and Mack Lipkin during a break in the meeting. (L. TRACTON)

Regional Coordinator Jane Geraci, keynote speaker Bob Centor, and moderator Judith Walsh (left to right) join Jeff Jackson (at the podium) to open the Theme Plenary Session. (FOSTER ASSOC.)

Bob Wigton (left) congratulates Mack Lipkin, Sr. Associate Award winners Eleanor Bimla Schwartz, Lisa Korn, and Michael Steinman. (FOSTER ASSOC.)

Bob Wigton (second from right) joins Milton Hamolsky Junior Faculty Award winners Matthew Davis, Christina Nicolaidis, and Jeffrey Wiese. (FOSTER ASSOC.)

Past-President Lee Goldman offers “Strategies for Future Success in Academic General Internal Medicine” during his Meet-the-Professor session. (L. TRACTON)

Past-President Tom Inui leads a discussion during the workshop “The IOM Report of Racial/Ethnic Disparities: Findings, Recommendations and Concrete Next Steps.” (L. TRACTON)
Meeting Closes with Awards Banquet, Peterson Lecture

Judy Tsui (second from right) and her quartet play against a backdrop of posters created by Special Programs Chair Linda Pinsky, illustrating events that shaped SGIM’s development over the past 25 years. (L.TRACTON)

Adesuwa Olomu charts the “Under Use of Beta-Blockers Following Acute Myocardial Infarction in Community Hospitals.” (L.TRACTON)

Council meets with members to discuss the recommendations of the External Funds Task Force. (FOSTER ASSOC.)

Selection Committee Chairs Hal Sox (left) and Said Ibrahim (right) congratulate Brian Gage, who won both the Outstanding Junior Investigator of the Year award and the Best Published Paper of the Year award. (FOSTER ASSOC.)

President-Elect JudyAnn Bigby (left) connects with Deborah Prothrow-Stith after the latter’s Peterson Lecture. (L.TRACTON)

Kurt Kroenke passes the presidential gavel to Martin Shapiro at the conclusion of the Awards Banquet. (FOSTER ASSOC.)
shortages, pay, and working conditions (reinforcing the old adage that the more things change, the more they stay the same). Refreshments, music by Judi Tsui (SGIM member and talented Julliard-trained cellist), and a tour of the facilities all helped to make this a memorable start to the meeting. (Judi also played with the Emory String Quartet at dinner three days later. We thank them for sharing their talents with us.)

Jeff Jackson opened the Plenary Session by noting the passion and dedication of SGIM members and appealing for the continuation of this passion in the work we love. Christina Nicolaids (“Could we have known? An in-depth look at the stories of women who survived an attempted homicide by an intimate partner”) and Lisa Korn (“Is screening for osteoporosis associated with fewer hip fractures?”) began the scientific program with their incisive, thought-provoking abstracts. These outstanding presentations would go on to win Hamolsky and Lipkin awards, respectively.

During his inspirational and humorous Presidential Address, Kurt Kroenke reminded us of the five P’s SGIM needs to include as we look to the future: Patients, Pupils, Physician-colleagues, Payors, and the Public. During one point in his address, the attendees were asked to introduce themselves to others in the audience. We were struck by the notion that we were sitting next to past, current, and future leaders: SGIM members who, in their own way, were, or would be, architects of change. It was a wonderful way to break the ice and reflected Kurt’s much-appreciated leadership style: warm, inclusive, and member-focused. Indeed, keen insight, a gift of handling controversial issues with grace, and high-quality accomplishments were hallmarks of his presidential abilities.

The Theme Plenary session opened with remarks by Ellen Yee on the transition of general internal medicine. General internal medicine’s rise to prominence and into mainstream medicine is mirrored in the move of general internal medicine divisions located in B-level basements and trailers, up to A-levels and better trailers. Much work has been done but more still remains! The featured speaker, Robert Centor, gave an eloquent history of academic general internal medicine and the forces that have shaped general internal medicine as we know it now. Following his talk, four abstracts on emerging issues were presented: “Implementation of a voluntary hospitalist system at a community hospital,” “The prevalence of physician participation in pharmaceutical-sponsored activities,” “Physician specialization and antiretroviral therapy for HIV,” and “A randomized trial of primary intensive care to reduce hospitalization in high utilizers.”

The theme was continued through precourses and workshops, with “Emerging Issues for Generalists” added as a category. Through the leadership of Anderson Spickard and Dawn DeWitt, Chair and Co-Chair of precourses, and Giselle Corbie-Smith and Eric Holmboe, Chair and Co-Chair of workshops, an outstanding selection of presentations were offered.

Deborah Prothrow-Stith gave a passionate and inspirational Peterson Lecture, discussing violence as a public health mandate. Is there an epidemic? What is behind this violence? Did we realize that violence is increasing among adolescent girls? This was a timely and moving lecture, especially following the events of September 11. Dr. Prothrow-Stith connected with many in the audience when she spoke from the heart about trying to reconcile her emotional “gut” reaction to this violence (Why aren’t we getting back at them? Drop the bombs!) with her intellectual, rational reaction (violence is not the solution).

This year’s Annual Meeting included several memorials. D.D. Eisenberg gave a moving tribute to her late husband, John Eisenberg. Alvan Feinstein was remembered at the Sydenham Society Dinner. The spirit of Elnora Rhodes, SGIM’s beloved first Executive Director who passed away last year, was felt in the hearts of those graced by her guidance and friendship.

Several novel innovations met with a warm reception. The newly inaugurated Lipkin and Hamolsky Award finalist sessions were a grand success, hosting overflowing audiences and bringing prominence to the work of the talented associate and junior faculty finalists. There was definitely a tension in the air not felt during other scientific abstract presentations! Kudos to Robert Wigton for chairing the Lipkin and Hamolsky Awards Selection Committee and to all the volunteer judges for their time and effort. An International Poster Session featured 38 presentations by members from Argentina, Canada, France, Sweden, Switzerland, and the United Kingdom. Incoming President Martin Shapiro, who hails from Canada originally, has noted that next year, all United States submissions might be considered International, as the meeting will take place in Canada.

Thanks to the vision of Regional Coordinator Jane Geraci, eight Regional Resident Presentation Award Winners received a scholarship to the meeting, a poster presentation (at a minimum), and recognition at the plenary session. Donald Brady and Lisa Inouye developed a special track for students, residents, and fellows (SRF) and creative touches, including a SRF lounge, interest group, and workshop. Linda Pinsky and Eric Whitaker enhanced Special Programs by conceiving the idea of historical posters and assembling a distinguished Meet-the-Professors panel. The wisdom and knowledge of these esteemed professors was the vital core of these sessions. Linda demonstrated that she is not only a gifted educator but also an artist and master of visual elements. Her montage of posters (integrating presidential wisdom and history), placards on continued on next page
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Planning for the 2003 Annual Meeting, to be held April 30–May 3, 2003 in Vancouver, is already underway. If you would like to volunteer, contact Sarajane Garten at the National Office (telephone: (800) 822-3060, e-mail: gartens@sgim.org), or Helen Burstin or Linda Headrick, Program Chair and Co-Chair. We give our best wishes to them and hope that they have as much fun working on the meeting as we did. SGIM

References

SOUTHERN REGION
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Vignettes Chair; and Sameh Basta, CME Coordinator. Lori Orlando was indispensable in helping many of the residents who presented clinical vignettes. We are happy to note she is staying in the Southern Region as a general internal medicine fellow at Duke next year! Many other individuals helped with judging awards. I also would like to thank the senior SGIM members and division chiefs who have supported this meeting over the years: Bill Branch, Jim Byrd, Bob Centor, Dennis Cope, and Andy Diehl. Thankfully, Karen DeSalvo has agreed to chair next year’s meeting, guaranteeing yet another successful program. And we should never forget Julie Machulsky, SGIM Director of Regional Services, who makes meeting planning and registration smooth and enjoyable. Thank you to you all! SGIM

SUMMER MEDITATIONS
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but most of the doctors whom I know devote much of their reading to the professional literature. Yes, we need to know a lot, but something is lost when we ignore the world of literature. For years, I would pick out those books that I believed that I had to read (Dr. Faustus, Ulysses, Remembrance of Things Past, and the like). They were great books. I regularly got one-third to half way through, then got bogged down. The books would rest on my night table for a year or two before working their way back to a bookshelf. Ultimately, I resigned myself to less stellar, but solid fiction. I was much more successful in completing the books. I have not yet descended to the level of Ludlum.

When I married and had children, summer became even more compelling as a time to vacation. Family vacations as I have experienced them fall into three categories.

The big family trip. Children appropriately consume much of our free time. My wife and I were determined not to let child-rearing stand in the way of exploring global vistas. We took our 16-month old to Europe. The plane trip was adventuresome (the child had great fascination with the stairs in the 747 and vomited between planes in London when we had no change of clothes in the carry-on luggage.) We got to see a lot of parks and zoos and took turns going to the theatre. Another such trip followed with a one and six year old, which took us to France during World Cup 1998. The sporting spectacle proved to be a thrilling distraction for the children. The older child made a bit of a scene at a gathering at the home of some French friends on the night of the final, when he came to the realization late in the game that he really wanted Brazil to win!

The family motor trip. There is a...
SUMMER MEDITATIONS
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wonderful tradition of such travel, but I must report that it has been completely
upended by the in-vehicle DVD player. We traveled to the Grand Canyon
without a complaint from either child. Of course, they didn’t look at the
scenery very much, either.

Family camp. This is a really fine
innovation. The kids do their thing,
and the parents do their thing. For me,
it is golf, as well as time with my wife.
In a week, I can bring my scores down
from the 120s to the upper 90s, and still
have time for Ludlum… I mean Joyce.
The other day, I chatted with my
10 year old about summer vacation. I
asked him to try and not get too
bummed out when his 73-day break
ended. That may have been unfair. Part
of the process is the liberation from
the regimentation of the school year. In any
event, he did not commit to that course
of action!

I now have lived through about two
thirds of my summers. Each one seems
precious. There is much to do. What is
most important?

• Spend more time with the children.
  They won’t be wanting to spend
  summers with you forever.
• Read some good books, if not some
great books.
• Get some momentum in outdoor
  activities. Run, swim, golf (and don’t
  forget the sunscreen).
• Visit some places that you have never
  seen.
• Get together with family and friends
  who live at a distance.
• Take a little time to think. We stop
  being creative if we are overwhelmed
  with busy work. The summer is a
great time for reflection.
• Realize that life is precious, that
  summer days are among the most
  precious, and that they should be
  invested in renewal and nurturing of
  relationships and friendships, in
  stimulating and challenging one’s
  values and ideas, in improving oneself
  intellectually, emotionally and
  physically.

Of course, there are some other
wonderful things to do in the summer.

• Take some nervous, anxious, unseas-
oned interns and walk them through
  their first rotations as a physician.
• Meet with some newly anointed
  fellows and instill in them passion for
  your vocation.
• Care for a patient in need.

• Put down on paper ideas that have
  been percolating within you.
• Decide what you really want to do
  with the next phase of your profes-
sional life.

Summer days are long, but their
difficult. But it is certain that general
numbers diminish rapidly. Use them
internal medicine represents both
well.

Funding sources for primary care
research started to emerge. The Na-
tional Center for Health Services
Research (NCHSR)—which begat the
Agency for Health Care Policy and
Research (AHCPR), which begat the
Agency for Healthcare Research and
Quality (AHRQ)—started to have
some funding, and general internists
started submitting to that funding
source. RWJF was a funding source, as
were a variety of other foundations.

And, most importantly, the Society
for Research and Education in Primary
Care Internal Medicine (SREPCIM)
was founded in 1978, which gave us an
academic home.

Once divisions were there, a variety
of things occurred. Many institutions
developed general medicine consulta-
tion services. There are some institu-
tions where that became a major focus
of research, a major focus of ideas.

At many institutions, the general-
ists slowly have grown into being the
primary ward attendings. More and
more subspecialists are uncomfortable
being an attending on a general
medicine ward. If you’re a rheumato-
gist—and I’m picking on them at
random — and someone has lupus,
you’re great. But as soon as they have
diabetes also, many rheumatologists
start to feel uncomfortable. And if they
also happen to have coronary artery
disease, they actually tremble. This, in
some way, led to the hospitalist move-
ment. And distinguishing between
hospitalists and general internists who
do a lot of inpatient care is often
difficult. But it is certain that general
internal medicine represents both
inpatient and outpatient medicine.

More recently some general
internists have begun to limit their
practice to outpatient medicine. All the
general internists that I knew in the
1970’s did both inpatient and outpa-
tient medicine. But that is no longer the
case.

And then, especially in the 1990’s,
we have seen the influence of managed
care on the growth of many divisions.
And I’m going to suggest that this has
been a very disruptive force.

And finally, we have what, for lack
of a better phrase, we’ll call the “cyclic”
appeal of primary care. We were the
kings in the early 1990’s. Everybody
wanted to be in primary care. I remem-
ber an ophthalmologist once telling me
that he was a primary care ophthal-
mologist. I was at a party with a radiolo-
gist. He told me he did primary care
radiology. That doesn’t seem to be quite
in vogue this week.

Our divisions changed a lot in the
1990’s. Research units benefited from
greater funding and more fellowship-
trained faculty. Just look at this meeting
and the evidence of increased research
productivity.

Many divisions took on a leader-
ship role in the educational activities of
their departments. Divisions of general
internal medicine often started out
focusing just on the clinic. Slowly but
surely, many have taken on more and
more major responsibilities in the
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REMEMBER, WELCOME, ANTICIPATE
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the Women’s Army Corps, and radar stands for radio detecting and ranging. Medicine is filled with acronyms for diseases (COPD), clinical trials (GUSTO), and professional organizations (ACP-ASIM, APDIM, AAMC).

Let’s look at our own Society’s acronyms. First there was the Society for Research and Education in Primary Care Internal Medicine, or the tongue-twister, SREP-CIM. During his Presidency, Tom Delbanco led the charge for a simpler moniker, which brought us to Society of General Internal Medicine. However, the acronym may not have a universal pronunciation. Let me take a quick poll. How many pronounce it S-G-I-M? Looks like we don’t have a consensus. Some say “tomahawk” while others say “tomato.”

Legacy, however, is greater than any eponym or acronym. Impact—or, as a health services researcher might say, “outcomes”—are one’s true footprints in the sand. It may be an institution like AHRQ. It may be a division of general internal medicine. It may be a generation of residents and students and fellows, who have been recipients of priceless teaching or mentorship. It may be the countless patients one has cured or comforted, the child who gifted us with a dozen years, or the parent. For SGIM, it has been addressing disparities in health care, quality in the doctor-patient relationship, respect for medical education, and parity for primary care and health services research. These actions speak louder than our Society’s name—or its acronym, however you pronounce it.

Now for the counterpoint. Names are not unimportant. Let’s take our own specialty. The discipline of “internal medicine” originated in Germany in the 19th century as “Innere Medizin.” With rapid advances in pathology, it soon became apparent that diagnosis and understanding of disease relied not only on external manifestations (e.g., physical findings) but also on investigation from the “inside” (e.g., tissue specimens). These origins over a century ago might explain why we as internists are fascinated by objective tests that explore the “interior” of a patient—bloodwork, x-rays, angiography.

Yet the public does not always understand us. Explaining internal medicine to the passenger next to me on an airplane—or, for that matter, my mother—is partly framed by what I don’t do: I don’t take care of kids, deliver babies, do surgery. I do take care of most adult medical problems, but I’m not a specialist. To clarify things, the ACP-ASIM has contemplated a name change, like “Adult Medicine.” However, if our specialty becomes “Adult Medicine,” does that mean we are called “Adultists”?

Many of us here proudly call ourselves general internists. One memorable image from Lee Goldman’s Presidential Address was a slide that unfolded something like this. I could almost hear the cheer: “GIM… GIM… General Internal Medicine… U–rah–rah.” Besides communicating this to the American public, however, we must also clarify to physicians in other countries whether we are more like their internists (who are primarily hospital-based consultants) or their general practitioners (or GPs). In fact, we are both, and that is what’s special. “Primary care physician” is another of our labels, but the realignment between hospitalism and office-based practice, reimbursement, and shifting career choices make the definition of primary care a work in progress. Still, how we define and label ourselves is essential to the five P’s: our patients, pupils, fellow physicians, payors, and the public.

Welcome

My second message, focusing on the present, is simple: Welcome the newcomer. One of the special things about our SGIM Meeting (capital “M”) are the innumerable one-on-one meetings (small “m”). On the way to a workshop, I am sidelined by encounters with friends, and I choose to be late in order to reconnect. As I meander through poster sessions, I juggle my desire to see the science with my need to reconnect with friends I bump into. What I have just described is sort of a “personal-professional balance” within the meeting itself. Like when you decide to skip a hospital meeting in order to catch your child’s soccer game.

I am not asking you to forgo any of this networking. In fact, I’m asking that we each do just a little bit more. We have hundreds of first-time attendees. A new meeting can be disorienting at first. Just this spring, I attended a professional society meeting I usually don’t go to because of an invited symposium. It was a strange feeling wandering through the poster sessions, recognizing no one. But I felt most ill at ease at the final banquet. The tables were filled, I looked self-consciously for a seat, and was nearly ready to leave (after all, I told myself I wasn’t that hungry). As I walked toward the exit, one person came up to me and invited me to their table. This broke the ice, and the rest of the evening was a rather easy conversation with people I had met for the first time.

Let’s do a practice run now. I want each of you to introduce yourself to one or two individuals either next to you, or in front of or behind you. Tell them your name, where you’re from, and one thing about yourself (e.g., level of training, or which SGIM meeting this is for you). Get on your mark, get set, go.

Your assignment is to repeat this exercise at least five times in the next two days—in abstract sessions and workshops, during breaks, and at mealtimes. If someone is searching for a seat, offer them a seat. This will guarantee that our Annual Meeting, historically one already of Brownian motion and individuals eagerly colliding, will be the most user-friendly ever.

Anticipate

My third message, also brief, is future-oriented. “Anticipate” is a proactive verb—not a “wait-and-see” part of our
vocabulary. Definitions include: “to act in advance; to feel or realize beforehand; to foresee.” For a geographical metaphor, I like promontory. A promontory is a tiny piece of land jutting out into the breakwaters, surrounded by pounding waves. A promontory is not safely inland, remote from the hurricanes. Neither is it an island, isolated from the mainland.

Some members appreciate in SGIM the feeling of “sanctuary,” a “haven” from things we may not like happening in other parts of the medical world. Here I say—be cautious. It is not refuge we seek. Talk to other organizations in medicine, influence them, form partnerships, negotiate, advocate, demonstrate if necessary. But avoid monasticism. While an oasis can be a wonderful place, remember that it is surrounded by desert. The territory outside SGIM is huge, and to keep it fertile, we must be in constant communication.

The good thing about a promontory is that it’s on the edge, the vanguard, not a safe place really, but a brave place. However, the promontory is tiny, and its distinctness is that it is juxtaposed to a greater land mass with which it remains constantly connected. Are these bigger neighbors Goliaths that we struggle against? Or are they the seven-foot center of our team, with us playing point guard? In fact, they are sometimes one and sometimes the other. Sorting out our battles from our alliances is both our challenge and responsibility.

Finally, don’t move inland. Remain the promontory. Reflecting on his Presidential address more than a decade ago, Robert Fletcher recently said, “I expressed hope that SGIM would not begin to act old just because it had become established and had something to lose. With time and success, professional societies tend to become less trusting, flexible, democratic, and daring than SGIM was at the time. Fortunately, SGIM has so far retained many of the advantages of youth, though it is now certainly well established.” Establishment is a two-edged word. Let’s take advantage of our quarter century of establishment but, in so doing, not become the establishment.

Past SGIM Presidents were asked to reflect on our 25th anniversary, which you will see displayed throughout this meeting. Let me close with what Suzanne Fletcher shared: “As John Gardner said, ‘We are constantly surrounded by golden opportunities cleverly disguised as insoluble problems.’ SGIM is good at recognizing the opportunities and figuring out the disguises.”

Remember our predecessors. Welcome those present, sitting next to you, or looking for a seat at your table. Anticipate the future outside these halls, the next 25 years. Issues are emerging that you will hear about at this meeting. As generalists, it is our privilege to be the promontory.

It has been my privilege to be your President. Thank you. Have a wonderful meeting. SGIM

PASSING THE TORCH

on their plans for the Annual Meeting and related items of interest (e.g., restaurants and other local attractions). Special thanks goes to the Chairs and Co-Chairs: Gary Rosenthal and Carol Bates (2000), Eileen Reynolds and Carol Mangione (2001), and Jeff Jackson and Ellen Yee (2002).

- Jas Ahluwalia and Joseph Conigliaro provided monthly updates on grant opportunities through the Research Funding Corner.
- Brent Williams offered regular reports on matters of interest to clinician-educators, such as faculty development, teaching about professionalism, and interdisciplinary education.
- Mark Liebow provided updates on health policy, ably assisted by SGIM’s health policy consultants, most recently Rob Blaser and Jenn Jenkins.
- Valerie Stone, Giselle Corbie-Smith, and Joe Betancourt wrote multiple articles on topics related to minorities in medicine and disparities in health and health care by race/ethnicity.
- Preston Reynolds authored columns on a diverse array of subjects, including SGIM’s mentorship program, health and human rights, and genetics and primary care.
- David Lee provided reports on important developments within the Veterans Health Administration.
- Jane Geraci solicited reports on regional meetings (all of them!) and even wrote a few reports herself.
- Bob Centor contributed several articles on matters of interest to the Association of Chiefs of General Internal Medicine (ACGIM).

I have been assisted in the production of the Forum each month by Stacy McGrath at Harvard Medical School, Mary Stone at Blackwell Science, and

NICKENS AWARD

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the Agency for Healthcare Research and Quality (AHRQ). As a result of Dr. Satcher’s leadership, the new Healthy People 2010 document is much broader than its predecessors, with a focus upon eliminating disparities by race/ethnicity in health status and health care by 2010. Dr. Satcher’s efforts also were critical to the passage of the Minority Health and Health Disparities Research and Education Act of 2000 (P.L. 106-525), which was signed into law in November 2000. This new legislation aims to improve minority health through research by establishing a Center for Research on Minority Health and Health Disparities within the National Institutes of Health (NIH) and increasing funding in this critically important area.

In summary, SGIM is honored to present the 2002 Herbert W. Nickens Award to Dr. David Satcher for his unparalleled contributions to improving minority health. SGIM
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department. At many institutions they are an integral part of the entire teaching program.

The clinical enterprise became a larger concern for many divisions. According to prevailing views of the health care system in the early 1990’s, primary care physicians were to be the front door. Academic institutions needed to have a bunch of people out there, doing primary care, bringing patients in, so that the institution could stay rich.

Now, in my mind, managed care has had a very questionable influence on general internal medicine. My view of this matter has been influenced by several articles published in JGIM earlier this year. These articles have helped shape my thoughts about the doctor-patient relationship, and about the time pressures we face. And I personally am very concerned about where we’ve gone: the pressure to see more patients, the impact that that has had on career satisfaction, the increasing number of general internists who do primarily outpatient medicine, the decreased satisfaction of patients. What is managed care doing to the doctor-patient relationship?

So let me give you my hypothesis about how we got to where we are. None of my advisors bear any responsibility for my hypothesis. I think that general internal medicine embraced the concept of primary care to emphasize continuity and comprehensive care, and that’s what we meant in the 1970’s and 1980’s. But that embracing of primary care did not mean that we wanted to abandon the complexity of secondary care.

In my opinion, the phrase “primary care” has become distorted to often exclude complexity, and that has led to great dismay among general internists. I believe many of our subspecialty colleagues look at those of us in primary care as “simple docs,” not complex docs, and I know the insurers view us that way.

We don’t want to abandon complexity. That’s why I chose internal medicine. I chose internal medicine because I liked the clinical complexity. I like the patient with five medical problems and 15 medications to figure out. I like the complexity of trying to figure out the interaction between the disease and the underlying psychosocial issues. I like the complexity of figuring out how to manage patients in the inpatient setting and then helping them transition back to outpatient care—and making all that smooth and without error.

So these are my questions for this century. Will research funding continue to grow? Will we be able to support the important research that members of this Society do?

How will we pay for education? At many institutions, the viability of educational programs in general internal medicine divisions is threatened because no one will pay them to teach.

We have to decide whether general internal medicine is primary care and/or complex care, and how to define it, and how to present ourselves to the rest of the world. We’re struggling with whether we can be both inpatient and outpatient physicians, and how do we balance that, not just in academics, but also out in our practicing communities.

We have to focus on how health care is funded, and how that affects generalists. Right now, it makes generalists depressed. Who’s going to pay for complex continuity care? Who’s going to pay generalists to see the patient who has diabetes, hyperlipidemia, coronary artery disease, congestive heart failure, and hypertension? And they’re trying to do that in fifteen minutes while they’re depressed. It can’t be done well. We are doing so much more, we should do so much more for our patients than we did 25 years ago. We know so much better how to do secondary prevention. But it does take time.

Let me focus on one or two other recent trends. There was a very good article in the New England Journal of Medicine recently on concierge primary care. When I was at the ACP-ASIM meeting, going through the exhibits, MDVIP had a booth. MDVIP is one of the concierge care companies. Now, you may think what you want of concierge care, but try to remember what the underlying forces were that have caused this to emerge and that have attracted both patients and physicians to the concept. A lot of it’s about time. A lot of it’s from the physician wanting to be Marcus Welby, really be able to go visit the patient at home, really go visit the patient and accompany them to the specialist. Now, some of us may not be happy morally with the concept, but try to understand why it has emerged. It’s not just about money.

We have physicians refusing new Medicare patients. Why are they refusing new Medicare patients? Because the overhead is greater than you get for seeing the patient, and you can’t make it up in volume.

We have alternate practice structures. If you have not read the recent article on this subject in the U.S. News and World Report, a link to the article will be on the SGIM Web site. You can actually read it online. It’s very interesting to see how different people are trying to approach practice in 2002.

I’d like to close with a quote from my favorite CD. It’s from a song called “Reservations.” It’s written by Jeff Tweedy of Wilco. How many people in the audience—raise your hands—are familiar with Wilco? We’ve got about 10 percent. That’s pretty good. Half of them have heard me talk about it in the last two days. The name of the CD is Yankee Hotel Foxtrot, and I’m not going to explain why it’s called that. But this is what he said:

“I’ve got reservations about so many things, but not about you.”

Editor’s Note—Bob Centor is the founding President, Association of Chiefs of General Internal Medicine. He is Director, Division of General Internal Medicine, and Associate Dean for Primary Care, University of Alabama School of Medicine. He has a golf handicap of six.
success as mentors, as advocates for research funding, or as leaders of research-related organizations.

SGIM is blessed to have many members who are terrific researchers. The Committee was fortunate to have a very strong group of candidates nominated for this award. After careful consideration, we selected John R. (Jack) Feussner, MD, MPH, as this year’s winner of the Eisenberg Award.

Jack was nominated by 15 individuals. In their nomination letter, they stated that Jack’s lifetime contributions have had a national impact by virtue of his own research; his training and mentoring of general medicine researchers; his leadership of a health services research program in Durham, North Carolina; and, most recently, his leadership of a national research program at the Department of Veterans Affairs (VA).

Jack’s early research focused on clinical trials of treatments for chronic medical conditions. He is one of the earliest and most effective advocates for the use of randomized, controlled trials in health services research. In 1983, Jack was named Director of the VA Health Services Research and Development Field Program in Durham, North Carolina, a position he held until 1996. He served as a primary mentor to general internists who subsequently established their own national reputations. Jack also served as Chief of the Division of General Internal Medicine at Duke between 1988 and 1996.

In 1996 Jack became the Chief Research and Development Officer, Veterans Health Administration, Department of Veterans Affairs. Under his watch, the VA research appropriation has grown from $251 million to $409 million. Jack’s responsibilities include setting VA research priorities and managing all aspects of a national research program, which includes more than 3,900 VA researchers. His accomplishments include determining the focus and priorities of VA medical research and creating a new career development program that supports clinician-investigators. Jack expanded the VA health services research and career development program to support almost 70 clinician-investigators, most of whom are general internists. Twelve VA health services research and development centers are affiliated with major medical schools. Most of the clinician-investigators associated with these centers are general internists. Together the operating budgets for these centers total more than $100 million.

The Eisenberg Award Committee applauds the work of Jack Feussner, and we are pleased to present him with this special award. SGIM

GLASER AWARD
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Clinical Investigation, and the Association of American Physicians. He was a Director of the American Board of Internal Medicine for four years. He is currently Editor-in Chief of the American Journal of Medicine…. “Lee has been an exemplary role model for many of us in SGIM. He attained his accomplishments while being an active participant in his community, and a devoted husband and father. For example, while a young faculty member building a career in a then-nascent area of medicine, he also served as the first president of his local synagogue, and coached his children’s sports teams.

“For all of these reasons, Lee Goldman is eminently qualified for, and deserving of the Glaser Award.”

The Selection Committee concurred in this assessment, which was echoed in letters of support from several former SGIM leaders, and named Lee the recipient of the 2002 Robert J. Glaser Award. SGIM

RHODES AWARD
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exemplifies, in her professional and personal activities, a balanced, tripartite commitment to clinical care, teaching, and parenting. Her SGIM national activities have included initiator, Personal-Professional Balance Interest Group, and member, Development and Presidential Nomination Committees. Carole championed the Mary O’Flaherty Horn Scholars Program—and worked successfully to endow it! Her SGIM Regional activities have included serving as President and Program Chair, California Region, and as Southern California Chair, Treasurer, and Secretary. As a clinician-educator she has been Director, Long Beach Memorial Medical Center Internal Medicine Residency, and member, Graduate Medical Education Policy, Medical Education Liaison, Continuing Medical Education, and Critical Care Committees. Her group practice has been in the Southern California Kaiser Permanente Medical Group, where she has held many committee responsibilities.

In her personal and family life, Carole has held multiple responsibilities for the Westerly School of Long Beach: Advisory Board, Annual Fund Co-Chair, Development Committee, Book Fair Promotions Chair, Soccer Team Mother, and Room Mother. At the All Saints Episcopal Church of Long Beach, she has served as a member of the Youth Advisory and Youth Task Force Steering Committees and as a Sunday School Teacher. With Carole, all things have been possible! SGIM

Editor’s Note—Members of the 2002 Rhodes Award Committee were Mark Linzer (Chair), Tom Inui, Martha Gerrity, and Mark Schwartz.
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Judy Davison at Odyssey Press. They have done their best to keep the Forum—and me—on schedule, not always an easy task. I also have received enormous help from Lorraine Tracton, Director of Communications in the SGIM National Office. Lorraine contributed numerous articles to the Forum and provided many of the photographs that have appeared in its pages (especially this issue). These folks deserve considerable credit for assuring that the Forum has arrived in your mailbox each month for the past three years.

When I took on the role of Editor three years ago, I told Brent Petty (then Chair of the Communications Committee) that my vision for the Forum was that “it should serve as a vehicle for sharing information and ideas among SGIM members [and]… allow us to continue the exchange of ideas which takes place at the Annual Meeting throughout the rest of the year.” Because of the contributions of the individuals listed above and others, I believe that we have been able to achieve this goal. Over the past three years, the Forum has published numerous articles about the work of SGIM’s Council and our many task forces (e.g., AIDS, Clinician-Educator, Evidence-Based Medicine), committees (e.g., Communications, Health Policy, Membership), and interest groups (e.g., Geriatrics, Minorities in Medicine, Physicians Against Violence). The Forum has informed members about new programs sponsored by SGIM (e.g., Research Mentorship, Horn Scholars, Increasing Education and Research Capacity to Improve Care of Older Americans). And it has served as a vehicle for debate about SGIM policy, in particular, the matter of acceptance of funds from external organizations.

I have enjoyed immensely the opportunity to serve as Forum Editor. It is with great confidence that I pass on the responsibilities of this position to Missy McNeil. Please help her by submitting articles, letters, and ideas about how we might strengthen this publication. The Forum is your newsletter, and it needs your continued support. Thanks for the support so many of you have given me over the past three years. SGIM