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REFLECTIONS OF A HORN SCHOLAR

Chinazo Cunningham, MD

It is difficult for me to believe that I am half way through the duration of the Horn Scholarship. In the past year and a half, my job description has taken several unexpected turns-a transformation from a general internist to an HIV and substance abuse doctor, and from a clinician-educator to a clinician-researcher. With these changes I questioned my identity as a doctor several times, and now accept the transformation and rise to the challenges associated with my new roles.

I am almost surprised at how loyal I have been to my commitment (and the Horn Scholarship commitment) of going into work three days a week. I essentially spend no more than 25 hours per week at work. My days at home with my children are wonderful. I am still sometimes forced to deal with work issues on my days at home; however, most of my colleagues have become accustomed to my schedule and rarely call me on my off days. Quality time with my children has increased significantly since being awarded the Horn Scholarship. I have the time to sit and read with them, play games with them, go for walks and bike rides with them, and have their friends over to play. I even have time to cook and exercise. All of these are the times that I cherish.

With all of my new and challenging roles, I still continue to work at home in the evenings (when my kids are sleeping). There is no way that the amount of work that I have to do can be done in the 25 hours of work time. In a typical week, I spend 8 hours in the clinic seeing patients and precepting, 3-4 hours on outreach in Single Room Occupancy (SRO) hotels, 2-4 hours in staff meetings, which leaves me with approximately eight hours left for the much of the real work. It just is not possible to complete all of my work in that time. I don't mind working at home while my children are sleeping, as long as the work doesn't interfere with my time with them. Before receiving the Horn Scholarship I spent many more hours working both at work and at home. Overall the time I spend working at home is substantially less, but it is still significant. I have found no way around this.

I have come to the realization that I will never "achieve balance," if there is such a thing. Depending on particular grant deadlines, presentations, and other circumstances, I feel at times I am more balanced with respect to personal and professional issues, and at other times less balanced. It is a never-ending fluid and dynamic process. When I feel a lack of balance in my life, I look to make sure there is an end

in sight of such disequilibrium. And, since receiving the Horn Scholarship, I can honestly say that there is always an end to sometimes frantic, late night workweeks.

I applaud SGIM for sponsoring such an endeavor to promote the balance of personal, professional and social responsibilities. I have had numerous female medical students, residents and junior faculty inquire about how to do this-how to maintain a successful academic career, while being a mother and wife who is present at home. There is unfortunately no easy answer. For me it has meant years of struggling, trying to find ways to make it work-some ways have been satisfactory, many have not. When most of us work well over 40 hours per week, and make repeated personal sacrifices to get where we are, it is difficult at some point to stop. It feels as though we (I) almost do not know how to stop. For me, the inciting factor was my application for the Horn Scholarship. After serious self-reflection, it became increasingly clear that I could not, and would not, maintain the fast-paced, pressured and stressed life, in which my family and I consistently fell short.

To sum up the past year and a half, there have been numerous changes in my career that are all exciting, demanding, and challenging. Now having experienced more balance between my personal and professional life than ever before, I realize that I will never again work full time. The Horn Scholarship has given me the room I need to breathe. It has given me a real presence at home-something I truly appreciate and hold as of utmost importance.

MAP FELLOWSHIPS OF THE OPEN SOCIETY INSTITUTE
Monica Peek, MD

As a Medicine as a Profession (MAP) fellow, I have had the opportunity to work with several advocacy and community-based organizations on breast cancer issues. It has given me the chance to combine medical expertise with insight into public health issues on projects that can have a greater impact on a community's health than is possible through individual patient encounters.
I am working with Cook County Hospital to increase the access of medically-underserved women in the surrounding communities to breast cancer screening. We have found that the highest rates of breast cancer deaths are found in the communities that have the highest rates of poverty and that are predominantly African-American.

Numerous studies have shown the effectiveness of these "natural helpers" in reaching previously underserved populations for preventive measures such as breast cancer screening. Health educators can address knowledge deficits and cultural beliefs that often keep women from seeking preventive health services; serve as a link between mobile mammography units and other health centers for ongoing comprehensive care; and organize communities around health issues that require grassroots action at the local and national level.

I am also working with Sisters, Inc. (the only African-American organization of breast cancer survivors), the Y-Me Breast Cancer Organization (the largest breast cancer advocacy organization in the country) and the National Black Women's Health Project (the only grassroots organization dedicated exclusively

to the health and well-being of African-American women) to create a program that trains women to become community health educators as well as health advocates on issues of breast cancer. By empowering and organizing women in the historically disenfranchised Chicago neighborhoods, they can begin to make important changes in the way their residents seek and receive health care.

The MAP fellowship also gave me the opportunity to create "The MammoVan Project," a service-learning program at Rush Medical Center, whose purpose is to increase the access of vulnerable populations to health education and to provide a forum for medical students to better understand the social determinants of disease, using breast cancer as a model. Medical students provide health education to low-income women in conjunction with the delivery of free breast cancer screening, through the Mobile Mammography Unit of Cook County's Bureau of Health Services, one of the nation's largest public health systems designed to meet the needs of the medically underserved.

This fellowship has also encouraged me to use my role as a clinician-educator as a forum for discussing the importance of physician advocacy and community organizing in establishing and maintaining healthy communities. I've had several opportunities to speak to medical students and residents on professionalism and advocacy. As the primary author of a chapter on Breast Cancer Screening, I was able to include a section on the importance of community organizers and educators in increasing the access of medically underserved populations to breast cancer screening.

As a physician, I have always believed in the importance of delivering the best possible health care to all people, regardless of their station in life. I have come to understand that realizing this goal means taking on the additional role of advocate, to help influence societal factors that create disparities in health and affect people's ability to access care. I now believe that being a good doctor means more than just delivering good care to individual patients; it also means being an advocate for your patients and the communities in which they live.

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PRESIDENT'S COLUMN
MAKING IT COUNT
Martin F. Shapiro, MD, PhD

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth

Life turns out to be short. I can't believe that it always has been as short as it is now. At 54, I feel like I am just getting started. Perhaps there is something about the nature of society today that makes time seem to go by more quickly. All that e-mail, perhaps. Or maybe the junk food. Or the paperwork in

clinic. Or the IRB documentation. In any event, it certainly is not at all credible that people didn't used to live as long as we do now. If that were the case, someone surely would have addressed this injustice. Life is shockingly brief.

Within that life, we don't have a lot of time for our professional accomplishments. Most of us finish training some time after the age of 30, and retire or reduce work substantially by the age of 65. In a research career, the active phase usually diminishes before the age of 60. Let's think about those 30 years. We have a lot to do: establish ourselves in our professional roles, get funded and published or get an educational program off of the ground. Get promoted. Acquire some security of employment. Save some money to buy a home, send kids to college, and plan for retirement. Care for ailing parents. Keep fit. Nurture a relationship with a loved one. Participate meaningfully in raising our kids. That is a lot to attend to. It is easy to lose sight of the big picture in terms of career, or even remember that there is one.

The big picture is what brought us into our academic medical careers: generally the desire to be an educator and/or researcher with specific ideals and objectives. For the researcher, much is driven by the need to get funding for the work. He or she may start with two or three years of protected time, but after that will generally need to have some funding in hand to continue. Many will scramble frantically for money that appears accessible. Even if the project is only marginally interesting to him or her, it may be irresistible. Suppose that that project runs for three years. The investigator does pretty well with it. The area becomes even more fundable. The investigator writes another grant for another three years. Where is this going?

A very productive scholar might obtain ten three-year grants during a 30-year career. The question the scholar must ask is: if I am going to do 10 major projects in my career, is this one of those ten that I want to do? Do I really care about this work? Is this really one-tenth of what I want to leave behind as products of my career as a researcher? While many researchers do choose to pursue lines of research that reflect what they care about, many others jump at the opportunity to study something, just because the money is dangling in front of them. I don't think that that is a good long-term strategy.
To be able to thrive in a career as a researcher, one needs to pursue one's passions early and often. A colleague once told me that, if you do work that reflects your core values and interests 10% of the time, you are ahead of the game. I couldn't disagree more. If you are not doing the stuff that matters most to you almost every day for a good bit of the day, you are not going to feel in the end that you have lived your professional life well. I believe that researchers who are able to stick with what they really care about are more likely to sustain their involvement in research over time. Those for whom a project is more of a means to an end are more likely to look early for transitions to administration or other activities.

Here is some more calculus. If we supervise residents on the hospital ward twice a year (an archaic concept, I know), that will be about 60 iterations. If we work with 3 to 5 residents during each rotation, that is 180 to 300 future internists who are exposed to us in that setting. The work is hard and the documentation requirements are endless, but this is a finite number of opportunities to deal intensively with house officers in a setting where the stakes are high, the margin for error is narrow, and emotions

always run close to the surface. If we reach one of them every two or three rotations and really help them find their way in life by becoming a better doctor, developing a career interest, addressing personal problems, and the like, then over time we will have influenced quite a few physicians in ways that matter. If, instead, we put in our time doing the minimum and move on to the next activities, those opportunities are gone for good and our prospects for having an impact as educators are diminished.

As educators and researchers, we only have a little time to do what we set out to do in our careers. It is very easy to be distracted by the clutter around us, and seduced by the opportunities that come our way, but that are decidedly not on the road that we had envisioned as our path through life. Eventually, we may come to be defined by the choices that we make. We may not even remember the ideals that we once possessed.

To accomplish our most heartfelt goals, we almost always have to take chances and often have to embrace the possibility of failing. The educator who wants to do something really innovative needs to anticipate that these efforts may be resisted or resented by colleagues and superiors. The scholar who has mastered one line of inquiry but dreams of pursuing another that is more than a little different needs to be prepared for rejection by funding agencies.
Years ago, when I decided to go to medical school (after much tortured consideration), my uncle commented that, had I made another career decision, I probably would have had little choice about what I did to earn a living. He contended that, as a physician, I would have lots of choices, and the ones that I made would define my worth as a human being. I often have measured myself against that metric. I have found that I am continually faced with decisions about career that require selection of a path, and that the easier way to go is often not the best one.

As academic physicians, our choices are very plentiful, indeed. If our careers are to have meaning beyond providing us with comfort or prestige, we must use our limited time very wisely and invest it in activities that reflect our ideals and our passions. If we do so, we may prove to be less well-funded and less influential as scholars, less admired as a team player by our institutions, and less well-paid for our work. Nonetheless, at the end of our careers, me just might be able to look back and feel that we lived our professional lives in ways that expressed who we were and what we cared about most.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I-
I took the one less traveled by,
And that has made all the difference.
-Robert Frost

SGIM AWARDS $910,000 IN GRANTS FOR RESEARCH AND EDUCATION IN THE CARE OF OLDER ADULTS
Karen Lencoski

On November 25, 2002, SGIM announced awards totaling $910,000 for 10 Collaborative Centers for Research and Education in the Care of Older Adults. The awards are the largest component of SGIM's initiative, "Increasing Education and Research Capacity To Improve Care of Older Americans," funded by a grant from the John A. Hartford Foundation. The 10 two-year grants of $91,000 each were made to:

- Baystate Medical Center (Stewart Babbott, PI; Sandra Bellantonio, Co-PI)
- Duke University (John W. Williams, PI; Mitchell Heflin, Co-PI)
- Geisinger Medical Center, Dansville, PA (Valerie Weber, PI; Robb McIlvried, Co-PI).
- Medical College of Wisconsin (Marilyn Schapira, PI; Edith Burns, Co-PI)
- MetroHealth Medical Center, Cleveland (Elizabeth E. O'Toole, PI; James Campbell, Co-PI)
- Oregon Health and Science University (Judith L. Bowen, PI; Carol Joseph, Co-PI)
- University of Michigan (Kenneth M. Langa, PI; Brent Williams, Co-PI)
- University of Pittsburgh (Asher Tulsky, PI; Hollis Day, Co-PI)
- University of Texas Southwestern Medical Center (Lynne Kirk, PI; Craig Rubin, Co-PI)
- University of Virginia (Andrew M.D. Wolf, PI; Jonathan Evans, Co-PI)

45 Applications Submitted in Response to RFA

Forty-five applications were submitted October 1, 2002 in a dramatic and enthusiastic response to the RFA (Request for Applications) publicized at the 2002 Annual Meeting. The RFA was also distributed to SGIM members and advertised to members of the American Geriatrics Society (AGS).

The 45 applications were reviewed by an eight-member Selection Committee chaired by Eric Larson, SGIM Past-President (1994-95). Other members of the Selection Committee were: Chris Callahan, Bob Centor, Elizabeth Eckstrom, Bree Johnston, Seth Landefeld, Ann Nattinger, and Sankey Williams. Proposal PIs, co-PIs, and co-investigators to be funded by the grant were ineligible for the Selection Committee. Members of the Selection Committee were recused from review of applications from their institution.

The review had two stages to assure selection of the highest quality applications from a diverse set of institutions. In the first stage, each application was read and scored independently by four members of the Selection Committee using five criteria specified in the RFA: collaboration between general internal medicine and geriatrics; development of general internal medicine leadership; potential relevance for other institutions; institutional support; and plans for program development after the funding period. Based on the scores from the initial review, 24 applications were selected as finalists for review in a day-long meeting of all eight members of the Selection Committee in Chicago. Each finalist application was read by each committee member, presented by primary and secondary reviewers, discussed by the Committee as a whole, and scored independently by all eight committee members. The 10 applications with the highest average scores were awarded grants.

Purpose of the Collaborative Centers

The goal of the SGIM Collaborative Center Program is to promote the collaboration of academic programs in General Internal Medicine and Geriatrics. The Program has two long-term aims:

o The identification and initial development of the generalist physician-educators needed to transform the education and training of the future physician workforce

o The production of the physician-investigators needed to build the clinical and system knowledge

base needed to advance the care of older adults.
SGIM believes the long-term aims can be achieved best through active collaboration of general internal medicine and geriatrics. It is anticipated, however, that the Centers will not achieve the long-term aims during the two-year funding period and that additional efforts will be necessary. Therefore, the program was designed with the following additional aims:
o To identify practices most likely to achieve the long-term aims from among innovations tried at the 10 Centers
o To provide the institutional foundation for initial collaborations to fuel further efforts to achieve the long-term aims.
It is planned that the Collaborative Centers will meet at the SGIM Annual Meetings in 2003, 2004, and 2005 to share their experiences and to begin dissemination of lessons learned.

Funding Reduced Because of Stock Market Decline
Funding for the Collaborative Centers was reduced to $91,000 each from an initial budget of $100,000 each. The effect of the stock market decline on the Hartford Foundation's net worth forced the Foundation to reduce all grant funding 25% in 2002. Accordingly, the Foundation's grant to SGIM was reduced $400,000 to $1.6 million. By eliminating other parts of the grant budgeted for approximately $200,000 and by eliminating the 10% indirect cost rate on all components of the grant, SGIM was able to maintain substantial funding for all 10 Collaborative Centers. SGIM

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RESEARCH FUNDING CORNER
Joseph Conigliaro, MD

NHLBI INNOVATIVE RESEARCH GRANT PROGRAM (PA-03-015)
EXPIRATION DATE: October 01, 2006, unless reissued.

National Heart, Lung, and Blood Institute (NHLBI) (http://www.nhlbi.nih.gov)
This looks like a great opportunity to receive preliminary funding to study existing data. The NHLBI Innovative Research Grant Program encourages both new and experienced researchers to explore new collaborations and approaches to heart, lung, and blood diseases and sleep disorders that address promising, yet underdeveloped, research topics and therapeutic approaches using existing data sets or existing biological specimen collections. To encourage the development of new ideas the NHLBI is utilizing an expedited Council review process and relaxing the stringent need for preliminary data and demonstration of concept feasibility required by standard NIH research project (R01) reviews. Support will utilize the NIH R21 award mechanism and should not exceed $100,000 in direct costs per year for up to two years. Applications are expected to focus on innovative new research with high impact potential. Studies must include human subjects and make use of existing data sets. Awards may be used to fund the addition and analyses of elements of existing data sets and specimen collections. Establishment of new collaborations is strongly encouraged. More on this announcement can be found at http://grants.nih.gov/grants/guide/pa-files/PA-03-015.html.

TRANSLATING TOBACCO ADDICTION RESEARCH TO TREATMENT (RFA: DA-03-010)
National Institute on Drug Abuse (NIDA) (http://www.nida.nih.gov)
LETTER OF INTENT RECEIPT DATE: March 24, 2003
APPLICATION RECEIPT DATE: April 23, 2003

The purpose of this RFA is to support research that translates existing knowledge into treatment and treatment practice, or research that will readily translate to clinical research or practice of nicotine addiction treatment. Although many of the studies that would fall under this RFA might involve volunteers in laboratory-based or Stage I style experiments, those studies developing and testing new behavioral approaches to treatment such as studies that explore ways to extinguish cues associated with tobacco use would be appropriate. Also studies that develop and validate treatments applicable to particular population groups such as women, minorities and those with co-occurring mental illness are encouraged. Gender-sensitive and gender-specific treatment research and approaches are needed because of the differences noted in smoking cessation and relapse rates that are governed by factors such as differences in the effectiveness of nicotine replacement and other pharmacotherapies, and issues specific to females such as menstrual cycle and weight control concerns. Smokers with co-occurring mental illness such as depression or schizophrenia engage in sustained, heavy use of tobacco. New approaches with medications and behavioral strategies may improve the effectiveness of treatment in such populations. This RFA is a one-time solicitation and will use the NIH research project grant (R01), the small grant (R03), and the exploratory/developmental grant (R21) award mechanisms. More on this announcement can be found at http://grants.nih.gov/grants/guide/rfa-files/RFA-DA-03-010.html

Please contact joseph.conigliaro@med.va.gov for any comments, suggestions, or contributions to this column. SGIM

CDC DES UPDATE: RESOURCES FOR HEALTH CARE PROVIDERS AND CONSUMERS
Anna Okula

To raise awareness about the health risks of exposure to diethylstil-bestrol (DES), the Centers for Disease Control and Prevention (CDC) developed the DES Update, a comprehensive national education program for consumers and health care providers.
An estimated 5-10 million people were exposed to DES in the United States between 1938-1971, including women who were prescribed DES while pregnant, and the female and male children born of these pregnancies. Initially, DES was thought to be a safe and effective way to prevent miscarriages or premature deliveries. However, later studies revealed that DES was ineffective in preventing pregnancy problems and that exposure to DES was associated with increased health risks. In 1971, the FDA issued a Drug Bulletin advising physicians to stop prescribing DES to pregnant women because it was linked to a rare vaginal cancer in female offspring.

While DES has not been prescribed for more than 30 years, it remains a current health issue because health risks associated with DES exposure continue to be uncovered by ongoing research. In the past

two years, a number of research articles have pointed to increased health risks for women exposed to DES while pregnant and the daughters of those pregnancies. (Titus-Ernstoff L et al., Br J Cancer 2001; Herbst AL et al., N Engl J Med 1971; Palmer J et al., Cancer Causes Control 2002)

Although most persons exposed to DES have no related health problems, others experience a range of health issues related to their exposure. Women prescribed DES while pregnant appear to have a modestly increased risk of breast cancer. Women exposed to DES in utero (DES Daughters) have an increased risk of clear cell adenocarcinoma (CCA) of the vagina and cervix. Recent studies indicate that some DES Daughters have been diagnosed with CCA of the vagina and cervix in their 30s and 40s (Hatch EE et al., JAMA 1998). Therefore, DES Daughters should have regular cancer screenings as they grow older. DES Daughters are also at increased risk for reproductive tract structural differences, pregnancy complications, and infertility. A preliminary study published in 2002 found an association between in-utero exposure to DES and increased risk of breast cancer in DES Daughters over 40 years old (Palmer J et al. Cancer Causes Control 2002). Men exposed to DES in utero (DES Sons) have an increased risk of epididymal cysts and may have an increased risk of other genitourinary abnormalities.

CDC's DES Update provides the first comprehensive set of information about DES for health care providers and patients, including findings from the most recent studies on the health effects of DES exposure.
Resources for health care providers (Power Point presentation and script, case studies, review essays, CME/CEU self-study modules) and patients (DES fact sheets, self-assessment quiz, personal health information record) are available for free on CDC's DES Update Web site at www.cdc.gov/DES or by calling toll-free 1-888-232-6789.
CDC's DES Update was funded by the U.S. Congress and developed in conjunction with the National Cancer Institute (NCI) and many other partner organizations, including American Academy of Physician Assistants, American College of Nurse Midwives, American College of Obstetricians and Gynecologists, American Medical Association, American Medical Women's Association, American Nurses Association, Association of Reproductive Health Professionals, Mennonite College of Nursing at Illinois State University, National Association of Nurse Practitioners in Women's Health, Registry for Research on Hormonal Transplacental Carcinogenesis/University of Chicago.

FINDING THE BALANCE: THE SOCIETY FOR GENERAL INTERNAL MEDICINE
Julia E. McMurray, MD
Introduction and Call for Reflections

The SGIM Personal and Professional Balance Interest Group was begun in 1999 to address issues of physician work life and the challenges that the medical culture places upon family and social responsibilities. To date the Interest Group has developed a varied agenda to advocate both individual and organizational change that will promote balance for physicians. The Mary O'Flaherty Horn Scholars Program in General Internal Medicine was begun in 2000 to fund a half-time position for a junior faculty that would allow for the pursuit of scholarly activities and social activism in general internal medicine while allowing individuals to care for family needs. Additionally, members of the task force have begun

working with the Chiefs of General Internal Medicine to advance the mission of balance-promoting policies for academic internists. The Task Force invites SGIM members to send in personal narratives regarding issues of personal and professional balance in medicine as a way of opening up discussion to the SGIM membership. Short prose pieces or commentaries may be sent to Julia McMurray, MD Department of Medicine, 2828 Marshall Court, Madison, WI 53705, jem@medicine.wisc.edu for consideration for publication in the SGIM Forum.

SOROS ADVOCACY FELLOWSHIP FOR PHYSICIANS

Claudia Calhoon, MPH

The Program on Medicine as a Profession of the Open Society Institute announces the next application deadline of January 14, 2003 for the Soros Advocacy Fellowship for Physicians. For more information on the fellowship and on the Medicine as a Profession program, please visit www.soros.org/medicine

The Soros Advocacy Fellowship for Physicians is designed to enable physicians to develop or strengthen advocacy skills through collaboration with U.S.-based advocacy organizations during a 12-24 month fellowship period.

Through this fellowship, participating physicians will design and implement projects that address health and service delivery or other social issues such as racism, violence, environmental hazards, and education. Projects should be focused within the United States and should identify system or policy level changes as the outcome of the fellowship work. Please note that we do not fund projects for direct service or research. Although the program welcomes projects that provide opportunities for role modeling, it does not encourage proposals that are solely devoted to training or curriculum development.

Applicants must apply for the fellowship with the commitment of an advocacy organization that is prepared to house, mentor, and support them throughout the fellowship period. A list of advocacy organizations that have expressed interest in participating in the fellowship is available at our website at www.soros.org/medicine. Applicants may also apply with organizations other than those listed on the website.

MAP accepts applications from physicians at all stages of their careers, but the most competitive applicants are practicing physicians. MAP encourages potential applicants who are completing their residency to apply after they have spent some time in practice post-training. Fellows will be chosen based on their achievements, a demonstrated commitment to public interest work, the strength of their proposed project, and the commitment of the participating organization. Projects will be judged on the capacity both of the individual and the organization to successfully implement the project and on how well the project uses advocacy strategies to address the needs of the target population. Please feel free to share this information with any colleagues or organizations to which the fellowship would be of interest. During the application process, inquires can be sent to ccalhoon@sorosny.org