

## PRESIDENT'S COLUMN

**Stronger Together**

Eileen E. Reynolds, MD

**SGIM has an amazing group of health-policy-focused members who have worked for years or even decades to promote generalist approaches to payment reform and research funding. It is exciting to imagine how much stronger our voices might be if we are joined by our family medicine and pediatrics colleagues in our advocacy.**



**D**o you have cousins who live at a distance? Maybe you grew up with them, maybe you only saw them during childhood vacations, but you know you have a lot in common. When you do get together, it's immediately as if you have been next door all these intervening years. Or maybe you have in-laws with whom you are not very close but with whom you get along because you know things will go better if you all cooperate. Or do you remember when you got assigned your freshman roommate? Some administrator (or some computer program) decided you and your new best friends had similarities and would do well in close quarters for the better part of a year. Or have you ever been set up on a blind date by well meaning friends or colleagues based on ideas about what you and your date have "in common"? A recent gathering of leaders from all the primary care disciplines, held at SGIM headquarters, felt like all those relationships at once to me.

Academic pediatrics and family medicine are more like general internal medicine than they are unlike it. They are our cousins or maybe our in-laws. (I mean that in a good way.) There are a lot of reasons why we should have been hanging out or working together or even living as roommates for years. We believe in the holistic care of patients (or families), in the importance of prevention, in evidence-based medicine, and together we reach and teach all the students in US medical schools. We prioritize the patient-doctor relationship, we see patients in the office and in the hospital (pediatrics has

more hospitalists than GIM in some ways), and we believe in high-value low-cost care. We support health care reform, and we advocate for payment reform.

But we haven't been hanging around together or working together. Why not? The institutions in which we work are often incredibly siloed. For example, here at Beth Israel Deaconess Medical Center, we don't have pediatrics or family medicine departments. (In fact, Harvard doesn't have a Department of Family Medicine at all, at any site.) Even in places where all three disciplines exist, departments often compete with each other rather than collaborate toward the same ends. There are long-held cultures in each specialty that are different. Our relationships and the history behind them are complex.

However, over just the past year, SGIM has begun meeting with groups representing pediatrics and family medicine—a collaboration that has felt part blind date, part the beginning of freshman year, and part family reunion. Last year, under the leadership of then-President Marshall Chin, SGIM began an effort to create a population health summit funded by the Agency for Healthcare Research and Quality (AHRQ). The bad news is that AHRQ did not fund the conference; the good news is that the Graham Center stepped in. The Graham Center ([www.graham-center.org](http://www.graham-center.org)) is a family medicine think tank that aims to improve individual and population health care delivery through the generation or synthesis of evidence that brings a

family medicine and primary care perspective; their work supports the policy and advocacy arm of the American Academy of Family Physicians (AAFP). The Graham Center invited leaders of primary care organizations to last spring's Starfield Summit. This population-health-focused conversation must have been a little like the dinner conversation at a first date—a conversation about a safe topic of mutual interest, with no ongoing commitments but an opportunity to explore personalities, values, and the potential of a second date.

That first date indeed led to another, and in late August, I was fortunate enough to attend the Primary Care Collaborative Retreat, held at SGIM headquarters. Physician leaders and executive directors representing general internal medicine (SGIM), pediatrics (the American Pediatric Association [APA] and the American Academy of Pediatrics [AAP]), and family medicine (the Graham Center and the Society of Teachers of Family Medicine [STFM]) gathered for a day and a half of work facilitated by Russ Phillips and Catharine Smith of the Harvard Center for Primary Care. The participants are listed in Table 1.

We divided up into small groups several times to discuss both how to work together and what to work together on. Each small group included at least one member representing each specialty. The work was intense, but the conversations were rich and productive. We developed a shared vision for our collaborative efforts, fo-

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*Primary Care Leadership Group in the Hess Conference Room at SGIM*

ocusing on potential areas for mutual growth and improvement and leaving to the side any areas of competition or conflict. The leadership group agreed that our work together should:

- Have a patient-centered focus since each of our organizations prioritizes patient-centered care as a core value;
- Unite primary care disciplines in an approach that seeks to achieve the “Quadruple Aim”;
- Be aimed at building a bridge, or structural alignment, across our organizations to engage our skills and resources toward innovative approaches to elevating primary care; and
- Include coordinated advocacy to leverage our membership numbers to advance a national

primary care agenda, inclusive of primary care reform and funding for primary care research and innovation.

So once we agreed on the principles of our collaboration (the “why”), we moved on to the near-term future of the “what” we should work on together. We identified two key areas for next steps:

1. Combine our advocacy, Hill Day, and payment reform efforts.
2. Create a comprehensive initiative related to identifying and addressing factors related to primary care physician burnout.

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Burnout is a problem for many specialties, but it is particularly problematic in many primary care practices and also among some hospital medicine groups. The pediatricians and family physicians share

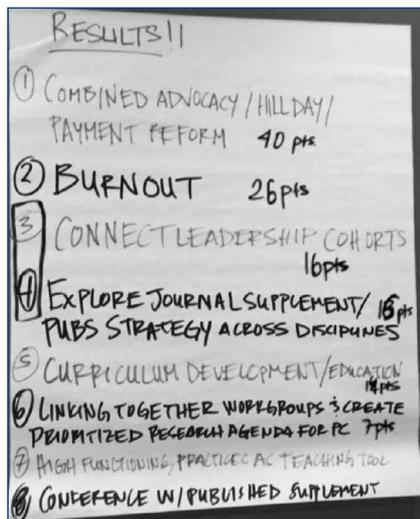
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**Table 1. Primary Care Leadership Group Participants**

Name	Organization
Eileen Reynolds, MD	SGIM President
Marshall Chin, MD	SGIM Past President
Russ Phillips, MD	Harvard Center for Primary Care
Ted Long, MD	Yale University
Catharine Smith, MA	Harvard Center for Primary Care Executive Director
Frank Fortin, CAE	SGIM Executive Director
Leslie Dunne, MPA	SGIM Development Director
Stacy Brungardt, CAE	Society of Teachers of Family Medicine Executive Director
Anton Kuzel, MD, MHPE	STFM representative
Andrew Bazemore, MD	Robert Graham Center, Director
Max Romano, MD, MPH	Graham Center, Resident
Shale Wong, MD	Academic Pediatric Association
Mary Ottolini, MD, MPH	Academic Pediatric Association President
Sandra Hassink, MD	President, American Academy of Pediatrics
Laure Falusi, MD	Immediate Past President, American Academy of Pediatrics

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Voting for collaborative projects

our desire to use systems-based approaches to work environment improvement and a focus on team-based care to combat burnout. SGIM and the Association of Chiefs

and Leaders of General Internal Medicine (ACLGIM) have both invested time and resources in this area; the value of sharing tools, innovations, and resources across specialties and societies who have common interests and goals is a no-brainer.

In both these areas, to coin a term, we are clearly Stronger Together. Are there any downsides of collaborating with academic pediatrics and family medicine? Well, there are a few potential unintended consequences. Our advocacy work is multi-dimensional; we don't want to leave behind important aspects of our platform just because it doesn't align with pediatrics or family medicine. (One example might be our work on behalf of additional NIH funding.) Our membership is not only primary care faculty—it's general internal

medicine with a wide lens. Advocating specifically for primary care might leave hospitalists feeling as if they are not our priority—even though they are (and we have a lot in common with pediatricians in this regard). Might SGIM's unique voice feel diminished in the context of these partnerships and the opportunity to speak as one about primary care? It is the work of SGIM's leadership to be aware of, and mitigate, those possibilities.

For now, we are approaching the "going steady" phase. We are excited about the opportunities to work together with pediatrics and family medicine in these two ways—on advocacy and on physician well-being. We are cousins, or happy roommates. Time will tell, but I hope we are off to what will be a productive long-term collaboration.

SGIM