ANNUAL MEETING UPDATE: PART I

Wrapping Up Wise, Wild, and Wonderful Washington
Dawn DeWitt, MD, MSc, MACP, FRACP

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As chair of the 2017 Annual Meeting devoted to “Resilience and Grit: Promoting Organizational Change and Preventing Burnout in GIM,” I am pleased to report on the innovations and successes of this meeting. Our theme was both inspired and timely. Suggested by Eileen Reynolds (2017 SGIM President) and adapted by the program committee, the theme inspired us all to think creatively and be innovative in our actions just as Council’s comments on the AHCA kept SGIM membership at the forefront of the current challenges facing physicians and patients in the United States.

In early 2016, when the Program Committee began to prepare for the 2017 annual meeting, we wanted to address some daunting challenges. As SGIM membership has grown over the last several years, acceptance rates had fallen. We wanted to increase meeting submission acceptance rates so that more members could present their work. After reviewing options and discussing educational evidence on learning and attention span, we redesigned the meeting to focus on 60-minute sessions, thereby giving more members a chance to share their work (see the “by the numbers” box). We continued on page 10
FROM THE EDITOR

Why Is the National Meeting Important? Reflections of an SGIM Groupie
Joseph Conigliaro, MD, MPH, FACP

Editor in Chief, SGIM Forum (editor.sgimforum2017@gmail.com)

I attended my first rock concert in 1982: Queen at Madison Square Garden—orchestra seats! There was nothing like having a chance to see Freddie Mercury live. Critics and fans said he had the broadest vocal range of any rock singer ever. I attended my first Society of General Internal Medicine National (SGIM) Meeting in 1991 in Seattle, Washington. What does one have to do with the other? Both are milestones in my life that I can vividly remember and that I often brag about to junior colleagues and those who don’t remember what real music was like.

As a young college student and budding air guitar virtuoso, I admired the talent and innovative music of Queen, and the band was among my favorite artists. As a primary care resident and later chief medical resident at Jacobi Medical Center in the Bronx, New York, I admired the commitment and talent of Pam Charney and Steve Hahn, my mentors, who inspired me to pursue a career in academic general internal medicine. The National Meeting in 1991 was one of the first glimpses of the career I wanted, but had no idea as to its national scope. I was to start my health services research fellowship at the University of Pittsburgh the following July.

The 1991 meeting was my first and, as luck would have it, the chair was Wiswaha Kapoor, who would become a key mentor, and whose approach to research and leadership I have since emulated throughout my career. In addition, the people I met and the workshops and abstracts I attended exposed me to the breadth and depth of general medicine in a way that has been hard to shake.

I’ve attended many concerts since 1982 (sadly none of them included Freddie Mercury) and I’ve attended every SGIM National meeting, save two, since 1991. Each year, it remains the highlight of my year and is the charge that I need to keep the spark of academic generalism strong within me. This year’s meeting theme was devoted to resilience and grit. That’s appropriate as the meeting had been the best way to recharge with like-minded colleagues. Every time I recommend the Society and meeting attendance to a medical student or trainee, I know that it can ignite a spark to choosing general medicine as a career. The following are similar sentiments from a couple of Forum associate editors:

“The most striking aspect of the annual meeting was the huge number of attendees who are somehow involved in the meeting—giving talks, workshops, or posters. It really made me appreciate the ethos of SGIM—we are a very inclusive, participatory organization—not one where a few people are the leaders and the rest are along for the ride.”

—Somnath Mookerjee

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An understanding of culture and its role in shaping societal behavior is essential to the effectiveness of all academic general internal medicine physicians, whether it is in research, teaching, administrative, or patient care.

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GIM’s 2017 Annual Meeting shone a bright spotlight on critical issues surrounding physician wellness and resilience. It is clear that just the day in and day out experiences of being a doctor in today’s healthcare environment can cause burnout with serious implications for the affected clinicians, healthcare organizations, and our patients. Many factors associated with physician burnout, such as production pressures and difficult-to-use electronic health records, feel out of our control. Yet, we are in control of how we respond as individuals to these pressures. We also create the culture of medicine that is both a source of psychological stress and of inhibiting our willingness to access helpful resources.

An understanding of culture and its role in shaping societal behavior is essential to the effectiveness of all academic general internal medicine physicians, whether it is in research, teaching, administrative, or patient care. My favorite definition of culture is “the way we do things around here.” Culture is the collection of individual and group norms that are as ubiquitous as the air we breathe, and, in many ways, as invisible. Seeking to change physician behavior without an understanding of the culture in which those behaviors exist is a recipe for failure. As organizational behavior experts note, “culture eats strategy for lunch.” Cultures never develop by accident and serve to advance powerful (though not always positive) interests within a group.

Culture is especially apparent during residency training. For me, the dominant cultural norm during residency was one of being “strong.” Not admitting a patient with borderline indications from the emergency room, succeeding at placing a challenging central line, getting a patient to agree to a DNR status, and discharging the patient who had been sitting on the service for a long time were all met with an enthusiastic “strong work!” (and sometimes a demonstrative high five) from our senior residents. Equally powerful was the desire to not do things that our peers considered “weak,” such as waking up the senior resident with a clinical question that should have been obvious to us, admitting a patient for primarily social reasons, or not being able to cover your shift for any health-related reason that did not require you to be personally admitted to the ICU.

A culture of strength has important benefits related to ensuring high quality, compulsive patient care, appropriate resource utilization, and cohesive teams. Yet, the downsides are considerable, as I learned early on in my residency. We had admitted a middle-aged patient to the coronary care unit with chest pain. He had a history of coronary artery disease, and we believed his presentation was consistent with unstable angina. I reviewed his chest x-ray, which looked okay to me, and reviewed it with the radiology resident who concurred. So, we started the patient on heparin, an appropriate treatment for unstable angina. He continued to have chest pain on and off throughout the night, which we treated with morphine. The CCU was extremely busy with complex patients that night. The next morning on rounds we got a frantic call from the attending radiologist.
In 2005, as part of its “100,000 Lives Campaign,” the Institute for Healthcare Improvement endorsed the widespread use of rapid response systems to identify and respond to clinically deteriorating inpatients outside of the intensive care unit (ICU) prior to a life-threatening event. Since then, most hospitals across the country have implemented them in some form, individualized to each institution’s needs. In addition to potential improvement in patient outcomes—such as emergent ICU transfers, in-hospital cardiac arrest, or mortality—rapid response systems are increasingly recognized for the broader value they add to health systems by supporting bedside nursing staff, fostering in-the-moment patient advocacy, enhancing a team-based approach to care, and facilitating goals of care discussions.

At teaching institutions, internal medicine house staff is often part of a rapid response system multidisciplinary team that works collaboratively with nurses, respiratory therapists, and other staff members to quickly assess the patient, initiate medical treatment, and decide on optimal disposition as indicated by patient and system factors. It is challenging to proactively prepare learners for these complex and unpredictable encounters. Residents receive training in running ACLS/Code Blue situations, but typically aren’t trained for the more nuanced rapid response encounters. Clinical triggers for rapid response activation are individualized to each system and can include a variety of inputs (see Table 1). Responding clinicians must be prepared with a broad set of skills: emergent assessment and resuscitation, differential diagnosis generation and hypothesis-testing, patient-centeredness, team-based inter-professional communication, and understanding of the hospital system and culture. As compared to ACLS, the complexity of a less-sick, but less-defined, rapid response patient is challenging to put into reproducible algorithms. To add to the complexity, different training sites may have important differences in rapid response team members, ICU transfer criteria, and available specialists and subspecialists. Table 1 outlines some of the differences between skills required for effective Code Blue management as compared to what is needed for effective rapid response management.

Rapid response systems are generally well received by house staff, though self-reported perception of educational benefits are mixed and there is limited research regarding the best methods for rapid response education. Didactic lectures or computer-learning modules can teach the diagnostic thought process for common triggers, but these modalities lack the benefits of real-world practice working within an inter-professional team in a time-sensitive, stressful environment. Simulation-based medical education can effectively continue on page 12.

### Table 1: Examples of “Code Blue” v. Rapid Response Skills

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<tr>
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<th>Code Blue</th>
<th>Rapid Response</th>
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<tr>
<td><strong>Trigger for Initiation</strong></td>
<td>- Cardiopulmonary Arrest</td>
<td>- Tachypnea or Bradypnea&lt;br&gt;- Tachycardia or Bradycardia&lt;br&gt;- Hypotension or Hypertension&lt;br&gt;- Hypoxemia&lt;br&gt;- Dyspnea&lt;br&gt;- Altered Mental Status&lt;br&gt;- Chest Pain&lt;br&gt;- Severe Bleeding&lt;br&gt;- General Concern</td>
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<tr>
<td><strong>Clinical Assessment</strong></td>
<td>- Airway&lt;br&gt;- Breathing&lt;br&gt;- Cardiac Rhythm Interpretation&lt;br&gt;- Reversible Precipitants</td>
<td>- Comprehensive evaluation of triggering sign or symptom&lt;br&gt;- Interpretation of patient, family, nursing concerns&lt;br&gt;- Integration of change in status with overall disease process trajectory and management</td>
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<td><strong>Interventions</strong></td>
<td>- ACLS protocol, which may include: CPR, venous access, advanced airway management, cardiac defibrillation, administration of advanced medical therapies, assessment for more specialized interventions</td>
<td>- Diagnostic evaluation, stabilization, and ongoing management of trigger and underlying etiology&lt;br&gt;- Symptom control&lt;br&gt;- Transfer to higher acuity setting, if consistent with patient goals of care</td>
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<td><strong>Communication</strong></td>
<td>- Leadership-focused&lt;br&gt;- Distribution of care to team members&lt;br&gt;- Task-oriented, “closed loop” feedback</td>
<td>- Patient-focused&lt;br&gt;- Shared decision making&lt;br&gt;- Collaborative discussion</td>
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In this unprecedented season of health policy challenges to SGIM’s core missions, it is vital that SGIM strengthen its members’ ability to respond and advocate for our patients, practices, and programs. Therefore, we are delighted that 20 participants (scholars) and 10 experienced health policy mentors gathered at this year’s annual SGIM meeting to launch the Leadership in Health Policy (LEAHP) program. LEAHP, a national health policy career development program, was created based on the successful models of the TEACH (Teaching Educators across the Continuum of Healthcare) and the Association of Chiefs and Leaders in General Internal Medicine’s LEAD programs.

After spending a few months reading primers on health policy and advocacy, the group met for a half-day session that included mini-lectures, case-based presentations, and interactive discussions on how health policy is made, the Affordable Care Act and the current state of healthcare reform, the federal budgeting process and its role in research funding, and how Medicare’s Graduate Medical Education (GME) policy shapes the physician workforce. The LEAHP scholars and mentors networked and began developing affinity groups on common interests and activities.

The LEAHP scholars range from resident to seasoned faculty with interests in how policy impacts clinical practice, education, and research. Over the coming year, participants will undertake a variety of Capstone projects based on their interests and expertise. These include developing health policy curricula for students, residents, and faculty, writing white papers or op-ed pieces, leading workshops at regional and the national meeting, and engaging in analysis, teaching, and advocacy on payment topics, such as alternative payment models and the Resource-Based Relative Value Scale (RBRVS).

Evaluation of the pre-course was highly positive, and comments from the scholars included the following:

“I liked the continuous engagement through debates/table sessions. I think that case-based examples… are most effective for my learning and would love to see that continue to be incorporated in the curriculum.”

“I definitely came out of the session with new ideas for my LEAHP year, and loved interacting with my colleagues.”

“I felt that the actual content was fascinating, and I liked how there were activities throughout to keep us engage and thinking.”

“I loved being “tested” to go out of my comfort zone with the “break-outs” at the end of each session. That was really great higher level thinking.”

The goals of the LEAHP program are to develop SGIM members who will become effective and active health policy advocates and local health policy experts, leaders, and teachers; to offer health policy career development resources and opportunities to all SGIM members; and, to develop an expanding, national cadre of Health Policy Committee (HPC) members and broaden engagement in the Society’s health policy efforts.

LEAHP is a year-long program focused on health policy knowledge and advocacy skills aligned with SGIM’s core missions. The program’s learning objectives include:

- Knowing the key structures and functions of the US health care system;
- Understanding the key players and processes in the federal health policy-making;
- Ability to critically evaluate healthcare delivery and economic models and to propose needed changes and/or additions;
- Ability to explain the impact of health care reform on the practice of medicine, education, and research; and
- Ability to advocate effectively with policy-makers.

During the coming year, LEAHP trainees will participate in the following:

- Quarterly Webinars led by LEAHP faculty with curriculum presentations, case discussions, etc.;
- Quarterly health policy/advocacy teleconferences (available to all SGIM members) for a health policy update by CRD (SGIM’s government affairs partners in DC), “Washington Post” journal clubs, and discussions of pressing issues to build a community of practice;
- Monthly phone calls with their mentors to make progress on their individual development plan and Capstone projects, guide learning, and discuss challenges and opportunities;
- Membership in a health policy subcommittee (education, research or clinical practice); participating in monthly calls and health policy committee advocacy activities;

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The Society of General Internal Medicine presented numerous awards and grants during its Annual Scientific Meeting, held April 19-22, 2017, at the Washington Hilton in Washington, DC. SGIM is proud and pleased to announce the recipients by category. For more information about SGIM’s awards, please visit https://www.sgim.org/career-center/awards-and-grants/2017-award-winners.

Recognition Awards
The Robert J. Glaser Award: Presented to Robert M. Centor, MD, (University of Alabama at Birmingham), 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.

Elnora M. Rhodes Service Award: Presented to Mitchell D. Feldman, MD, MPH, and Richard L. Kravitz, MD, MSPH, (University of California San Francisco and Davis, respectively), for their outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine.

Herbert W. Nickens Award: Presented to Marcella Nunez-Smith, MD, MHS (Yale University), for a demonstrated commitment to cultural diversity in medicine.

David R. Calkins Award in Health Policy Advocacy: Presented to Mark D. Schwartz, MD (New York University School of Medicine), in recognition of his extraordinary commitment to advocating on behalf of SGIM.

ACLGIM Chiefs Recognition Award: Presented to Deborah Burnett, MD, MA (University of Chicago). This award is given annually to the general internal medicine Division Chief who most represents excellence in division leadership.

Lawrence S. Linn Award: Presented to Dana D. Hines, PhD (George Washington University). This award is presented to young investigators to study or improve the quality of life for persons with AIDS or HIV infection.

The ACLGIM UNLTD (Unified Leadership Training in Diversity) Award: Recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM. The 2017 recipients are Kierstin C. Kennedy, MD, MSHA, (University of Alabama at Birmingham), and Tanya S. Sam, MD, MPH, (The Brooklyn Hospital Center Medicine).

The ACLGIM Leadership Award is given to a member of the ACLGIM who is within the first 10 years of faculty appointment. It recognizes skills in leadership in any number of areas of academic medicine, including clinical, educational, research or administrative efforts. The 2017 recipient of this award is Carrie A. Herzke, MD, (Johns Hopkins Hospital Hospitalist Program).

The Quality and Practice Innovation Award: Recognizes general internists and their organization that have successfully developed and implemented innovative role model systems of practice improvement in ambulatory and/or inpatient clinical practice. The 2017 award was presented to GIM at Boston Medical Center and Boston University School of Medicine, Jeffrey Samet, Chief.

Research Awards
John M. Eisenberg National Award for Career Achievement in Research: Presented to Joann G. Elmore, MD, MPH, (Harborview Medical Center), in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator of the Year: Presented to Yael Schenker, MD, (University of Pittsburgh), for early career achievements and overall body of work that has made a national impact on generalist research.

Mid-Career Research and Mentorship Award: Presented to Joseph S. Ross, MD, MHS, (Yale University School of Medicine), in recognition of mentoring activities as a general internist investigator.

Best Published Research Paper of the Year: Presented to Victoria L. Tang, MD, (University of California–San Francisco), for her 2016 publication “Clinician Factors Associated with Prostate-Specific Antigen Screening in Older Veterans with Limited Life Expectancy.” This award is offered to help members gain recognition for their papers that have made significant contributions to generalist research.

Founders’ Award: Presented to Melissa Y. Wei, MD, MPH, SM, (University of Michigan), for her proposal entitled “Chronic diseases and physical functioning: development and validation of an ICD-coded multimorbidity index.” The SGIM Founders Award provides $10,000 support to junior investigators who exhibit significant potential for a successful research career and who need a “jump start” to establish a strong research funding base.
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had amazing engagement from many fronts on everything from how to best use limited meeting space (e.g., room plus table options to accommodate the burgeoning number of interest groups) to re-designing poster presentations with video tutorials on best practices by Steve Fihn and friends.

To increase the quality of presentations, Workshop Chairs Mukta Panda and Waseem Khaliq developed a completely new peer review rubric. The Program Committee then worked to increase the quality of accepted content overall by developing a peer review rubric for each submission type. New rubrics were posted online alongside submission criteria for transparency.

As the planning year progressed, additional people were inspired by the spirit of innovation surrounding the meeting. SGIM staff members Shelly Woolsey, Julie Machulsky, Lisa Le, and Steve Scruggs designed a new annual meeting Web site look, launched a new meeting app and conference library, and enhanced social media presence. The new SGIM17 Conference Library increased the value of the meeting to attendees by allowing post-meeting views of up to 30 sessions if they were unable to attend during the meeting. Recorded video sessions include the Plenaries, Distinguished Professor Keynotes, Special Symposia, and Clinical Updates (see Web site https://connect.sgim.org/sgim17/program/library). Our Special Symposia Chairs, Stewart Babcock and Elizabeth Eckstrom, designed a series of sessions and recruited speakers for topics such as preventing burnout, from developing personal skills to organizational approaches; resilience programming brought in “physiology of mindfulness” experts Avid Haramati; while SGIM star Mark Linzer and others tackled the issues of institutional change at all levels. The Clinical Update Chairs, Gail Pokorney and Paul O’Rourke, designed a new SGIM-MED talk series to bring some spark to the already excellent Updates format. Mark Linzer and Colin West delivered an invigorating SGIM-MED talk on Resiliency and Wellness, while D.C. Dugdale, Karen Horowitz, and I presented a SGIM-MED talk on Diabetes. MOC credit was available for the first time at this meeting, an incredible value-add for meeting attendees, thanks to the efforts of MOC Chair Eric Green, the MOC Task Force, and Evaluation Chairs Bobby Baron and Somnath Mookherjee.

There were so many highlights during the meeting that it’s difficult to name just a few. The Opening Plenary session was full of fantastic presentations—from resident Maureen McCamley’s presentation highlighting the importance of home visits to Eileen Reynolds’ Presidential Address “Reflections on Resilience” that reminded us of the wisdom and persistence of our members, our history, and our mission, as SGIM forges new advocacy strategies to support our goals and our members. The untimely fire alarm did nothing to dampen the spirit of the session and we should congratulate ourselves, and the speakers on staying calm in the face of sirens and flashing lights! Thursday, informally dubbed “Celebrating Our Humanities Day,” included additional special sessions: a book club, a member-driven performance venue showcasing participants’ artistic contributions and discussion on how engagement in the arts and humanities contributes to personal resilience, and an evening concert. This piano reception brought resilience and grit home via Dr. Rich Kogan’s performance that intertwined Chopin’s music with stories of his life.

Additional programming on Friday and Saturday included a plenary presentation from Vivian Lee, who highlighted how one organization vastly improved its quality and outcomes by becoming more financially transparent and accountable through physician-led initiatives. Saturday morning began with a fascinating armchair discussion moderated by Steve Fihn, featuring Tom O’Toole and Erika Poethig, on the critical nexus between housing and health. Then, Madeline Sterling and Barbara Turner hosted a panel of past presidents of SGIM as they reflected on our history and mission. About 550 audience members participated in SGIM’s 40th Anniversary Symposium which actively engaged senior and junior members to ‘look back’ and ‘look forward’ about SGIM’s past and future in an evolving health care system.

I’d like to thank the program committee and the many submission reviewers. The astonishing Margaret Lo, who co-chaired the meeting two years running, contributed weeks of work—her wisdom and incredible organizational talents made the meeting a success. Everyone on the SGIM staff, from the indefatigable Sarajane Garten, to the enthusiastic Lisa Le, and the fantastically loyal and talented Kay Ovington, demonstrated true resilience and grit!

Our three-pronged approach to the theme—personal, workplace-based, and systems-based—resulted in a broad array of sessions with excellent attendance. Personally, I felt invigorated by the shorter sessions—knowing I could stand up and walk every hour was refreshing, and I felt I could attend more variety of sessions.

As we look forward to next year’s meeting in Denver, with a theme related to health information technology, I am reminded of why we are such a strong organization. I look to each and every one of us to carry each and every one of us forward as we face the considerable political challenges and many professional, practice and personal issues going forward. Please volunteer to review, mentor, advocate, and contribute to the 2018 meeting and to the mission of SGIM—remember being connected is a huge predictor of happiness and health. See you in Denver!
ologist, who was reading films from the day before. He informed us that the patient was having a massive dissection in his ascending aorta. The radiology attending came by later to show us the dissection, which was not subtle—we just missed it. When the radiology attending called, we told him we wished we’d had that information sooner, because about two hours earlier the patient had coded and died.

Our team was in shock. We huddled on rounds to formulate a plan for what the attending physician was going to say to the family, who was sitting in the waiting room. Then, we put our heads down and moved on to the next patient. I figured that this was what professionals do, and we never spoke again about the case itself or how it affected anyone on the team.

Research that we and others have conducted on the emotional impact that involvement in adverse events and errors has on healthcare professionals has highlighted this important area of unmet need related to physician wellness. The vast majority of physicians have been involved in cases like these, yet only 10 percent of physicians in one survey reported receiving adequate support from their institution. Interestingly, the severity of the emotional distress does not always correlate with the level of harm the patient experienced. For some physicians, involvement in a near miss, especially if it had potential to seriously harm the patient, evokes considerable emotional distress.

The consequences of this distress are equally apparent: anxiety, poor sleep, loss of confidence, and sometimes suicide. For some clinicians, the emotional response resembles PTSD, with persistent and bothersome intrusive reflections and flashbacks. Yet, the impact extends far beyond the affected clinicians—physicians who experience distress after an error are more likely to make subsequent errors. I have no doubt the patients we rounded on next in the CCU did not receive the attention they deserved from us.

Fortunately, in the decades since this case happened, important new resources and programs have been developed to support clinicians after adverse events and medical errors. Formal initiatives to “care for the caregiver” are being implemented, often as part of a more comprehensive Communication and Resolution Program. Many of these new programs are based around a peer support model, in which clinicians in various specialties are trained to offer support to their colleagues. When the need for support extends beyond what these peer supporters can offer, formal processes are in place for referral to trained mental health professionals and fitness to work evaluations.

While these programs are a positive development, important barriers limit their impact. For example, some physicians question whether such support is effective and confidential or have difficulty taking time away from work. This culture of strength, where acknowledging the emotional impact of adverse events and errors on oneself and being open to support is seen as a sign of weakness, can prove doubly toxic. It can increase the probability of adverse events and errors, and also limits our ability to get support when such events occur.

Some peer support programs don’t wait for the affected clinician to ask for help, but rather involve proactive outreach after adverse events and errors with an offer of support from a colleague. Yet, even active outreach has limited impact when clinicians reflexively respond that “they’re fine” and brush off the need for support. Other professions involving first responders and other high-stress occupations that can be involved in accidents—such as law enforcement, firefighters, and air traffic controllers—take a much more proscriptive approach, mandating time off and clearance from a mental health professional before return to work.

Our choices in how we respond to adverse events and errors have important implications for our long term personal and professional growth. Peggy Plews-Ogan and colleagues interviewed 61 physicians who had been involved in significant errors to explore the factors associated with clinicians learning and adapting positively. Physicians who reported positive growth after the harmful error were more likely to have disclosed the error to the patient and family, talked about what had happened with colleagues or others in a way that acknowledged the mistake and diminished their isolation, forgave themselves, and devoted energy to preventing recurrences and improving teamwork.

The culture of strength from my days as a resident had short-term appeal in terms of establishing ground rules in a chaotic and disorienting clinical environment. But, over time, I came to see that in more productive and supportive medical cultures, true strength lies in a willingness to acknowledge the emotional impact that practicing medicine has on all of us, both on a daily basis and in the face of individual traumatic experiences. SGIM members can lead the way in reshaping “the way we do things around here,” role modelling productive and supportive approaches to coping with dips in our emotional well-being.

References
tively teach teamwork, communication, and leadership skills during crisis situations, and may serve as a useful augment especially if integrated into ongoing educational activities. An important aspect of rapid response implementation may be that it allows junior trainees to feel more comfortable involving supervising physicians in the assessment of decompenulating patients who can provide additional educational opportunities such as role-modeling and in-the-moment feedback.

A set of nine skills is proposed in Table 2 to guide resident preparation for rapid responses and to frame directed feedback from team members. These skills are based on the unique requirements of a rapid response as noted above, literature review of barriers to successful rapid response team activation, and the author’s personal experience performing and supervising rapid responses. Additional studies are warranted to identify optimal educational strategies, including curricular content and modality, in order to best prepare resident physicians to manage a clinically deteriorating patient in the patient-centered, team-based context of a rapid response activation.

### Table 2: Nine Skills for Trainees on Rapid Response Teams

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<tr>
<th>Skill</th>
<th>Description</th>
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<td>1.</td>
<td>Prepare ahead of time: understand the differential diagnosis and basic workup for common triggers of rapid-responses</td>
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<td>2.</td>
<td>Show up: when called, respond promptly at bedside; there is no substitute for face-to-face interaction</td>
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<td>3.</td>
<td>Introduce the rapid-response team: explain the role of the team and its members to the patient and any family members or surrogates at bedside</td>
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<td>4.</td>
<td>Listen carefully: engage the patient, family members, and bedside staff to elicit concerns triggering the rapid-response as well as the patient’s hospital course and goals of care</td>
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<td>5.</td>
<td>Make a plan: assess the patient to determine appropriate diagnostic and/or therapeutic interventions based on rapid-response trigger and underlying etiology, guided by patient goals</td>
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<td>6.</td>
<td>Probe for understanding: use patient-centered language to explore and confirm patient understanding and agreement to interventions or monitoring offered, including potential escalation of care to ICU; if there is discrepancy, seek assistance from a supervising physician</td>
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<td>7.</td>
<td>Give a clear timeline: if the patient is to transfer to the ICU, communicate directly with the accepting team and provide anticipatory counseling to the patient regarding next steps; if temporizing measures are to be attempted prior to escalation of care, provide a specific monitoring plan including who will follow-up and when, as well as specific parameters to recall the rapid-response team prior to planned follow-up</td>
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<td>8.</td>
<td>Communicate clearly and thoroughly: ensure the patient, family members, bedside nursing/support staff, and rapid-response team members have clear understanding of management and follow-up plans; understand institutional culture regarding whether other team members should be notified (e.g. supervising physician, ICU physician, etc.)</td>
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<td>9.</td>
<td>Use team members’ expertise: if there is confusion or disagreement about disposition, seek additional input from members of the rapid-response team, bedside nurse, unit charge nurse, nursing supervisor, ward supervising physician, or ICU physician</td>
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- Reading and contributing to resources curated on SGIM’s Advocacy Web site, including a core set of books, key papers, online sources on policy basics, and news feeds on health policy;

At the national meeting in Denver in April 2018, a new cohort of LEAHP scholars will be welcomed. And we will celebrate the accomplishments of the first graduating cohort of LEAHP scholars. The call for applications for the 2018-19 LEAHP cohort will be sent out in August and applications will be accepted until November 16th. For more information, please go to SGIM’s Health Policy Web page: http://www.sgim.org/communities/advocacy/leadership-in-health-policy.

Passions for learning and for making a difference are the essential attributes for LEAHP scholars, but no prior health policy expertise is required. We encourage prospective LEAHP applicants to sign up for one of our Health Policy Committee Subcommittees (clinical practice, education, research) which can help improve the likelihood of acceptance to the program. To sign up for a subcommittee or for more information about committee participation, please contact Ms. Francine Jetton at jettonf@sgim.org. Accepted applicants will be notified in January.

In this year in which SGIM has announced a fund-raising campaign devoted to advocacy, the LEAHP program aims to prepare a diverse set of health policy scholars and advocates that can represent our patients and SGIM’s missions. We look forward to seeing your application for the 2018 LEAHP program!

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National Institute on Drug Abuse (NIDA) - Mentored Training Award in Substance Use Disorder Treatment Science Dissemination: Presented to Tiffany Y. Lu, MD, (Montefiore-Einstein). Supported by the National Institute on Drug Abuse (NIDA) from the National Institutes of Health (NIH) and sponsored by the Society of General Internal Medicine (SGIM).

Clinician-Educator Awards

National Award for Career Achievements in Medical Education: Presented to Daniel R. Wolpaw, MD, (Penn State College of Medicine), for a lifetime of contributions to medical education.

Frederick L. Brancati Mentorship & Leadership Award: Presented to Margaret C. Lo, MD, (University of Florida). The Brancati Award honors an individual at the junior faculty level who inspires and mentors trainees to pursue general internal medicine and lead the transformation of health care through innovations in research, education, and practice.

National Award for Scholarship in Medical Education: Presented to Abby L. Spencer, MD, MS, (Cleveland Clinic), for her individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

Mid-Career Mentorship in Education Award: Presented to Alda Maria R. Gonzaga, MD, MS, (University of Pittsburgh School of Medicine). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician educators.

Presentation Awards

Mack Lipkin Sr. Associate Member Awards are presented to the scientific presentations considered most outstanding by students, residents and fellows during the 2017 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2017 are as follows:

- Anna Goldman, MD, (Cambridge Health Alliance), “Early Impacts of the ACA on Out-of-Pocket and Insurance Premium Spending”
- David Levine, MD, MA, (Brigham and Women’s Hospital and Harvard Medical School), “Hospital-Level Care at Home for Acutely Ill Adults: A Pilot Randomized Controlled Trial”
- Adam Markovitz, BS, MD/PhD Candidate, (University of Michigan), “Incremental Effects of Antihypertensive Drugs: An Instrumental Variable Analysis of the SPRINT Trial”

Milton W. Hamolsky Junior Faculty Awards are presented to the scientific presentations considered most outstanding by junior faculty during the 2017 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2017 are as follows:

- Melissa Wei, MD, (University of Michigan), “Multimorbidity and Physical and Cognitive Function in Nationally-Representative US Adults: Performance of a New Multimorbidity-Weighted Index”
- Renuka Tipirneni, MD, (University of Michigan, Michigan Medicine), “The Impact of Michigan’s Medicaid Expansion on Low-

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Income Enrollees’ Functional Status, Ability to Work, and Employment: A Mixed Methods Study

SGIM Clinical Vignette Oral Presentation Award recognizes the best presented clinical case by a medical students, internal medicine residents or GIM fellows (not faculty) at the SGIM National Meeting. This year’s recipient is Kaylan Christopher, MD, (New York Presbyterian–Columbia), “Don’t Always Follow Your Heart: A Caveat to Troponin-T.”

Outstanding Quality & Patient Safety Oral Presentation Award recognizes the most outstanding oral abstract presentation related to quality assessment, gaps in quality of care, medical errors, quality improvement or patient safety in the inpatient or outpatient setting at the SGIM National meeting. This year’s awardee is John Mafi, MD, MPH, (David Geffen School of Medicine, UCLA Department of Medicine), for the abstract entitled “Evaluation of Choosing Wisely Intervention to Reduce Low Value Preoperative Care for Patients Undergoing Cataract Surgery at a Safety Net Health System.”

Women’s Health Oral Abstracts Award: Carolyn Gibson, PhD, MPH, (San Francisco VA Medical Center), for “Interpersonal Violence, Post-Traumatic Stress Disorder, and Age-Related Genitourinary Dysfunction in Women.”

Best Geriatrics Research Poster Presentation: Maria Patanwala, BA, (University of California, San Francisco), for “Prevalence, Severity, and Factors Associated with Multi-dimensional Symptoms in Older Homeless Adults: Results from the HOPE HOME Study.”

Best Geriatrics Research Oral Abstract: Timothy Anderson, MD, (University of California, San Francisco), for “Changes to Outpatient Hypertension and Diabetes Medications in Older Adults Following Unrelated Hospitalizations.”

Best Cancer Research Oral Presentation Award: Leland Hull, MD, (Boston VAMC), for “Screening Rates for Genetic Counseling Referral are LOW Among a National Sample of Women at Risk for a BRCA Mutation.”

Best Cancer Research Poster Presentation Award: Arjun Theertham, MD, (Creighton University) for “Incidence of Colorectal Carcinoma Following Lung or Heart Transplant—A Descriptive Study Using the UNOS Database.”

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“Every time I give a lecture or a motivational talk on the topic of burnout, I begin with the caveat that I hate talking about burnout; I want to talk about the good things. So, I was pleased that the organizers of SGIM 2017 chose to emphasize “Resilience & Grit,” as opposed to their absence. As clinician educator, I’m constantly searching for new ways to access the deep wells of meaning that lie beneath our work, and I found the many workshops and presentations on narrative medicine particularly inspiring. I also found it fitting that we gathered in our nation’s capital at a time when our patients and our healthcare system require our advocacy and activism more than ever. Leaving SGIM feeling energized and recommitted to our work is nothing new, but there’s nothing like a march on Washington to punctuate the experience.”

—Gaetan Sgro

As is the tradition, the August issue of SGIM’s Forum is dedicated to our Annual Meeting where readers will see engaging photographs, read incisive recap essays, and congratulate again the award winners. In addition, we recap the 40th annual event celebrating Generalism, the LEAHP program, and a piece on residency competencies around rapid response teams.
Summary of the Event
The SGIM 40th Anniversary Symposium, on the last day of the National Meeting in April 2017, actively engaged senior and junior members to “look back” and “look forward” about SGIM’s past and future in an evolving health care system. The symposium had two components: First, four past presidents from each of four decades since SGIM’s founding offered brief reflections about the key issues confronted by SGIM at the time and ways in which it advanced academic general medicine. Second, SGIM leaders directed discussions by attendees at each table about future directions for SGIM in response to one of three questions:

1) How can SGIM continue to grow as a leading organization in academic general internal medicine? Attendees at 25 tables discussed this question about SGIM’s role as a leading organization and the following four key themes emerged:
   1) Trainees are critical for growth (25 tables).
      “Students, residents, and fellows are our future. We must find a way to get them to our meetings, and get them excited about general internal medicine. If the spark is lit early, it often stays lit.”
   2) SGIM needs to continue advocating for patients through its health policy work at the regional and national level (24 tables).
      “Lobbying for our values, for social justice—this is key. Especially now.”
   Several related comments urged SGIM to invite patients to meetings as some other organizations have done.
      “Patients have the opportunity to attend other medical conferences and meet with researchers and physicians. Perhaps SGIM could consider this.”
   3) SGIM should further increase its efforts to integrate hospitalists (15 tables).
      “SGIM members are general internists. That means we are primary care doctors and hospitalists. We need to include hospitalists more, particularly as transitions of care work and QI aligns us more than ever.”
   4) SGIM should partner with other generalist societies to increase our voice in health care reform (16 tables).
      “We need to align forces with STFM, Pediatric societies, AAFP, ACOG.”

2) What are ways for SGIM to expand its role at the forefront of research on health care delivery and primary care practice redesign? Groups at only six tables responded to the second question about primary care practice redesign and all endorsed SGIM’s health policy advocacy as the most effective way to operationalize our role in primary care practice redesign. Four groups suggested collaborating with other like-minded societies and organizations on this effort.
      “SGIM should team up with family medicine and pediatrics to see how they are doing this. Why re-invent the wheel?”
   In addition to policy efforts, five groups recommended that SGIM should promote research by directly addressing practice transformation. Suggestions included using the annual meeting, publications, and webinars to showcase health services research related to health systems and primary care practice redesign in which our members are engaging.
      “SGIM’s annual meeting, the Forum and JGIM would be great outlets to showcase current efforts and work of leaders in these areas.”

3) In what ways can SGIM encourage trainees to pursue GIM?
For each table of attendees, a designated scribe took notes about the discussion and submitted them to the session leaders. Notes were analyzed using ATLAS.ti qualitative software.

Results
Fifty-two SGIM leaders served as table leaders for this event that had 533 attendees. Of 46 table groups, 43 (93 percent) submitted notes regarding discussions about at least one question, with 40 percent answering more than one question. The following section describes themes that emerged from the discussion about each of the questions with illustrative quotes.

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1) Trainees are critical for growth (25 tables).
   “Students, residents, and fellows are our future. We must find a way to get them to our meetings, and get them excited about general internal medicine. If the spark is lit early, it often stays lit.”

2) SGIM needs to continue advocating for patients through its health policy work at the regional and national level (24 tables).
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Several related comments urged SGIM to invite patients to meetings as some other organizations have done.
   “Patients have the opportunity to attend other medical conferences and meet with researchers and physicians. Perhaps SGIM could consider this.”

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Question 2. What are ways for SGIM to expand its role at the forefront of research on health care delivery and primary care practice redesign?
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“Special symposium on these topics—at annual meetings or at webinars”

**Question 3. How can SGIM continue to encourage medical students and residents to pursue general internal medicine as a career specialty?**

Groups at 30 tables discussed promoting GIM as a career. Related to the theme of engaging trainees from the discussion about the first question, many endorsed attendance by trainees at regional and annual meetings to stimulate enthusiasm about GIM as career. Another strategy was offering more trainee scholarships and travel stipends, suggested by groups at 25 tables.

“We must encourage students and residents to attend. SGIM ought to offer more scholarships and travel stipends.”

Fostering and growing the GIM pipeline was a theme from discussions at 25 tables. Specific ways to accomplish this included: payment reform, decreasing burnout, increasing mentoring at the institutional level as well as at regional and annual SGIM meetings; involving trainees in GIM and health services research; expanding the “Proud to Be GIM” campaign; and offering leadership opportunities for trainees within SGIM.

“The pipeline is the key to our success. In order to inspire the next generation, SGIM must continue to do what it does best—mentor!”

**Next Steps**

The newly identified member-driven themes were the subject of lengthy discussion by the SGIM Council during its June 2017 retreat. Council identified initiatives that are already underway related to themes from the Anniversary Symposium, such as:

- SGIM’s new year-long Leadership in Health Policy (LEAHP) course, that teaches SGIM members to become effective and active health policy advocates, local health policy experts, leaders, and teachers.
- The Primary Care Collaboration (PCC), a newly formed consortium of GIM, family medicine, and pediatric societies which is working to advance policies that support generalists.
- The Hospital Medicine Task Force, which works to better engage and incorporate hospitalists within SGIM.
- The #ProudtoBeGIM Campaign, that aims to cultivate the next generation of general interests.
- The Young GIM Scholars program, which offers scholarships for medical students and residents to attend the annual SGIM annual meeting.

Thus, in addition to improving how ongoing activities are communicated to SGIM members at large, the themes from the Symposium provided an impetus to advance additional initiatives. Specifically, Council committed to further developing initiatives that align with SGIM’s six strategic priorities: 1) Improving the work environment, 2) fair reimbursement for primary care providers, 3) increasing the value of SGIM for members, 4) increasing career development opportunities, 5) leadership in cutting-edge issues, and 6) growing SGIM membership at a healthy rate.

Although the data presented herein reflects suggestions from only a subset of SGIM’s members, the themes are likely to resonate within a broad membership. This conversation needs to be continued into the next year as we celebrate our previous successes as a thriving organization but also consider ways to increase its role in advancing the role of GIM in education, research, clinical care, and national health policy. Additionally, upcoming annual meetings might consider adopting this event’s format to solicit the perspectives of members about SGIM’s future.

* Leaders were defined as past presidents, current and former council members, current and former regional leaders, chiefs of GIM divisions, and current and former committee and/or task force members. In addition, we sought to achieve a geographically representative sample.