CONTENTS

PERSPECTIVE

The Impact of Technology Policy on Health Disparities

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From patient portals to mobile health apps, patients interface with digital platforms to manage their health. Technology policy establishes the groundwork for equitable access and privacy. Recent changes to broadband privacy rules, rollbacks to the Lifeline program, and proposed changes to "net neutrality" rules will halt the progress made in achieving digital equity. Such support structures are paramount for all patients, especially for vulnerable populations who struggle with access to technology and trust in institutional structures. Without free access and ensured privacy, health technologies will fail to reach these populations. Consequently, the purported benefits of digital health may paradoxically exacerbate health disparities. Internet access, privacy, and neutrality are key policies that significantly influence patients' ability to equitably access online health tools.

Internet Access

The first step in achieving digital equity is ensuring Internet access. The digital divide has long been a barrier to developing digital health tools. In 2000, only about half of adults in the United States had access to the Internet. By 2016, 88% of adults had Internet access.[1] Despite these improvements, low-income, low-literacy, and rural populations continue to lag in their Internet use. Given their higher risk for poor health outcomes, these populations would benefit from digital health solutions. For example, some of these solutions include chronic disease self-management, online disease specific communities, and access to health services and information.

Aiming to expand technology access, the Lifeline program was established under President Reagan to provide subsidized phone service to low-income populations. Prior to the current administration, the Federal Communications Commission (FCC) had planned to extend the program to include subsidies for broadband access. However, Ajit Pai, the new head of FCC, limited these efforts by removing several Internet providers from the program. He cited legal limitations and fraud as reasons behind

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"You Like Me. You Really Like Me!"*

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(*Sally Field, upon receiving the 1984 Academy Award for Best Actress in *Places in the Heart*)

There are no Academy Awards for newsletters. At least, not that we know of. Yet, it's important for a vehicle such as *Forum*, which plays such an important role in our professional community, to be accountable to our audience and determine if we are doing our jobs. It isn't enough that we are liked. Are we relevant? Do we represent everyone in our community? Frankly, are we worth the time and effort to read?

Evaluation and feedback are keys to success and maintaining relevance. Among the diverse membership of SGIM, clinicians examine patients and follow-up on the results of laboratory tests and imaging, researchers study the efficacy and effectiveness of interventions and advance knowledge, and medical educators assess and evaluate their students' and trainees' progress and readiness to act independently. So it is true for *Forum*. A few months ago we asked you to fill out a readership survey to help us improve *Forum* as a source of news and scientific information for members. Our goal was to understand if we are hitting the mark on several variables important to our ability to communicate such as:

- How do readers interact with the newsletter either in print or online?
- What types of articles are readers most interested in reading?
- How does the newsletter rate in terms of design elements like article layout color length, etc?

In addition, members provided us some suggestions for improvement that we will use in our upcoming *Forum* "refresh" over the next several months. Overall, the survey confirmed that *Forum* is a widely read and well-regarded offering of SGIM (hence the Sally Filed quote). That being said, there is still plenty of room for improvement.

The *Forum* survey received a total of 164 responses (49% Clinicians, 46% Educators, 19% Researchers and 13% Administrators—survey total was more than 100% because of multiple roles). Ninety four percent of respondents read the *Forum* with 70% reading most to all of it. Seventy eight percent preferred to read it in print as opposed to the online version with 11% utilizing both platforms. Interestingly, if there were additional content on line and not in print, only 39% answered that they would visit the Web site to access it. The vast majority of the readership was interested or very interested in the different *Forum* content categories and rated the quality of that content mostly in the good to excellent range.

When asked to suggest new topics and other suggestions, respondents conveyed the desire for more content in a particular area previously

Debunking the Patient-Centered Myth

Thomas H. Gallagher, MD, President, SGIM

> Debunking the myth of patient centeredness, and rethinking how we can involve patients in the design of our clinical care, education, and research missions, as well as in our Society, is an important new frontier for us individually and for our organization.

It's easy to convince yourself of things that turn out to be completely false. My daughter, a senior in college, is interested in pursuing a career in medicine. This summer, she was preparing for the MCATs. I announced to my spouse with great confidence that the medical school application process was entirely my daughter's undertaking, and that I was not going to get worked up about things one way or the other. I was quite proud of my ability to remain supportive, but neutral, while lesser mortals would certainly be helping their child develop a study schedule and quizzing them. I drove her to the testing center, still persuaded that I had accomplished the admirable feat of not personalizing my child's aspirations. The night before the test results were due to be released was a different matter. Neither my wife nor I slept a wink. Every time my phone buzzed I wondered if it was a text from my daughter. When the word finally came that she was pleased with the results, I felt incredible relief. Clearly, I was much more invested in how the test went than I had believed.

As a profession, we have convinced ourselves to a similar degree of certainty that we are extremely patient centered. And, in reality, this assertion involves the same self-deception as did my attitudes about my daughter's MCAT results. Patient centeredness should be a bedrock principle on which the profession rests. Indeed, the entire concept of a fiduciary relationship between physicians and patients has at its core the importance of physicians orienting themselves completely to advancing the best interests of patients. Yet, one does not need to look far for examples of how our care systems are designed with the interests of others over those of the patients'. Don Berwick aptly noted that every system is perfectly designed to get exactly the results it achieves. If health care were truly patient centered, it would be just as easy to get a lower-extremity Doppler on Sunday as it is on Monday.

It shouldn't be all that surprising that the profession is far less patient centered than it aspires to be. For centuries, medicine was highly paternalistic. We professed a desire to act in the patient's best interest, but those interests were defined by what the physician thought would be best for the patient. The patient's job was to agree with what the doctor recommended. The profession has only recently embraced the notion that patients are the most appropriate judge of what is in their best interests. Debunking the myth of patient centeredness, and rethinking how we can involve patients in the design of our clinical care, education, and research missions, as well as in our Society, is an important new frontier for us individually and for our organization.

Our inability to match our patient-centered rhetoric with action became abundantly clear to me through our work on patients' experiences of problems in their care. All healthcare organizations have mechanisms by which patients can complain about their care, programs that generate no shortage of responses from patients. These organizations also regularly survey patients to understand their

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Feedback Paradigm Shift: Encouraging Learners to Seek the Feedback They Need

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Despite extensive efforts in recent years to optimize feedback in medical education, current feedback techniques and outcomes remain suboptimal.[1] Trainees continue to feel dissatisfied with the frequency and quality of feedback they receive.[1] Surveys of trainees and educators show a discrepancy between learners' perception of feedback received and educators' belief about the feedback delivered.[2] Barriers that prevent teachers from understanding their learners' educational needs, goals and interests include: time constraints, workload of determining and providing meaningful feedback and lack of learner engagement.[2] We believe that the latter two barriers are reinforced by the current teacher-centered way of delivering feedback. Rethinking our conceptual feedback model in medical education may alleviate these barriers and result in the development of key lifelong learning skills and improved learner-teacher relationships. We recommend a complete paradigm shift: explicitly placing learners in the center of their own education and development and requiring them to actively seek high-yield, even critical feedback.

Learners are more likely to improve their skills if they seek feedback based on self-identified learning goals rather than passively awaiting feedback from supervisors.[3] This concept of learner-driven feedback is well developed in business, organizational, and education fields, but only recently gaining traction in medical education.[3-5] Psychologist Carol Dweck describes the important role that a learner's mindset and goals play in feedback seeking and ultimately performance improvement.[5] She defines a "fixed mindset" as the belief that ability and intelligence are innate, unalterable traits. A fixed mindset coincides with a performance based goal-orientation (i.e., "look smart" rather than "learn"). Fixed-mindset learners tend to be afraid of revealing deficits and therefore avoid challenges and critical feedback. A "growth mindset," on the other hand, is the belief that one can gain ability and intelligence through hard work and feedback. This mindset fosters goal-orientations around learning and improvement.[4]

Traditional feedback, anchored in behavior modification and correction of deficiencies, emphasizes achievement over process and often reverts to a one-directional knowledge transmission from the "expert" to the "trainee". We believe that this model actually strengthens a fixed mindset and, along with the inherently hierarchical and achievement-based nature of medical training, can lead to avoidance of critical feedback. By implementing tools to normalize a culture of abundant feedback and create a psychologically safe environment where the learner is able to identify learning goals, we can help transform learner mindsets from fixed to growth and overcome the shortcomings of traditional feedback.[2-4] Additionally, by supporting the learner's developmental process as well as the *outcome*, we place value on improvement and encourage a growth mindset. We have an opportunity as educators to purposefully foster a growth mindset in our learners and motivate them to take on the responsibility for seeking and using high value feedback.

To achieve this, a complete paradigm shift is needed: imagine the learner proactively deciding when, why, how often, how much, and topic of feedback they receive. This does not mean that the educator abdicates their responsibility for helping to foster a successful physician. The educator must still give appropriate and sometimes unsolicited feedback, particularly when the learner has poor insight into her or his goals. Most importantly, the educator must provide an accurate professional context in which the learner can anchor her or his goals—what should the learner aspire to be? What knowledge, skills, values, and attitudes are needed to be an excellent physician?

Educators can encourage a growth mindset and shift the responsibility for feedback to the learner by following these suggestions in their day-to-day interactions with learners:

1. Have clear expectations and high standards. Learners know the most about themselves and what they need to succeed, but they need external signposts to guide their learning and to calibrate their own competency.[5] Be specific about each standard and where the standard was not met.
2. Create a welcoming environment for your learners to feel safe to make mistakes and be vulnerable. Be supportive and approachable. Get to know the learner at a personal level.[5]
3. Explicitly state the expectation for learners to identify learning goals and ask for feedback. Tell them, "On this rotation, you are responsible for identifying areas you wish to improve on and for getting the feedback you need."
4. Encourage learners to get

General Internists Contribute Health IT Transformation at 2018 Annual Meeting

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The 2018 SGIM Annual Meeting will encompass the breadth of General Internal Medicine, including health services research, medical education, advocacy, and exemplary clinical care. The theme for this year's meeting is "Health Information Technology," an area that has become integral to every aspect of health care. In particular, mobile technology and electronic health records are changing the way we deliver education, conduct research, and care for patients. We believe that the meeting will be an opportunity for the GIM community to discuss how digital innovations can enhance—and sometimes detract from—our work, whether in the hospital, the clinic, the classroom, or the laboratory.

> **Important Dates for the Annual Meeting**
> *Final Submission Deadline*
> January 4, 2018
> *Early Registration Deadline*
> February 15, 2018
> *Standard Registration Deadline*
> March 8, 2018
> *SGIM 2018 in Denver, CO*
> April 11-14, 2018

In support of the meeting's theme, we are including two new components in this year's meeting:

1. A pre-course on Health IT for the general internist that will provide a background in informatics-related content that is relevant to GIM, as discussed in the *Forum* article in June 2017: (http://www.sgim.org/File%20Library/SGIM/Resource%20Library/Forum/2017/SGIMJune2017_03.pdf) by Tom Gallagher and Tom Payne, the chair of the Board of Directors of the American Medical Informatics Association. We are thrilled that David Dorr and William Hersh have agreed to lead the course; Dave and Bill are two active members of the GIM community who are also national leaders in informatics-related research and education.
2. "Hands-on Tech"—a theme-related innovation that will be an opportunity for members to showcase technology innovations. Presenters for abstracts related to Innovations in Medical Education and Innovations in Clinical Practice will have the opportunity to exhibit and demonstrate a piece of technology, such as an app, mobile health, or clinical decision support tool. The technology can be newly developed or an innovative use of existing technology. Presenters for this session must be SGIM members.

We are happy to announce that the Malcolm Peterson Lecture will be delivered by Eric Horvitz, managing director of Microsoft Research in Artificial Intelligence, who is a proponent of data science to improve public health. He has kindly offered to attend several hours of meeting after his lecture, during which time he will provide mentorship to SGIM members in several formats.

In addition to these and other Health IT-related components, the meeting will cover the scope of the field of GIM. Given current policy proposals to alter our healthcare system and how we deliver health care, we are confident that the meeting will be an opportunity for our community to discuss advocacy and social justice for our patients. As with all SGIM annual meetings, the vast majority of the meeting content is submitted in advance and peer-reviewed by members. And so, we request that you submit your best science, clinical and education innovations, and clinical vignettes by the due date for abstracts on January 4, 2018.

We look forward to seeing all of you in Denver!

SGIM

MEDICAL EDUCATION
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specific about goals. Prompt them, "The more specific the question is, the more valuable the feedback will be. For example, instead of saying 'Can you give me feedback on efficiency today?' A better question might be, 'Can you pay close attention to the first 5 minutes of my encounter? I haven't come up with an effective way to agenda set with this patient.'"

5. Differentiate formative feedback from evaluation: Make it clear that frequent critiques do not represent an evaluation of their performance but are meant to help coach them as they develop into a future physician.
6. Model feedback seeking: we can normalize feedback by publicly inviting observation and feedback from colleagues. Reflecting out loud when things haven't gone perfectly also helps normalize a

Itching for Pain Relief: NSAID-Induced Urticaria

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The patient is a 70-year-old female with a history of osteoarthritis who presented to her primary care clinic with a rash and swelling of her tongue and throat. The rash was episodic and intermittent, with the first episode occurring six months prior. The current episode of rash started 2 weeks prior to this presentation and had progressed steadily to cover her trunk, arms, and legs. The patient reported no new medications, foods, or changes in her daily routine during this time. On the night prior to presentation, the patient had experienced moderate swelling of her tongue and throat and decided to seek care. When seen in the clinic, she reported no difficulty breathing. On exam, there was no obvious edema of the throat; skin exam revealed raised hives and excoriations on her upper back, lower abdomen, and bilateral arms and legs. Initially, no clear etiology for her symptoms was evident. Further history revealed that the patient had been managing her osteoarthritis with acupuncture until 8 months prior, when she had been prescribed naproxen and ibuprofen, which she had taken as needed for her osteoarthritis pain. She had taken a dose of naproxen 2 hours before experiencing the throat swelling the night prior. The patient was advised to take diphenhydramine for throat swelling and to stop both naproxen and ibuprofen. The patient had subsequent improvement in her symptoms.

Non-steroidal anti-inflammatory drugs (NSAIDs) are widely prescribed in primary care settings for pain and in the Unites States, around 12% of adults report regularly using them. NSAIDs are also known to have many side effects and some of the more common adverse effects, such as GI ulceration and hemorrhage, are widely recognized. Others, such as NSAID-related cutaneous reactions, occur in <1% of patients and have the potential to be missed. In patients with known chronic urticaria or asthma, NSAIDs can trigger and exacerbate symptoms. However, even in patients who are otherwise healthy, such as in this patient, NSAIDs can induce a hypersensitivity reaction that can include urticaria, angioedema, or both.

NSAID-induced urticaria in otherwise healthy patients is thought to be related largely to COX-1 inhibition, although in some cases patients may have IgE mediated hypersensitivity to specific drugs. Diagnosis is generally made through history which reveals onset of rash or angioedema within hours of taking NSAIDs. In many cases, especially in patients on chronic NSAID therapy, temporal association between NSAID use and symptoms may not be evident and requires a high degree of suspicion. In some patients, reactions are limited to a particular drug with quicker symptom-onset and can include anaphylaxis, reflecting underlying IgE involvement. Physical exam can reveal diffuse urticarial wheels as well as perioral/pharyngeal edema. Primary therapy is to reassure patients and to simply avoid further NSAID use. In patients with a suspected diagnosis, alleviation of symptoms with empiric cessation of NSAID use is highly suggestive. Symptoms can also be managed with diphenhydramine. Many patients will do well without recurrence of symptoms if NSAIDs are avoided. However, in patients with single-drug reactions, severe reactions, or in patients who require long-term NSAID use, an allergy consultation can be helpful for potential desensitization or for confirmation of cross-reactivity.

NSAID-induced urticaria and angioedema is a rare side effect of NSAID use, but is one that will certainly be seen in primary care settings. While symptoms can be alarming, treatment is straightforward and symptoms resolve quickly with discontinuing NSAID use. While diagnosis may not be obvious, a high degree of suspicion in patients taking NSAIDs can aid in quick recognition and appropriate treatment and referral.

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Coping with Bias and Discrimination from Patients: A Primer for Physicians and Administrators

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Note: Dr. Redmond contributed to this article as the chairperson for the SGIM Disparities Task Force. The views expressed are her own and do not necessarily represent the views of the National Institutes of Health, Department of Health and Human Services, or the United States Government.

Though acts of violence and discrimination against physicians have been prevalent for quite some time, social and electronic media have given Drs. Tamika Cross, Suzanne Barakat, and many other physicians a venue to share their experiences, leading to increased awareness and debate on this issue. In a survey of 214 mother-daughter physicians, both mothers and daughters reported similarly high rates and severity of sexual harassment prior to medical school, during their training years, and in work settings by both teachers and supervisors[1]. There is also a high prevalence of workplace harassment and discrimination among physicians belonging to racial and ethnic minorities and the LGBTQ community, leading to poor career satisfaction and increased job turnover. This article is the first in a series highlighting types of harassment, discrimination and aggression towards physicians—particularly among racial, ethnic, gender and sexual minorities—and dissemination of best practices to foster physician resilience. For this article, we focus on physician-patient interactions.

Situation

A medically unstable patient refuses to be cared for by a black physician in the Emergency Department (ED), and yells racial slurs at the physician.

a. How should the victim (physician) respond to the patient?

b. How should other healthcare providers involved in the care of this patient (bystanders) respond?
c. How should the hospital administration respond?

Victim's Response

Physicians are generally in a position to alleviate suffering and save lives, and are expected to do so without prioritizing their political and religious beliefs or those of the individuals they serve. However, political unrest and resultant discrimination and violence across the nation (and the globe) are without boundaries and, therefore, may exist in healthcare settings. Despite feeling hurt and humiliated when hearing racial slurs directed at him by this patient, the black physician in this scenario is not sure he can grant the patient's request to walk out of the room. We have summarized below an algorithm of action for the front line physician (victim), derived from Paul-Emile, et al, on "Dealing with Racist Patients"[2]:

1. Assess for any emergent medical need
2. Determine decisional capacity
   a. If the patient lacks capacity, negotiate to provide care until medically stable.
   b. If patient has capacity, try to determine the reason behind refusal of care. If legitimate reasons (problems with language, religious preference in requesting provider with same gender etc.), try to accommodate the request.
   c. If the patient has capacity and refuses care by a provider based on bigotry, the physician can explain to the patient how dealing with this issue may delay life-saving care and may affect clinical outcomes. Also the physician can discuss options with the patient, including transfer of care to another provider permanently (after medical emergency resolved), transfer of care to another provider at the moment (if available), transfer to another facility when medically stable, meeting with on-call hospital administrator etc.
3. In scenario # 2c, the physician should also place limits, informing the patient that he/she cannot use derogatory language in the hospital.
4. In scenario # 2c, the physician should report the case to the on-call hospital administrator.

Bystander's Response

Bystanders in this situation include healthcare providers present in the ED, who may or may not be involved in the care of this patient, staff and other patients present who witness

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Guppies

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Mr. T was back in the hospital for the 11th time that year. From the doorway we could see the pulsations in the superficial veins of his forehead portending a left ventricular ejection fraction of less than 10 percent. Attempts to manage his heart failure with more aggressive medication regimens, daily home nursing care, and weekly cardiology appointments had failed. Frothy pink fluid had again filled his lungs and so he was back once more, delivered by ambulance. After a tortured night in the emergency department he had found his way to a bed upstairs. I sighed when I saw his name on my list.

His chart was peppered with terms like *non-compliant* and *lacks insight,* which had become more frequently used to describe him of late because Mr. T was refusing to go to a nursing home. This, we asserted, was the only way to keep him from coming back a 12th and 13th time, or dying. Yet, he steadfastly refused to go anywhere but back home alone, growing angrier each time we brought it up. "I've got important business to attend to." he grumbled. Such conversations typically ended with Mr. T signing the pink form accepting the risks of leaving the hospital against our good medical advice.

On this admission, the newly minted intern and the harried resident performed a detailed history, asking Mr. T a careful combination of open-ended and directed questions for clues into the etiology of his decompensation. Too much salt, too much soda, too much crack, not enough medication, they concluded. They didn't ask about the guppies. They biopsied his chart, noting every unfortunate detail of each of his hospitalizations, which evidence-based medications had been trialed and had

failed, and the results of every echocardiogram and stress test. They performed a physical examination, noting the soft gallop which sounded like a bag of dirty laundry thrown softly on the ground, the wet rales filling all lungs fields, and the degree of pitting when one pressed firmly on the soft tissues of his lower extremities. They didn't even notice the guppies.

Mr. T made little eye contact as we politely encircled his bed. He made no secret that he hated the hospital and everyone in it, with the exception of Lorraine who brought his food trays. With his skin stretched so thin over his skeletal frame, he looked much older than his stated age of forty-seven. In fact, he looked significantly worse than when I had cared for him only a few weeks before. My own heart sank as he glared at us. Yet, we made a plan, titrated medications, and arranged for a family meeting to talk some sense into Mr. T. At his request, we invited his mother. We never thought about the guppies.

The following morning we again arrived at Mr. T's bedside. His mother sat at the foot of his bed with a calm-before-the-storm look of someone who has seen it all before. In fact, she had already lost one of her two adult children and was now facing the death of the other. She greeted us simply with a nod. Then, she did something which none of us had thought to do, or had the time or energy or perhaps courage to do. It was something so human that it shocked us as we sat there in our coffee stained white coats. "Son, how are Earl and Tiny?" she asked. Suddenly, Mr. T sat up a little in bed and a faint, far-away light flickered behind his dark eyes. "Oh man, do I miss my boys!" he said. Sensing this

shift and drawing on his mother's courage, we too finally asked Mr. T about his guppies.

Several years ago, I attended a keynote address by Vivek Murthy, my fellow hospitalist and former Surgeon General of the United States. He asserted that as physicians "we must understand and somehow connect patients' source of joy with healthy behaviors in order to motivate them." I never fully understood the significance of his words until that day with Mr. T. Now, I know he was talking about the guppies. You see, while Mr. T's New York Heart Association Stage IV heart was failing, Earl and Tiny were thriving. In fact, thanks to Mr. T who fed them each day even when he went hungry, and kept their tank immaculately clean, they had far exceeded their life expectancy. He had even arranged for a friend to care for them during his hospitalizations. While we were busy admonishing him for his failures—non-adherence, dietary indiscretions, positive urine drug screen, and lack of insight—we failed to recognize the single thread of joy which kept him clinging precariously to life.

Mr. T never came back to the hospital. He was discharged to a skilled nursing facility with hospice care, and more importantly, his guppies. Years later, I recognized his mother in a restaurant. I was not surprised to learn that Mr. T had far exceeded his life expectancy. As for me, I continue to search for guppies on the wards of my safety-net hospital and find them in the most unexpected places. Sometimes I discover entire vibrant oceans teeming with life, other times just one tiny guppy which keeps me precariously attached to my profession.

SGIM

SGIM Finances 101

DC Dugdale, MD, and Leslie Dunne, MPA

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Introduction

Have you ever wondered how the Society of General Internal Medicine (SGIM) manages its finances? How does our membership-based organization raise money and allocate funds? How do we stay afloat to serve our members and mission? Our aim is to promote transparency around SGIM's finances and to invite your participation in the process (comments, engagement, questions). Ultimately, the goal of SGIM's financial management activities is to maximize the resources available to SGIM to carry out its mission, as was discussed by Tom Gallagher in his President's Column in the July, 2017 issue of the SGIM Forum (http://www. sgim.org/File%20Library/SGIM/Resource%20Library/Forum/2017/SGIM July2017_03.pdf).

Financial Management Structure

The Society's financial management structure consists of the treasurer who oversees the development and maintenance of budgets, financial plans, and accounts. The treasurer is elected to a three-year term, spending one year of it as "treasurer-elect," and is a member of and is accountable to the SGIM Council.

The director of development and project management oversees the day-to-day financial operations. She manages the budget reports and accounts, serves as a liaison to our outside fund manager and auditor, and supports the finance committee—the committee meets monthly to support the processes of budget development and oversight, investment account oversight, and financial policy development. Committee members include the treasurer, treasurer-elect, and three SGIM member-volunteers. The committee

makes recommendations to the SGIM Council which has the final decision making authority regarding financial policy and finances of the Society. Examples of financial policies include SGIM's financial reserves policy and investment policy. Finally, the Society uses outside consultants who provide focused expertise to support the work of the above. These include Laura Barwick, CPA who conducts the annual SGIM audit, and Adam Warshavsky (Morgan Stanley Wealth Management) who helps manage SGIM's investments.

Financial Management Policies and Scope

SGIM's budget is managed to attain and maintain six months of budgeted expenses in unrestricted reserve accounts. To accomplish this, 25% of surplus funds are placed in unrestricted reserves at the end of each fiscal year. SGIM's funds are invested in several accounts with a balanced mix of asset classes to create income while protecting capital. The scope of budget oversight includes SGIM, JGIM, and regional SGIM budgets.

SGIM Budget

SGIM's fiscal year runs July 1 to June 30. The finance committee begins developing the next fiscal year budget in January of the current fiscal year. All known expenses and revenues are included. A longer term projection extending up to three fiscal years is also performed. SGIM's goal is to always run a small surplus. The finance committee uses the budgeting process to evaluate alternative strategies and approaches to assure that this occurs, including setting membership dues, annual meeting fees, and exploring and modeling other potential sources of revenue. A draft budget is presented to Council in March, and approved at its April meeting. The fiscal year closes on June 30, and the audit is completed by the fall after the fiscal year closes.

Revenues: The top 4 categories of budgeted revenues are shown in Figure 1. For fiscal year 2018, the budgeted revenue is $3,137,837.
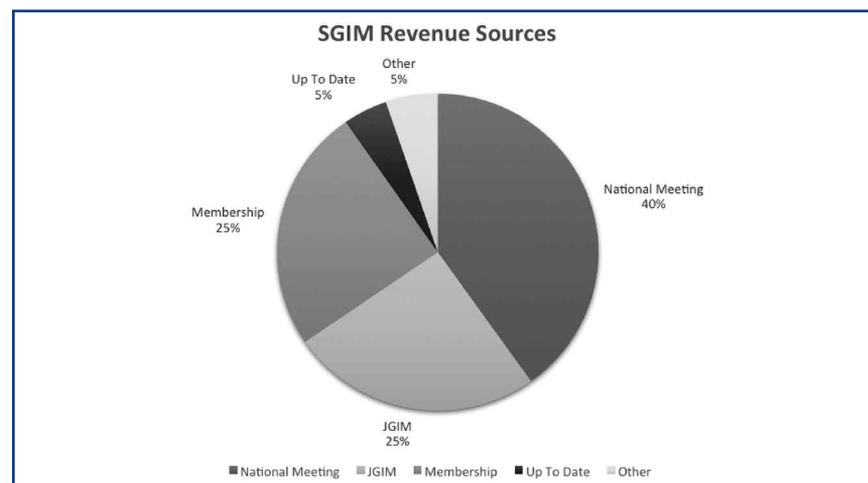
this change. Nevertheless, Pai has stated that narrowing the digital divide is one of his priorities. He has presented policy proposals to extend broadband and mobile Internet access, but these have yet to be realized. Without policy focused on addressing existing divides, inequities will persist and health disparities will extend to digital health.

Internet Privacy

In December 2016, the FCC introduced "Protecting the Privacy of Customers of Broadband and Other Telecommunications Services" that sought to adopt the privacy protection measures of the Communications Act of 1934 and apply them to broadband communications. Initially due to take effect in January 2017, these measures provided a privacy framework protecting consumer rights related to transparency, choice, and security while accessing the Internet via Internet service providers (ISPs). ISPs serve as the "on-ramp" to the Internet. However, in April 2017, President Trump signed into law Senate Joint Resolution (SJR) 34, which nullified these provisions. Now, consumers are left with less privacy protection and ISPs are allowed broader control over their customers' data. The current policy climate puts consumers at risk, exposing broad swaths of financial and health data.

Low health and digital literacy (the ability to use digital technologies to find and share information) complicate the nuances of broadband privacy. Vulnerable populations have opposing perspectives of overconfidence and skepticism about their privacy. While some patients cite surveillance concerns as a barrier, others do not consider this when engaging with digital health tools.[2] One patient may be hesitant to use a health app or website fearing government surveillance. Another patient may freely offer personal information, unaware of how their information is shared with other parties (e.g., ISPs). A patient-centric broadband privacy policy is critical to bridging these pri-

vacy perspectives and protecting vulnerable patients. This does not exist in the current political climate.

Although broadband privacy has declined, digital solutions continue to play a larger role in healthcare, creating a diverging path where vulnerable populations may be left unprotected. In other words, with nearly 259,000 health apps and digital health investments reaching $4.2 billion, technology's role in healthcare continues to grow.[3] However, the passage of SJR 34 puts health, a field markedly concerned with privacy, essentially at odds with the Internet, one of its most important platforms.

Furthermore, healthcare providers may be placed in difficult situations as they endorse digital health solutions to patients who may not want or be able to safely navigate the digital health space. Patients with low health literacy tend to lack trust in the media, government, and technology companies. Given current broadband privacy rules, this is not unfounded. In contrast, they place great trust in their healthcare providers. Since healthcare providers are key stakeholders in promoting digital solutions, it is essential to educate them about the risks for their patients when they prescribe digital health tools.

Internet Neutrality

Net neutrality allows the Internet to be an equitable platform. It maintains that ISPs should treat the transfer of all data equally. ISPs cannot: (1) block content or data based on the user, source, or type of data, or (2) create paid prioritization or "fast" lanes on the Internet. In 2015, the FCC adopted Title II of Communications Act of 1934 to place broadband and mobile Internet in the same regulatory category as public utilities, thus preventing discriminatory practices. This commitment to digital equity designated the Internet as a necessity rather than a commodity. However, on May 18, 2017, the FCC voted on the proposal "Restoring Internet Freedom," taking its first steps towards revers-

ing these regulations. Without net neutrality, ISPs could block content or give preference to entities willing to pay for fast lanes. Essentially, it could allow ISPs to control what patients see on the Internet and how fast they see it, creating a biased online environment.

For low-income Internet users, reversing net neutrality means that the freedom offered by the Internet would be lost. The Internet experience would vary from ISP to ISP, depending on which content is prioritized. ISPs could charge consumers premiums for an Internet connection with less throttling (slowing of Internet service) or blocking. Internet service could become similar to cable access where different packages with different content create a different experience. Without net neutrality, low-income patients could experience a limited digital interface. Their ability to use the Internet to access health information, patient portals, and mobile apps would be dictated by ISPs.

For a system that is increasingly asking its patients to go online for their healthcare, this presents several challenges. Meaningful Use policies require healthcare centers to provide patients access to their data through patient portals. However, patient portal uptake has been particularly low among vulnerable populations.[4] Patients already identify Internet access and technical skills as prohibitive. Placing further barriers on their Internet access and experience exacerbates existing digital disparities.

The rise of mobile first Internet users, or those who rely on their mobile phones for Internet access, has narrowed the digital divide. Mobile phones are also platforms for mobile health apps. However, with 23% of smartphone owners canceling their service due to cost, paid prioritization could lead to further financial burdens on patients.[5] How are we to see the beneficial impacts of digital health if the platform itself is inequitable?

Net neutrality regulations provide

PERSPECTIVE

not only a safety net for patients, but also can foster health innovations. As burgeoning technologies like telehealth, virtual reality, artificial intelligence, and machine learning begin to play a role in healthcare, inequitable policies may cause new developments to stagnate.

Opponents of net neutrality argue that it places excessive regulations on ISPs. These regulations limit market competition, ultimately hurting consumers. With the income accrued through paid prioritization, ISPs could reinvest in extending Internet infrastructure. However, this argument assumes ISPs will have consumers' best interest in mind. Along with the recent reversal of broadband privacy rules, which gives ISPs control over consumer data, ISPs are becoming the self-serving gatekeepers of the Internet.

To be an active citizen, Internet access is *indispensable*. To be a digitally engaged patient, Internet access, privacy, and net neutrality are all essential. The Internet is a platform for civic engagement, education, economic advancement, and healthcare. We cannot allow it to become yet another place where the vulnerable are left behind. For technology to be the driver of health equity, the technology must itself be accessible for all.

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SGIM

MEDICAL EDUCATION

safe learning environment. When we hide difficulties or only teach things we know well, we role model playing it safe. We should instead model receiving critical feedback in a positive manner.[4]
7. Explicitly teach learners about mindset/goal orientation theory: once fixed mindsets or performance-oriented goals are discussed with learners, they may feel inspired to identify habits that are not positively contributing to their learning and shift towards a growth perspective.
8. Praise the process of learning as well as the outcome. For example, "I like the way you persevered by trying many strategies for motivational interviewing until you found one that worked," is more meaningful than saying "Awesome job, your patient lost weight."

Educator-driven feedback still has a key role in medical training: specific competencies must be observed and met, and some learners may have poor insight into their performance making remediation necessary. But we believe a paradigm shift towards learner-centered, learner-directed feedback will enhance the learning experience and foster a growth mindset that will benefit learners even after their training. To have the most impact, institutional leaders should integrate these concepts into the medical curriculum: educators need faculty development on the guidelines suggested above in order to effectively share the responsibility for feedback with the learner. We now have the opportunity to train our learners in effective goal identification and feedback seeking from the beginning of their medical education, which will inspire proactive, learning-oriented future physicians.

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SGIM

FROM THE EDITOR

not well covered by *Forum* (Perspectives, Board Review section, Cartoons, more applicable content for international members), in addition to formatting and accessibility (Pub Med searchability and better online indexing). No one was fond of the fragmentation of articles with the need to skip to two and three sections to read one article completely. Finally, the "left leaning" predisposition of *Forum* content was noted.

Without exception, all the comments and suggestions (and there were many) were constructive and thoughtful which reflects the diverse character of our members and their passion for what we do and for what they get and want to get from *Forum*.

Okay, so now what? With the help of *Forum*'s current cadre of associate editors, SGIM's Director of Communication & Publication, Francine Jetton, Design Editor Howard Petlack and Managing Editor Frank Darmstadt we will be embarking on a refresh of *Forum* on both layout and features. We will also continue to explore innovative ways to deliver *Forum* through online media. Be on the lookout as we roll out some of these out in the next few issues. Let us know what you think of these innovations informally through e-mail and phone calls as well through our more formal survey solicitations.

As always, we have prepared a great issue this month with thoughtful pieces on how technology and policy impact healthcare disparities, turning learner centered feedback on its head, an upfront discussion on finances from the Society and much more. Getting back to Sally Field's quote, most people remember the quote as I stated it above. But this comment has been widely misquoted. The truth is, Ms. Field actually said, "You like me. Right now, you like me." The award was the result of years of hard work honing her craft and gaining respect but she knew that popularity and recognition in Hollywood is often grudgingly given and fleeting at best. So, too, for *Forum*. We know you like us now—help us continue to grow our newsletter into something the GIM community can love.   *SGIM*

FROM THE SOCIETY

Expenses: For fiscal year 2018, the budgeted expenses shown in Figure 2 are $2,991,125. "SGIM Operations" is the largest and includes expenses for SGIM leadership and staff that help carry out all SGIM programs:

SGIM Expense Categories

Operations 53%
National Meeting 21%
JGIM 16%
Committees 9%
Other 1%
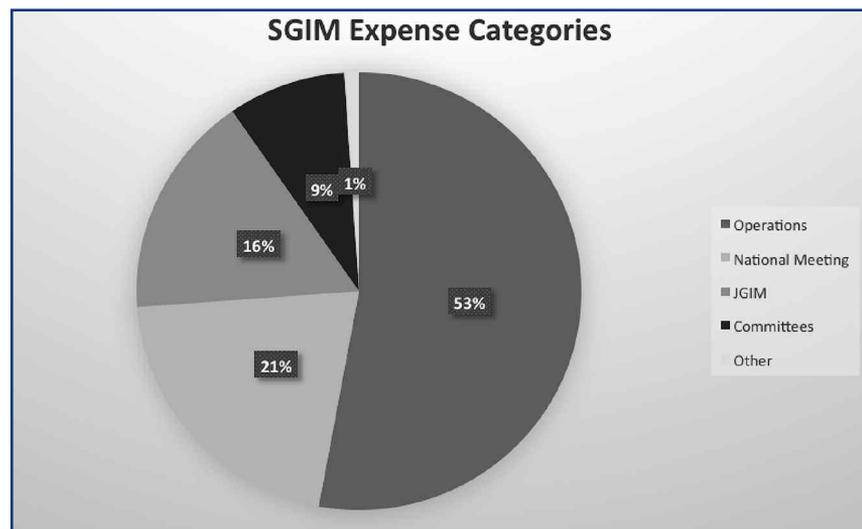
What funds does SGIM have and why? SGIM has restricted reserve funds that serve as an endowment for many of SGIM's awards. These have often come from donations for the specified purpose. SGIM also has unrestricted reserve funds that would allow SGIM to continue operating in the case of a financial catastrophe, such as the cancellation of the national meeting. SGIM reserves policy is to build the unrestricted reserves to a level equal to or exceeding 50% of the annual budgeted expenses. As of June 2017, the unrestricted reserve funds contain 52% of the FY18 budgeted expenses.

How are the budgets of SGIM's regions managed? SGIM regional officers manage the individual regions' budgets in accordance with SGIM policies and sound accounting principles. Recently, steps have been taken to assure that the regions (their principal expense is the regional meeting) are able to hold their regional meetings requiring staff and administrative support from the national SGIM office but no funds from the national SGIM budget.

What large expenses are expected in the near future? How are they budgeted? In the next five years, several large expenses are anticipated for SGIM. SGIM does not have a formally defined capital budget and will use a combination of operating funds and reserve funds to pay these expenses. These include expenses related to a new membership database system; an upgraded SGIM Web site; and maintenance of the SGIM office. SGIM recently used funds from its reserve account to pay down the mortgage on its property, which decreases our ongoing ex-

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care experience. Surely these existing mechanisms provided ample opportunity for patients to let the organization know if something had not gone well. It turns out that these existing complaints are only a very small tip of a much larger iceberg. When asked, approximately 30 to 40% of patients identify something that went wrong in their care and that they consider to be harmful. Yet, less than 10% of these patients had formally reported their concerns to the organization.[1] There were several reasons why patients kept their concerns about care breakdowns to themselves. But, for many patients, the most important barrier was fear that raising their hand to let the organization know about the breakdown might adversely affect their care. Health care has created a system that prompts patients who think something has gone wrong to suffer in silence rather than letting the organization know. In response, our research team developed and pilot tested "We Want to Know," a program that helps patients feel more comfortable sharing concerns about care and couples this with a real-time response from a navigator, engaging patients in identifying problems and solutions.[2] But, as we looked for organizations to adopt this model, we found more often than not that organizations actually did not want to know about patients' experiences of breakdowns, fearing that such reports could overwhelm their system. It's hard to imagine a less patient-centered perspective.[3]

Looking at our medical education and research programs, one sees a similar gap between patient centered rhetoric and practice. To what extent are our medical student and resident teaching programs geared towards meeting the needs of learners, rather than the needs of patients who receive care in these settings? Do we involve patients and the public in identifying key research questions and designing studies to address them to the extent that we should?

Fortunately, there are examples of ways that patients can be truly central to our clinical, teaching, and research missions. For many years, most hospitals have had a patient representative on their boards. But, too often, these patient representatives were tokens, not drivers of these leadership groups' activities. However, many organizations are now developing much more formal and robust Patient and Family Advisory Committees (PFAC), and are ensuring they play a central role in shaping the organizations' strategic plans. In addition, while Community Based Participatory Research has been occurring in some quarters for decades, the work of the Patient Centered Outcomes Research Institute (PCORI) has greatly accelerated our understanding of how patients can function as partners in the research enterprise.

Patients can also be critical partners in the design of educational programs. A few years ago, I was leading a large grant project on how the response to adverse events could be more patient centered. We asked the project's PFAC to lead the design and implementation of a day-long multi-stakeholder program to help healthcare leaders understand how patients currently experience the response to adverse events and opportunities for improvement. It seems self-evident that patient input would be critical to such a program. But it was a significant paradigm shift to have the PFAC planning and executing the program. Giving up control over the program's design and execution was not easy for the faculty. Some of the assumptions we made as "experts" in education on this topic about what would, and would not work made little sense to PFAC (which came as a surprise to the faculty). But once the faculty abandoned its assumptions about roles and responsibilities, and allowed the patients to lead the way, the end result was far superior in that the patient's voice felt authentic in a way that no amount of faculty expertise could have achieved.[4]

These examples of successful integration of patients and their perspectives into the clinical, education, and research space have several common themes. Just as physicians have struggled to discard their paternalistic attitudes, becoming patient centered requires completely letting go of our prior assumptions regarding authority and expertise, and embracing patients as equal partners. Equally as important is relinquishing our long-held beliefs about how patient care, teaching, and research should be organized, and embracing new and innovative strategies. The profession should adopt a new status quo where patient involvement in these activities is pervasive and robust.

Increasing patient engagement in these activities is not without potential pitfalls. Without sufficient training and support, patients may struggle to have their voices heard. In addition, the type of patient engagement described above works considerably less effectively if the patients involved are single-mindedly advocating for a specific disease or point of view. Well-developed best practices for patient engagement are beginning to emerge.[5]

Is SGIM sufficiently patient centered as a Society? We are currently exploring two options for involving patients more fully in the work of the Society. First, we hope to have a cadre of patient advisers attend the 2018 annual meeting in Denver. These patient advisers would be participants in plenary and other large group sessions, available to respond to workshop, abstract, and poster presentations, and meet one-on-one with interested SGIM members. We are also considering forming an SGIM PFAC in order to provide more explicit guidance to Council, our Committees, Task Forces, and Interest Groups about how the work of the Society can be better aligned with the needs and experiences of patients. These ideas are early in their development. I welcome your feedback on them and on other suggestions for making SGIM a truly patient-centered organization.

BEST PRACTICES

the scenario. We have summarized the suggestions below for by-standers from available literature[3]:

At the Moment:

- Name or acknowledge the offense
- Point to the "elephant in the room"
- Interrupt the behavior
- Publicly support the victim
- Use body language to show disapproval
- Use humor (with care)
- Encourage dialogue and help calm strong feelings
- Call for help (e.g., security, supervisor or administrator on duty based on the nature of the encounter)

After the Incident:

- Privately support an upset person
- Talk privately with the inappropriate actor
- Report the incident, with or without names

Suggestions for Supervisors:

Though the AMA code of ethics (Opinion 9.12) bars physicians from discriminating among patients based on "race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination", such code of ethics does not exist for patients accessing healthcare systems. The Title VII of the 1964 Civil Rights Act guarantees a workplace free from discrimination based on "race, color, religion, sex, and national origin". But physicians are often independent contractors who are not covered under the title VII. Additionally, physicians often discuss reassignment of patients amongst themselves and are therefore not forced by the employer to accommodate such requests. In a survey of medical providers in the ED, a third of the providers felt that patients perceived better care from providers of similar racial background. Female and non-white physicians were more likely to accommodate such requests[4].

Summarized below are suggestions for supervisors, on call administrators, etc., when dealing with these situations.

Interaction with Perpetrator: suggestions below have been derived from Paul-Emile, et al[2] on "Dealing with Racist Patients":

1. An on-call administrator should inform patients of their responsibility to refrain from hateful speech and their right to seek care elsewhere.
2. Healthcare systems should not accommodate patients in stable condition who persist with reassignment requests based on bigotry, as it rewards the behavior.
3. Stable patients who refuse care by a provider of a different racial or ethnic background may be assisted in transferring to another hospital.
4. Patients in outpatient settings who refuse to be cared for by a physician on racial/ethnic grounds may be informed that they are free to seek treatment elsewhere.

Interaction with Victim:

1. Initial interview: The BATHE technique is a psychotherapeutic procedure that serves as a screening test for anxiety, depression, and situational stress disorders. It can be used by a supervisor when dealing with a situation of reported discrimination at the workplace or an academic institution[5].
   - Background: "What is going on in your life?"
   - Affect on the victim: "How do you feel about it?"
   - Trouble: "What troubles you most about the situation?"
   - Handle: "What helps you handle the situation?"
   - Empathy: Make a conscious attempt to envision the stigmatized person's viewpoint. You may utilize techniques to visualize a person as 'in-group' rather than 'out-group'
2. Show value to the stigmatized individual:
   - Provide standardized written information as a mission/vision statement

PRESIDENT'S COLUMN

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SGIM

BEST PRACTICES

- Actively seek presence of role models exhibiting counter-stereotypical traits
- Focus on person's strengths, prior success
- Review objective data to reaffirm "normality" of the process
- Frame critical feedback with reassurance of individual's capability to improve/meet objective standards

3. Use individualized information: Make a conscious effort to focus on specific information about an individual, making it more salient in decision-making than that person's social category information

Summary
Physicians are frequent targets of discrimination by patients, often based on racial and ethnic grounds. However, the principles of beneficence usually supersede any personal emotions of hurt or humiliation that physicians may experience in these encounters, leading to under reporting of these incidences. We hope that the tips in this article will enable our readers to handle similar situations more effectively. In the next article in the series, we will discuss managing bias, harassment, and discrimination occurring in interactions with physician providers and other healthcare staff.

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SGIM

FROM THE SOCIETY

penses for space and allows for increased flexibility in the budget.

How can SGIM create more revenue to support its mission? The more revenue SGIM can create, the more it can deliver on its missions. The principal sources of revenue for SGIM are its members. Growth of membership and meeting attendance is the best way to increase SGIM's revenue. Fundraising by donations is a small but important source of revenue. While we typically budget ~$15,000 per year in donations, this year we are launching an advocacy campaign, to provide a substantial boost in funding to strengthen our health policy advocacy impact and career development activities in health policy, given the need for increased vigilance and activism in the current political climate. Prior campaigns have raised large amounts of money that allowed SGIM to more rapidly purchase its office space. SGIM has strict policies that limit external funding of its operations to 33% of its operating budget, with smaller limits on funding from each source, especially for-profit health care related organizations (http://www.sgim.org/File%20Library/SGIM/About%20Us/Policies/External-Funds-Policy-Dec-2005.pdf). The Finance Committee and Council carefully review every fee charged to members to ensure they have an appropriate balance of value to SGIM and affordability to the members, and also compare these fees to other similar national organizations to make sure that we are in line with what others are charging.

How can interested members participate in the financial management activities of SGIM? The Finance Committee is seeking additional members. If you have interest in serving on this committee, please contact DC Dugdale at dugdaled@uw.edu!

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