

MEDICAL EDUCATION:  
PART I

## Resident Wellness—A Chief Resident’s Perspective

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**W**ellness is a new buzzword throughout the medical community. Healthcare systems struggle to prevent burnout and encourage wellness for physicians at every stage of their training and careers, enough so that it was the focus of the Society of General Internal Medicine (SGIM) national meeting in 2017. The topic has increasingly captured the attention of residency programs, especially given the rigor of academic training programs and the various pressures they exert—intellectually, physically, and emotionally. Suicides and major depressive episodes are illustrations of the challenges faced by residents, but often overshadow the less dramatic but similarly important struggles that all residents increasingly face.<sup>1</sup> As residents strive to simultaneously provide outstanding patient care, build on their medical education, and excel in research activities, they often feel overwhelmed, and their profession conflicts with their efforts to maintain a personal life.

It is no secret that the heavy workload during residency is a major negative contributor to resident wellness.<sup>2</sup> At the onset of our chief residency

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## Auld Lang Syne

Joseph Conigliaro, MD, MPH, Editor in Chief, *SGIM Forum*

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With each passing of an old into a new year, we often think about the good old days with a bit of nostalgia, sadness, and occasional good riddance. *Auld Lang Syne*, the song oft-associated with New Year's Eve, describes exactly that sentiment. It translates from an old, Scottish dialect, meaning "Good Old Days." The yearning for the good old days can happen at many levels—at the personal level (were you in good or bad health?; great or worst year for career?; personal achievements; loss and grief, etc.) or societal (political upheavals here and abroad; natural disasters; favorite sports team winning [I'm talking to you, Houston!]).

So what did you think of 2017?

Tom Staiger's article this month describes the year in review from the perspective of SGIM's Health Policy Committee. You will all agree that it indeed had a hell of a year! From the inaugural class of the Leadership in Health Policy (LEAHP) program and the annual Hill Day, to its relevant and timely responses to the activities going on nationally, the Committee has been tirelessly working to advance SGIM's mission. Our outgoing and incoming presidents, Eileen Reynolds and Tom

Gallagher, were equally adept in their ability to respond, inform, and inspire in their *Forum* columns. It's hard work writing something fresh every month and, as Editor-in-Chief, I've been amazed and appreciative of their efforts.

In this issue, there is also much that we can be reminiscent about. Doctors Oyler and Bruti recap what sounded like a great Midwest Regional meeting that touched on important themes related to professional development throughout one's career. Of note as well in this issue is the work of Nandiwada and colleagues shared some original research evaluating the degree that consult notes communicate the evidence behind their recommendations. Saab, et al., also highlight a robust and ambitious program to promote wellness undertaken at Denver that can serve as a model for other programs. Steve Asch and the new JGIM Editorial Team share their vision for the next iteration of our already outstanding Journal and Nathan Mesfin reminds us of the good old days how we learned so much about our patients from visiting them at home and why we became better physicians for doing so.

We enter this New Year with many challenges. Fortunately with a passionate and able membership, SGIM can have a positive influence on the debate to deliver health care with optimal health outcomes for all. Our elected president and council members, along with our new CEO, will continue to work with the team in Alexandria, VA, to accomplish SGIM's mission to lead, change, and innovate in clinical care, education, and research in general internal medicine.

As the song goes: "For auld lang syne, my dear, for auld lang syne, we'll take a cup of kindness yet, for auld lang syne."

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# Do You Have a Minute to Talk?: Feedback, Face, and Becoming a Learning Organization

Thomas H. Gallagher, MD, President, SGIM

There is a range of communication skills that can help peer feedback discussions go better. (It is useful to approach these discussions from a perspective of curiosity (assuming you do not have all the relevant facts) rather than accusation. Pay equal attention to both information sharing and emotion-handling dimensions of these discussions. Yet, most critical may be our willingness to take the initiative to have such discussions in the first place.



The notion that treating our colleagues well is the first principle of medical professionalism harkens back to the Hippocratic Oath. The oath begins not with our duties to our patients, but rather “to hold my teacher in this art equal to my parents;... When he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art.”

Many of my columns have highlighted the importance of understanding the culture of medicine. And nowhere does this culture exert a stronger influence than the way it affects our behavior toward our fellow physicians. While a strong sense of collegiality has many benefits, it also complicates our attempts to become a self-regulating profession. In my September 2017 column, I discussed the importance of adopting a framework of continuous self-improvement, one that hinged on seeking feedback on our performance. Yet a continuous self-improvement mentality calls on us not only to pursue feedback but also to provide feedback to *each other*. However, for many of us, the prospect of offering peer feedback has all the appeal of an ice-water colonic.

I became aware of how difficult physicians find it to give their colleagues feedback during my work on

disclosing medical errors to patients. The most common question I heard from physicians was, “What do I do when I am aware that a colleague has made an error in the care of a patient I am responsible for? Should I tell the patient about my colleague’s mistake?” As we explored this topic, it became clear that there were actually two challenging discussions<sup>1</sup>. One was a potential conversation with the patient about the colleague’s mistake. But prior to talking to the patient, clinicians struggled with whether or not they should reach out to the involved colleague and talk with them about what happened. The prospect of confronting a colleague about an error was considerably more intimidating to physicians than the conversation with the patient. More often than not, physicians decided to just skip talking with their colleague altogether, preferring to move the patient’s care forward rather than dwelling on the past.

How physicians approach feedback is a paradox. In a national survey of internists, 94% said it was important to get feedback on their clinical care, yet only 27% reported receiving such feedback<sup>2</sup>. Similarly, physicians express an eagerness to know about mistakes they have made, and a desire that their colleagues let them know if they were concerned about

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their performance. Many of us also routinely provide feedback to learners. Yet, this desire for feedback on our own performance and experience giving feedback to learners seldom translates into a willingness to speak with a colleague about a potential care problem. In the words of Jack Handey, “Before you criticize someone, be sure to walk a mile in their shoes. That way, when you criticize them, you are a mile away and have their shoes.”

The reasons why we hesitate to provide feedback to our colleagues are complex. For instance, we realize we may have incomplete information about what happened, and don’t want to jump to conclusions. There can be

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## Midwest SGIM 2017: Optimizing Professional Development and Patient Care Across the Career Spectrum

Julie Oyler, MD, and Christopher Bruti, MD

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The midwest is home to SGIM's second largest region, spanning 13 states with approximately 700 members. This year, the Midwest SGIM Annual Meeting was held at the Northwestern Convention Center in downtown Chicago, IL, on September 14-15, 2017. We had great attendance with >250 attendees and 247 submissions. Our theme was "Optimizing Professional Development and Patient Care across the Career Spectrum." Our meeting focused on understanding how physicians can focus on professional development during early, mid, and late career.

Each plenary speaker addressed a component of our Professional Development theme with 4 main objectives:

1. Define three best practices for maximal physician engagement in personal and professional development.
2. Develop a personal strategy to align one's career mission with the needs of one's academic institution.
3. Describe four factors that lead to optimal patient care and its delivery across the physician career lifespan.
4. Appreciate that ongoing coaching and mentoring is essential to physician professional development.

The Thursday plenary session was devoted to top-ranking vignettes, innovations, and scientific research. Dr. Jennifer Merrill from the Ohio State University presented "Isolated Elevation of Serum Alkaline Phosphatase"—a case to remind us to assess isolated elevations in alkaline phosphatase which could be the first sign of metastatic lung cancer.

Alexa Minc described efforts at the University of Chicago to validate a computerized adaptive screening test for depression and anxiety in primary care. Finally, David Liss from Northwestern University presented a smartphone app that uses location based alerts to coordinate care after ER visits and hospitalizations.

Meeting highlights include updates from national SGIM by ACLGIM president Laurence McMahon, MD, of the University of Michigan; JGIM updates presented by the newly named JGIM editor, Jeffrey Jackson, MD, from Medical College of Wisconsin; and, a highly informative update in GIM in both primary care by Elizabeth Schulwolf, MD, from Loyola University, and hospital medicine by Manya Gupta, MD, from Rush University and Joshua Lennon, MD, from Northwestern University. Dr. Eric Bass, the newly named part-time CEO for SGIM, was able to attend the meeting and share his vision for leading SGIM. We had great opportunities for networking with small group round tables, a panel on navigating the academic career lifespan, and an informal happy hour on the Chicago River. Innovations included going paperless and using a Midwest SGIM smartphone application for the agenda and poster/oral judging and changing the workshop/oral sessions to 60 minutes to mirror the SGIM national meeting.

On Friday, Liz Jacobs, MD, immediate past president for ACLGIM, shared about opportunities to get more training through SGIM by applying for LEAD and TEACH. She also shared that ACLGIM was not only for chiefs but also for clinical, educational, and research leaders in GIM across the nation. Health Policy Committee member Mark Liebow, MD, of the Mayo clinic presented health

policy updates and invited Midwest SGIM members to participate in SGIM Hill day on March 2018, learn about how SGIM lobbies Congress, and apply for LEAHP.

We were also honored to have Dr. Andrea Sikon, chair of Cleveland Clinic General Internal Medicine and Geriatrics and the director of the Cleveland Clinic Center for Excellence in Coaching and Mentoring talk to us about "Optimizing Professional Development across the Career Spectrum". Dr. Sikon started with the concept of "finding your why" in medicine. This came from her experience reading author Simon Sinek's "Start with Why: How Great Leaders Inspire Everyone to Take Action." Finding what you are passionate about in medicine can be at the core of professional development. Dr. Sikon also talked about the difference between mentoring and coaching. Mentoring is often an experience where the mentor gives advice, opportunities, and does most of the talking. On the other hand, coaching is more of a listening role, hearing what the mentee's goals are and helping shape those goals into opportunities. Dr. Sikon finished by giving members a framework for the three stages of relationship-centered, asset-based coaching:

1. Goal setting: self-assess and establish well defined specific goals, motivations, and tie these to values.
2. Action planning: Build confidence using prior successes and strengths and identify resources to overcome barriers for action.
3. Create accountability: Narrow focus towards achievable outcomes and commitment, and engage accountability partners.

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## Shave and Repeat: New Onset Obsessive Behavior in a Nonagenarian

Janelle L. Weaver, PhD (presenter), Seki A. Balogun, MBBS, FACP, AGSF (discussant)

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*(The texts in italics below are comments from the discussant.)*

**M**r. A is a 96-year-old male with a medical history of dementia, uncomplicated type 2 diabetes mellitus, hypertension, benign prostatic hyperplasia, hypercholesterolemia, and hearing loss, who lives in a nursing home. He ambulates with a walker, is dependent on others for all of his instrumental activities of daily living and some of his basic activities of daily living, such as bathing. During a physician visit, his nurse reports an ongoing issue of the patient repeatedly shaving his face and neck throughout the day. This behavior was first noticed several weeks prior, continuing to worsen, and now resulting in skin irritation and abrasions. His current medications include aspirin, hydrochlorothiazide, simvastatin, losartan, melatonin, and donepezil. Physical exam is notable for erythematous, dry, irritated skin over bilateral jaw and neck. He is alert and oriented to person and place but not to time, and has 1+ bilateral pitting edema in the lower extremities.

*Based on the information so far, it is important to think of the differential diagnoses for this behavioral change. A broad differential for the new onset of obsessive-compulsive behaviors in this individual would include a mood disorder, worsening dementia, a structural brain lesion or new onset obsessive-compulsive disorder (OCD). Geriatric aged patients, particularly those with co-morbid memory dysfunction, can exhibit differing manifestations of depression as compared to younger individuals. Older depressed adults with memory impairment can present with increased agitation or somatic symptoms instead of the typical symptoms of depression.<sup>1</sup> In addition, mood disorders are common in the setting of cognitive impairment*

*with an estimated prevalence of up to 40%.<sup>2</sup> New onset OCD after age 50 is rare and, in the majority of cases, is related to structural cerebral damage or lesions.<sup>3</sup>*

About six weeks prior to this evaluation, his wife of 60+ years died. When asked how he felt about his wife's death, he smiled and pointed to her picture above his bed saying "I am the luckiest man alive... I am grateful to have spent so long with such a lovely woman". He denies depressed or anxious mood, though he became tearful when talking about his wife and could not recall the exact date of her death. Otherwise, he does not display any acute changes in cognitive function, sleep or appetite.

*With this additional information, one should consider bereavement as a possible factor in his presentation. There is very little data on the impact of grief and bereavement in older adults with memory impairment or dementia. However, several studies link bereavement to adverse health outcomes such as depression, anxiety, and even death.<sup>4</sup> Older adults with dementia may be unable to verbalize their grief or lack the cognitive ability to process and appropriately develop an acceptance of the death of their loved one. There are also several reports of grief related distress presenting in varying forms in older adults with dementia such as perseveration, psychosis, and increased anxiety. In our patient, while he maintains an awareness of his wife's death, he does not recall when it occurred and he may be unable to completely process the event. Alternatively, there may be a decline in cognitive function, such that he forgets that he shaved and is misinterpreting his abrasions from prior repetitive shaving as stubble.*

*However, it is important to note that he did not exhibit this behavior before his wife died.*

*While OCD symptoms may increase in the setting of acute distress, these are overall generally thought to decrease with age and are usually preceded by past OCD symptoms, in addition to other associated areas of neurological impairment.<sup>5,6</sup> Some intracerebral lesions, particularly in the frontal or caudate nuclei, can produce OCD symptoms in older adults.<sup>3</sup> In this case, imaging would not be indicated in the absence of other neurological findings and likely not be beneficial for the patient, given his co-morbidities and goals of care.*

Behavioral modification strategies were instituted to help with this symptom, which included frequent discussions with the patient about the need to minimize his shaving activities, and taking pictures of the facial abrasions to show him. He continued to insist that he required additional daily shaves. Ultimately, his access to the electric razor was limited to once per day and gentle reorientation was provided if he requested repeat shaves throughout the day. A geriatric psychiatry consultation was also sought with recommendations for continued behavioral modification. Over time, he continued to exhibit the same behavioral issues and was eventually started on escitalopram, a selective serotonin reuptake inhibitor (SSRI) with some improvement in his symptoms.

*In this case, a simple behavioral intervention was initially chosen given the ease of implementation, the patient's advanced age and co-morbidities, and the lack of clear evidence for a mood disorder. This*

*continued on page 11*

## A Rare Call for the Old Medicine

Nathan Mesfin, MD

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Home visits are a relic of a bygone era of medicine. The quintessential family doctor with a black bag carrying his stethoscope rarely occurs these days. Yet, as part of the global health track in my internal medicine residency program, I was afforded a unique opportunity to visit two of my patients, who, before then, I had only seen at 30-minute intervals.

My first visit was to a younger African-American man with poorly controlled hypertension living on the west side of Chicago. The drive to his house was mured with boarded-up houses, closed down storefronts, and overgrown lawns. His neighborhood, North Lawndale, has witnessed 34 homicides and 63 shooting victims already this year. There was a murder less than two blocks from his home. The theoretical consequences of uncontrolled hypertension are trivial compared to the palpable fear of gun violence that pervades his neighborhood.

During my drive, I took notice of the schools in the area. Most were charter schools, and most of which were new, without clear reputability or accountability. I remember cringing when my patient talked about enrolling his kids in charter schools under the misguided hope of a better education.

My second visit was with an older gentleman who illustrated the visceral struggle of poverty while suffering from worsening health. He was candid, and went through his and his wife's monthly finances in detail. At the end of each month, they would have no money left, and recently resorted to sharing a single pay-as-you-go cell phone. The instability of living pay-check to pay-check coupled with his mounting medical issues creates an unbearable situation. From my visit, it became clear to me how ridiculous our expectations for our patients can

be when we don't understand their day-to-day struggles. He currently takes 85 units of a long acting insulin every morning and 90 units of a rapid acting insulin with each meal. It took me some time to understand the mere logistics of having to go through this insulin regimen. That means he needs to prick and inject himself seven times each day. His insulin dose is so large that his injection pens last no more than a day. Although he does his best to follow this regimen, I can better understand his trip ups.

In addition to learning about my patient's daily struggles, I also learned about his joys in life. I saw my patient's craftsmanship in the dream catchers covering his walls. He is able to interlace and weave these beautiful pieces of art despite thick callouses from his finger pricks.

I was also able to tag along with a home health nurse, a physical therapist, occupational therapist, and social worker to get a clearer picture of their impact on patient care. I learned about the therapists' flexibility in working in patients', often cluttered, homes. I was impressed by the practical solutions they can provide working in a patient's own home.

I remember one patient had a small bathroom with a high-edged bathtub. A cramped bathroom, slippery bathtub, long shower curtains, and ill-placed bath chair were inevitably going to lead to a dangerous fall. However, we were able to rearrange a few things to reduce his risk of falling. Every living situation has its own hazards, and the best way to identify them is to visit a patient at home.

The World Health Organization recognizes social determinants of health as the economic, educational, and environmental factors that shape a person's overall health.<sup>1</sup> Only when I stepped into my patients' homes

could I truly begin to grasp the interconnectedness of these factors. How the lack of educational opportunity spills into the lack of employment opportunity. Only when I sensed the danger that my patient faces every day could I understand how these factors could be as determinative as the person's genes. When you become proximate to your patient's neighborhood, you become emboldened to challenge the status quo in their lives.<sup>2</sup>

More than a year ago, I applied for the Global Health track with the aim of learning about health inequities on a local and global scale. I was eager to learn about different healthcare infrastructures, most of which are ill equipped to serve both the haves and the have nots. The Global Health program helps apply the tenets of global health to local issues. These home visits help connect residents to different neighborhoods and communities they might otherwise never be exposed to. It also exposes residents to volunteering and community engagement opportunities that may serve the patients further than the medications prescribed in the office. It contextualizes patients in a way that cannot be seen in clinic. Most importantly, it makes us more forgiving clinicians towards our non-complaint patients since we form new bonds with our bridged communities.

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## Vision of New JGIM Editors

Steve M. Asch, MD, MPH, Carol Bates, MD, and Jeffrey L. Jackson, MD, MPH

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We are very excited to assume the helm at JGIM! The *Journal of General Internal Medicine (JGIM)* has a long history of employing excellent editors (see table) and we are grateful that our predecessors have done such a wonderful job and handed us a journal in excellent shape. There are many measures that one can use to assess the strength of a journal—the most common is the *impact factor*, a simple ratio of the number of citations divided by the number of “counted” publications over the past 2 years. *JGIM* is currently at an all-time high with an impact factor of 3.7. This is 22<sup>nd</sup> on the list of general and internal medicine journals and 13th on list of healthcare sciences and services journals. The impact factor has become so important that many journals have taken drastic steps to massage their impact factor. *JAMA*, for example, publishes fewer research articles than before, thereby reducing the number of counted articles that figure into its ratio. While we believe that the impact factor is important, it is not the only measure of a journal’s health. *JGIM*’s Google *h5* index is the number of times an article has been cited *h* times in the previous 5 years. On this measure,

**Table. Former Editors of JGIM**

1986-1989	Robert H. Fletcher & Suzanne W. Fletcher
1990-1994	David C. Dale
1995-2000	Sankey V. Williams
1999-2004	Eric Bass
2004-2009	William Tierney, Martha Gerrity
2009-2017	Richard Kravitz, Mitch Feldman
2017-2022	Steve Asch, Carol Bates, Jeffrey Jackson

*JGIM* has an *h5*-index of 55, placing it #1 on journals focused on primary health care. With an average monthly download of 84,022 in 2017, we also know that *JGIM* is being copied and read; we therefore encourage SGIM members and other authors to publish in *JGIM*.

One of the advantages of having three editors is that it allows us to have a more ambitious agenda of goals. Each of us has a particular focus that represents the breadth of GIM and the diversity of the Society’s membership. As the flagship journal for SGIM, we believe that *JGIM* can play an important role in helping SGIM accomplish its six

strategic goals: 1) Improving work and practice environment for general internists, 2) Ensuring that reimbursement systems fairly compensate generalists for their work, 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.

Steve is very interested in helping to grow the field of implementation science, an important step in moving research from the bench to the bedside. Often, traditional review approaches can be constraining and there is a lack of understanding of what represents excellence. Steve is hoping to help clarify the review methods and guide researchers in using appropriate techniques. Lisa Rubenstein has joined him in this venture and if this is an interest for you, please feel free to contact them.

Carol’s goal is to increase the clinical content published in *JGIM*. Two new series that are contemplated include “News Flashes for Daily Practice” and “Controversies in Clinical Care.” She’s also working closely with the *JGIM* educational affinity group, and we expect to announce another call for a dedicated issue on medical education very soon. Carol’s focus on education is particularly timely in that *JAMA* has recently decided to no longer publish its annual medical education symposium. We believe that medical education is a critical component of what academic medicine is about as a majority of SGIM members identify themselves as clinician-educators. We encourage

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## Do Trainee Consults Communicate Evidence-based Medicine and Clinical Reasoning?

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The practice of medicine is constantly evolving, requiring physicians to be aware of new research and the impact it may have in the delivery of high quality and high value care (HVC). Over the past 20 years, the use of evidence-based medicine (EBM) techniques in clinical practice has become increasingly recognized as a critical part of residency training and a key component in physician life-long learning.<sup>1</sup> The deliberate, daily use of EBM is called *Evidence-based Practice (EBP)*. The Accreditation of Graduate Medical Education (ACGME) has incorporated the practice of EBM into its milestone competency framework, one of which is under the competency of practice-based learning and states the learner should “learn and improve at the point of care.” EBP teaching is most effective when it is tied to directly to patient care. Real-time EBP learning (in the clinics, on rounds) is more effective than journal clubs and group didactics, which create a temporal and physical space between the evidence and the patient.<sup>2,3</sup> Teaching trainees ways to promote value through evidence-based medicine to help with cost containment and reduce waste has become paramount.<sup>4</sup> An integral part of EBP is including the patient’s perspective, expert opinion, and clinical reasoning in areas where the evidence is gray. Communication of these thought processes is an essential skill for residents and fellows on consult services who are at the edge of expert opinion and EBP in direct patient care.

There have been limited studies assessing facilitators and barriers to residents using Evidence-Based Practice. In a 2010 review in *Academic*

*Medicine*, nine studies were identified to assess facilitators/barriers to EBP and, of these, 4 assessed internal medicine or family medicine. They reported that time, EBM skillset, and learning environment were significant barriers to practicing EBM.<sup>5</sup> The majority of studies assessing curricular interventions focuses on lecture or modules rather than the use of EBP and point of care HVC.<sup>2,3,5</sup> Although point of care barriers and facilitators have been explored in the literature, few studies describe what residents and attendings feel would be a non-burdensome, sustainable point-of-care intervention to promote evidence-based practice on consult services.

The consult services are an ideal place to deliberately practice the use of EBP as a tool to create high value consults. Residents have more time and are primed with a clinical question with each consult. Residents also serve a unique dual role as both a consulting physician and primary physician who request consults during their training. There are few studies assessing communication of clinical reasoning or EBP on consult services.

Our study was designed to assess current attitudes and perceptions and to receive input from all physicians who interact with residents on the consult service in order to develop sustainable and feasible curricular interventions that routinize EBP on the consult service to promote high-value consults.

The survey covered four domains: teaching practices, communication of evidence-based practices, communication of clinical reasoning, and ideas to promote daily practice of evidence-based medicine. The survey was de-

signed after an extensive literature search for published assessment tools yielded no validated assessment tools for EBM consult communication practices. Questions were designed and piloted by an expert group of medical educators based on existing quantitative and qualitative assessments within the literature. Surveys for fellows contained questions that overlapped with both attendings’ and residents’ surveys. Residents answered questions from two perspectives: as the primary team placing the consult and as residents on a consult service rotation. Residents and fellows were asked to report perceived frequency of communication of clinical reasoning and evidence base medicine. Fellows and attendings were asked to report on their perceptions of resident communication behaviors of evidence-based medicine and clinical reasoning. Questions utilized a five-point agreement Likert scale (strongly disagree, disagree, neutral, agree, strongly agree), a frequency Likert scale (almost never, seldom, half the time, usually, almost always), and a free text option for ideas on how to promote EBP. The study was approved by the University of Pittsburgh Institutional Review Board.

All data was entered into Redcap and then analyzed using STATA with support from the University of Pittsburgh Clinical and Translational Science Institute. ANOVA was used for comparison of means and paired t-test for within group comparisons. Free text comments were evaluated and divided into categories based on content by two independent reviewers with an adjudication process to come to a consensus on categories.

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## Looking Back at an Active Year for SGIM's Health Policy Committee

Thomas Staiger, MD

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The iconic 1978 photo “Blown-away Man” shows a man sitting in a chair with his hair and tie blown back by the sound from a set of speakers in front of him. This image conveys what it has sometimes felt like to be involved in SGIM's many health policy activities during the past year. Our Health Policy Committee's expected annual activities include advocating for policies that improve patient care, strengthening education and training, and promoting researchers and their research in general internal medicine.

In addition to these activities, the committee, in partnership with former and present SGIM presidents Eileen Reynolds and Tom Gallagher, with council, and with CRD Associates—our governmental affairs liaison—also engaged in the following unanticipated activities, during the last year:

1. Revised our health policy agenda to include the following language regarding access to affordable healthcare services:

*The implementation of comprehensive health care reform under the Affordable Care Act (ACA) has fundamentally improved how patients obtain insurance and access care. As Congress develops legislation to*

*repeal the ACA and replace it with an as yet undefined set of “reforms,” SGIM will advocate to ensure that patients continue to have access to affordable health care services. Any future reforms targeting access to insurance and payment models must continue to improve patient access to needed, quality health care services.*

2. In response to concerns from numerous members, sent letters to the leaders of the Association of American Medical Colleges (AAMC) and the American Medical Association (AMA) regarding their endorsements of Dr. Tom Price as Secretary of Health and Human Services. Given his opposition to the ACA, the letters expressed the concern “that if Dr. Price's past policy proposals are pursued under the new administration, it would severely harm our ability to adequately care for and serve our patients.” The letters also detailed SGIM's concerns regarding the impact of Dr. Price's voting record on vulnerable populations and asked these organizations to reconsider their endorsements.
3. Submitted a proposal for a special symposium at the

national meeting on “Health Reform 2017: Preserving Access to Health Care at the Nexus of Policy and Politics,” which was accepted and moderated by Mark Schwartz.

4. Worked with council and CRD Associates to initiate monthly updates on health policy issues for all SGIM members and to expand the number of individuals allowed to attend the March 2017 Hill Day.
5. Developed a set of principles on legislation that could affect the ACA to distribute at Hill Day that included the following:
  - We believe access to health care is a fundamental right and that keeping Americans healthy strengthens our economy, families, communities, and security.
  - Any changes to the ACA should maintain or increase the number of Americans with health insurance.
  - States that have chosen to expand Medicaid eligibility through the ACA should be able to maintain this expansion. Medicaid provides critical health care services for our most vulnerable patients. We oppose any changes to the Medicaid program that would result in coverage loss for low-income Americans.
  - Other patient protections in the ACA should be maintained, including ensuring those with pre-existing conditions have access to affordable coverage, prohibiting the retroactive denial of coverage, and eliminating lifetime and annual

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This has been an unusually active and important year for SGIM's health policy activities. I am exceedingly grateful to our health policy committee members and our organization's leaders for their commitment and efforts necessary to support this level of important health policy activity.

## MEDICAL EDUCATION: PART I

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in internal medicine, we collectively agreed that while we could not modify ACGME duty hour rules and while there was value in our rigorous training, we could focus on promoting the well being of our residents within the confines of this system. With the complete support of our program leadership, we were allowed the opportunity to innovate and advocate for our residents. We set out to both implement new programs and re-interpret existing rules in order to create an environment that prioritized wellness and cultivated a more balanced life for our residents.

### **Scheduling and the Jeopardy System**

At the beginning of the year, our chief group agreed that the jeopardy system should apply to any case where a resident felt unfit to work. Traditionally, this included sick days and instances of a personal or family emergency. Yet we believed that it should also include days when a resident felt particularly exhausted, depressed, or stressed. Whether it was due to lack of sleep from a sick child at home or feeling burnt out from a prolonged call schedule, we agreed that such residents should be excused both to support their mental health and to protect patient care. Residents are a highly select group of individuals who have continuously proven to be hardworking and ambitious. We believed it was important to trust them and found that they did not abuse the system. Instead of worrying about the short amount of time a resident would miss from their training, we believed it was important to support them through their training and avoid the harmful perception that they were working in an inhumane system.

### **The Power of Debriefing**

Evening resident rounds—where second- and third-year residents come together for separate monthly sessions to discuss difficult cases with their peers—are a longstanding feature of our program. We assign three residents ahead of time to in-

formally share a case that was challenging from a non-medical perspective, often sharing experiences with patient deaths, difficult social situations, or mistakes they feel they have made. For the first time, we began implementing similar forums for the intern class, recognizing that our residents experience challenging cases early on in residency and desire this opportunity for decompression and reflection. Given the high emotional toll of the rotation, we also initiated a similar debriefing intervention with our residents on the solid oncology service, which helped transform it into one of the more highly rated inpatient rotations.

Our program also conducts a rapid mortality review in our intensive care unit, whereby residents review deaths from the previous week with ICU attendings, fellows, and nurses. Chief residents ask the house staff whether anything about the case particularly bothered them. This is intended to extract any lingering feelings of guilt, worry, or unanswered questions they may have about the death. The aim is to establish a sense of closure for the resident and to avoid any instance of prolonged self-blame that would have a negative impact on their mental health.

### **Professional Services**

To further support our residents' well being, this year our institution developed a Behavioral Wellness Center consisting of psychiatrists, psychologists, and a full-time therapist to serve medical and graduate students and residents and fellows. The Center provides confidential counseling and psychiatric services with no "out-of-pocket" expenses to those seeking care. We were lucky enough to have our institution recognize how invaluable is this service, as having reliable referrals available when residents need them can be challenging.

### **Stepping Away from Work**

In an effort to be able to experience a sense of normalcy while at work, we instituted monthly "Wellness Fri-

days" whereby residents on outpatient rotations take turns planning an outdoor catered lunch for their co-residents. This is a chance for all residents to have a meal away from the normal noon conference didactics and enjoy the company of their co-workers while decompressing over lawn games and desserts.

One of the most powerful ways to reset from the stress of the work environment is to completely disconnect. In the fall, a full day at our outdoor university recreation center is dedicated to team-building activities with events such as a high and low ropes course and to hear resident feedback on rotations and review program policies and changes. In the spring, we spend two full days at a local beachside resort dedicated to similar activities. Our supportive faculty and fellows cover resident shifts and the accommodations are funded by the department.

### **Transforming the Program into a Community**

This year, we formed a residency council that asks three representatives from each class to solicit their co-residents' feedback and suggestions and to bring them to a monthly discussion over dinner with a chief. The topics ranged widely and included improving certain call schedules, revising admitting rules, diversifying conference lectures, and requesting work room amenities. The council was successful in cultivating a culture of inclusiveness and open-mindedness, as well as allowing the leadership to hear the thoughts of the residents more frequently.

We also asked our house staff to send us "shout-outs" acknowledging the hard work or impressive skill of a co-resident that were included in our weekly newsletter to the entire program. In response, we were inundated with examples of residents providing exemplary patient care, going above and beyond in their work. We cannot overstate how important it is to openly recog-

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## MEDICAL EDUCATION: PART I

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nize admirable work, as residents may often feel that their deeds go unnoticed.

### Progress, not Perfection

Medicine is caught at a crossroads. It is a fascinating and rewarding career, but the scheduling and emotional demands it requires, especially during residency training, often lead to burnout. With increasing ACGME focus in the Common Requirements on resident well-being and burnout mitigation, programs are looking for strategies to help provide these resources for residents.<sup>3</sup> While we

await radical innovations that help balance these interests, we believe that there are tangible changes a program can make to improve the resident experience. Given their unique roles as departmental leaders who have a fresh memory of the challenges trainees face, chief residents can play a key role in advocating for house staff wellness.

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## FROM THE REGIONS

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Our meeting was a huge success. We were able to offer the second annual Midwest Young Scholars Scholarship to one student and one resident and multiple faculty, poster, and oral presentation awards. We

learned, collaborated, and became rejuvenated from all of the inspirational stories and talks. Finally, we could not have accomplished this without our member volunteers who served as abstract reviewers, poster judges,

moderators, meeting participants, committee chairs, and institutional champions.

We look forward to building on the success of this conference as we look forward to 2018!

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## MORNING REPORT

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*approach proved to not be effective for this patient and he was ultimately started on an antidepressant (SSRI), to treat possible bereavement-related depression. It is not clear how effective antidepressants are in treating complicated bereavement in older adults with cognitive impairment, though in this patient, it led to improvement in his symptoms. SSRIs are also the suggested first-line medical treatment for OCD in older adults.<sup>5</sup>*

*Overall, it is important to remember that symptoms of bereavement in older adults with cognitive impairment can be atypical and assessment for bereavement-related depression is indicated in these patients. Behavioral modification intervention should be considered first in the management of bereavement-*

*related obsessive behaviors in older adults with cognitive impairment. While new onset OCD is possible in geriatric aged patients, it is rare in individuals who have not experienced OCD symptoms before.*

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## MEDICAL EDUCATION: PART II

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**Participants:** Surveys were designed and sent to first-year subspecialty fellows (n=49) (cardiology, pulmonology, rheumatology, palliative care, endocrinology, hematology/oncology, nephrology, gastroenterology, infectious disease), all internal medicine residents (n=159), and coinciding subspecialty attendings who had spent at least two weeks on the consult service (n=141) between May and October 2015.

**Key Results:** Response rates for attendings, residents, and fellows were 45% (64 of 141 attendings), 40% (63 of 159 residents), and 84% (41 of 49 fellows) respectively. In general, lack of standardized orientation and lack of teaching about how to write consult notes were reported by more than 60% of all groups. Overall, attendings agreed it was more important to communicate clinical reasoning (mean 4.6, SD 0.8) as compared to evidence (mean 4.1, SD 0.9,  $p=.0001$ ), although both were rated highly. Residents and fellows both communicated clinical reasoning (mean 4.5, SD 0.7) more frequently than evidence (mean 2.5, SD .6,  $p=.0001$ ). From the perspective of the primary team requesting the consult, residents agreed that they value evidence in the note and that they are more likely to follow a consult recommendation if evidence is provided. However, they do not provide evidence in their notes when re-

sponding to consults on their consult electives (Figure 1).

Regarding internal communication on consult services, attendings and fellows felt that residents seldom communicated evidence in notes. Conversely, residents felt they communicated evidence in notes more frequently, about half the time, significantly higher than their supervisor's perceptions ( $p=0.002$ ). Attendings and fellows alike rated "as seldom" that residents provided evidence on rounds without prompting. Attendings and fellows perceived residents communicated clinical reasoning in their notes about half the time compared to residents who rated themselves at almost always ( $p=0.001$ ).

To assess communication of evidence and clinical reasoning between a consulting service and the primary team, we grouped residents and fellows on consults together and did a mean comparison to the primary teams' perception of communication patterns. The combined group consulting team perceived that it communicated clinical reasoning "almost always" (mean 4.5, SD 0.7) compared to the primary team placing the consults perception of "usually" (mean 3.9, SD 0.8,  $p=0.001$ ). Overall communication from the consultant team to the primary team of evidence was "low" (mean 2.5, SD 0.6) and was corroborated by similar low ratings from the primary team

perspective (mean 2.5, SD 0.9).

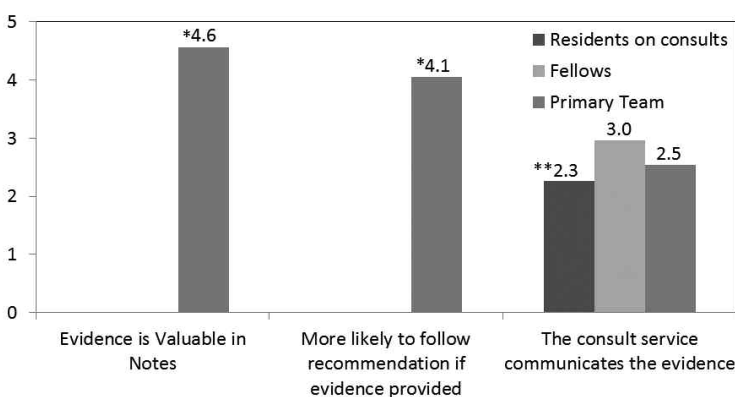
Four EBM promotion categories were generated from the free response questions: improved accountability, the need for expectations on rounds, increased transparency in notes, and development of online shared resources. Ideas proposed included online blogs, shared e-libraries, questions of the day, and to require evidence as part of morning presentations and in the notes.

**Conclusions:** This assessment shows that although EBM and clinical reasoning are deemed important by all groups, communication of evidence on consults is poor and residents have higher self-perceptions of communications skills of CR and evidence as compared to their supervisor's perceptions. In the development curricula for high value consults promoting communication of evidence is clearly a need. This highlights a target for application of the EBM promotion categories to develop future curricular innovations.

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Figure 1: Residents want evidence in consult notes, but when they are on consult electives they don't communicate evidence in their notes:



\* Likert Scale: Strongly disagree (1), disagree (2), neutral (3), agree (4), strongly agree (5).

\*\*Likert Scale: Almost never (1), seldom (2), half the time (3), usually (4), almost always (5).

## PRESIDENT'S COLUMN

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power dynamics stemming from level of training, gender, financial relationships, and hierarchy. We all make mistakes, and hope our colleagues would treat us with kindness and deference if the roles were reversed.

A professional culture that prizes collegial relationships has significant advantages. Medicine is a team sport, and a responsibility to interact respectfully with one another is essential for patient care. As the Hippocratic Oath notes, the medical profession also relies on senior physicians passing their knowledge down to younger colleagues. However, a blind commitment to collegiality has downsides. Most patient complaints cluster around a small number of physicians. In one study, 50% of all complaints against Australian physicians were attributed to just 3% of doctors, with some physicians accumulating more than 10 complaints<sup>3</sup>. How do individual physicians accumulate such a high number of complaints? All of us know which of our colleagues are struggling to interact effectively with patients because they are also having difficulty interacting effectively with us. But rather than stepping forward, we look the other way, hesitating to have a potentially uncomfortable interaction with a colleague. While some training models have been developed to make it easier to communicate against power gradients, such as TeamSTEPPS<sup>4</sup>, speaking up in these situations is not our strong suit<sup>5</sup>.

While speaking up when a colleague is struggling is an important litmus test of the bounds of collegiality, the more pressing need is for us to get better at providing each other with routine feedback. This may be one of the few areas where our surgical colleagues have an advantage. Morbidity and mortality conferences are a valued aspect of surgical culture. Surgical M&Ms reinforce the notion that professionalism includes having frank conversations among peers about breakdowns in quality. Accepted criteria exist for which cases will be discussed at surgical M&M conferences, with all of the

cases meeting these criteria presented and reviewed (such as every surgical site infection or unplanned return to the operating room). Internists might question what can appear to be a blaming tone of the stereotypical surgical M&M conference. Nonetheless, the importance of discussing quality of care and providing each other feedback is more deeply integrated into surgical culture than it is in internal medicine.

If sociologists were to observe internal medicine physicians struggling with whether and how to provide each other with feedback, most would turn to the work of Erving Goffman, and later Penelope Brown and Steven Levinson on *politeness theory*. Goffman wrote, "Just as the member of any group is expected to have self-respect, so also he is expected to sustain a standard of considerateness; he is expected to go to certain lengths to save the feelings and the face of others present, and he is expected to do this willingly and spontaneously because of emotional identification with the others and with their feelings"<sup>6</sup>. *Face*, in Goffman's terms, is "the positive public image you seek to establish in social interactions." Contemporary scholars distinguish between "fellowship face" (the want to be included), "competence face" (the want to have one's abilities respected by others), and "autonomy face" (the want to not be imposed on). Much of politeness theory goes on to describe "face-work"—the behaviors we exhibit during social interactions to maintain, restore, or save face.

How can we focus less on politeness and more on providing feedback to one another? SGIM's membership is fortunate to include national leaders in medical education—individuals to help us understand models of peer feedback developed for the teaching setting and apply them to a broader array of peer discussions. Mookherjee and colleagues highlighted the benefits that peer feedback can have both for the observer and for the feedback recipient, such as promoting collegiality and strengthening the learning envi-

ronment<sup>7</sup>. Most peer feedback models start by asking the subject of the feedback to provide their perspective on the topic at hand, followed by behaviorally anchored feedback including both reinforcing and constructive comments, and a closing that includes reflecting on the feedback and developing a shared approach to moving forward.

There is a range of communication skills that can help these peer feedback discussions go better. When it comes to having difficult discussions with peers about potential breakdowns in the care, it is useful to approach these discussions from a perspective of curiosity (assuming you do not have all the relevant facts) rather than accusation. Pay equal attention to both the information sharing and emotion handling dimensions of these discussions. Yet, most critical may simply be our willingness to not look the other way and take the initiative to have such discussions in the first place.

For SGIM to become a learning organization, we also must do a better job of providing each other with feedback. At present, our mechanisms for soliciting feedback are limited to a periodic member survey, discussions via GIM Connect, and informal feedback via e-mail and hallway meetings. Committees and Task Forces receive bi-annual feedback from Council on their annual plan and progress towards meeting these goals (though the reverse is not true; i.e., Council does not receive formal feedback from Committees or Task Forces about its goals and progress towards meeting them).

How can we start nudging our SGIM culture a little bit away from politeness and more towards feedback and improvement? Ultimately, our obligations towards one another as colleagues, as well as our obligations as members of SGIM, require that we start taking small steps towards making providing such feedback the norm, rather than the exception. I welcome your thoughts about how we can move in this direction.

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## FROM THE SOCIETY

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anyone interested in helping Carol with any of these initiatives to contact her.

Jeff is focusing on increasing the number of systematic reviews *JGIM* publishes. While systematic reviews, when well done, can provide a solid evidence base for clinicians and policy makers, poorly conducted ones can mislead readers. We're offering streamlined two-week reviews for meta-analytic and systematic review submissions. In addition, we hope to publish articles on systematic methods to help readers better understand how to interpret and incorporate and be critical consumers. An upcoming February *JGIM* editorial outlines some common weaknesses in systematic reviews.

*JGIM's* success, however, has not come without some unintended consequences. Recently, the acceptance rate has fallen to less than 9%. We believe this discourages submissions to our journal. In a previous study, we evaluated the outcome of articles that were rejected by *JGIM* and found that articles that were "close" to acceptance had the same impact factor as those that were accepted.<sup>1</sup> In an effort to increase the number of publications, we believe we can accept many of these articles on the cusp with no

deleterious effect on quality. In addition, we're launching a new category of submissions, called the "Concise Research Report." Since many articles don't need a full 3,000 words to make their point, we believe these brief, focused research missives will be attractive to authors as there is no need to delve deeply into the background and discussion and the shorter length will allow for an increase in the number of research articles published in *JGIM*.

Several other ideas include an occasional series on the history of medicine and facilitating the publication of articles from outside the United States by naming "*JGIM* Ambassadors" from countries that currently have significant SGIM membership. Akira Kuriyama has been named a *JGIM* Ambassador to Japan. He will liaise with the Japanese Medical Society to promote *JGIM* and will serve as deputy editor for submissions from Japan; we welcome additional volunteers from Japan and from other regions outside the United States. This will increase the diversity of SGIM and *JGIM* by soliciting international perspectives and articles. We also plan to increase *JGIM's* social media presence; any of our readers who are interested and experienced in

this area would be most welcome to join our team.

We are excited about the next five years, look forward to your help and involvement, and welcome your suggestions. One of our charges is to continue the practice of publishing special issues of *JGIM* and welcome your ideas on supplement topics. We believe the journal belongs to all the members of SGIM and there are a number of ways that members can get involved. Serving as a reviewer and then as a deputy editor is a great way to advance your career by allowing you to give back to the Society and the medical profession. If this or one of our initiatives is of particular interest to you, we strongly encourage you to volunteer. Like SGIM, we believe in a *JGIM* that is inclusive, our journal will be all the better for it. Please send us your ideas on how to improve the journal. We even welcome your criticisms. We're strong, we can take it.

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## HEALTH POLICY

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- coverage limits. Insurance plans should continue to be required to provide access to essential benefits, including laboratory services, mental health and addiction treatment, maternity and newborn care, and ambulatory care.
6. Had more than 60 SGIM members attend our March 13th Hill Day on the day following the introduction to the House of Representatives of the American Health Care Act (AHCA) repeal and replace legislation. Those who attended were among the first healthcare providers to have the opportunity to talk to legislators about the impact of this proposed legislation on our patients.
  7. Sent multiple “call to action” messages to all members and targeted messages to members in key states regarding a series of attempts to “repeal and replace” the ACA.
  8. Sent multiple letters to congressional leaders based on our health insurance principles regarding SGIM’s opposition to these “repeal and replace” efforts.
  9. Signed a multi-society letter indicating SGIM’s opposition to President Trump’s executive order on immigration and visas.
  10. Joined the Medical Consortium on Climate Change and appointed Elizabeth Gillespie as SGIM’s representative to the group.
  11. Submitted a detailed response to a draft Health and Human Services strategic plan. Included in our response was a suggestion to add to the objective to “Expand safe, high-quality healthcare options, and encourage innovation and competition,” the following language:
    - “Develop payment models and incentives to encourage high value, high quality care that are timely, easy to understand and simple to implement, while avoiding additional administrative burden.”
    - “Develop innovations and payment incentives to encourage high value, high quality care, that take into account illness burden and baseline population risk, to preserve patient access to care and avoid punitive effects on providers serving high risk populations.”
  12. Worked with the Board of Regional Leaders and with the scholars in the Leadership in Health Policy (LEAHP) program to encourage submission of advocacy workshops to multiple regional meetings.
  13. Sent a letter to congressional leaders urging them to remove the provision in the Senate’s version of the Tax Reform and Jobs Act of 2017 that would effectively repeal the individual shared responsibility (individual mandate) provision of the ACA because of our concern that elimination of the mandate would result in a significant increase in premiums and create an exodus from individual insurance markets.

This has been an unusually active and important year for SGIM’s health policy activities. I am exceedingly grateful to our health policy committee members and our organization’s leaders for their commitment and efforts necessary to support this level of important health policy activity.

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