

PERSPECTIVE

Being a Generalist and Donor Advocate: Seeing Both Sides of Transplantation

Patrick Hemming, MD, MPH

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Disclaimer: The names of patients as well as certain identifiers have been changed to protect privacy.

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Every Tuesday, I have the good fortune of carrying out two of my favorite patient care responsibilities, making the jump halfway through the day from one end of the chronic disease management spectrum to the other. First, after finishing up a clinic session with my low-income primary care patients in the morning, I pull out of my clinic's parking lot next to the Discount Tire store. Second, 10 minutes later, I am at the expansive Duke Clinics, where I am the independent living donor advocate for individuals seeking to donate a kidney or liver. These two roles are fascinating and rewarding, presenting striking contrasts and similarities.

I knock on the exam room door and enter, seeing a fifty-something-aged woman seated with her husband, his arm draped behind her on the back of her chair.

I shake her hand: "Hi Ms. Brown. It's good to meet you. I'm the donor advocate for our transplant program and I'm going to do your medical evaluation for transplant. I'm also going to ask you some questions about how you decided to pursue becoming a donor. How has the day been so far?"

"Oh, long... but good," she says as she briefly peeks at her husband. The Browns have already been here for 5 hours—attending an educational session and getting labs and radiology tests. I'm the fourth member of the transplant team to interview her this afternoon.

Her husband speaks up, "We drove in from South Carolina last night. We're staying with Angela's sister. At dinner last night, she told us her kidneys are only working about nine percent."

During my visit with the Browns, I have several items to assess. Does she understand the medical risks of donation and how to mitigate them? Is she at increased risk for coercion or false expectations about how the donation may affect herself and her intended recipient? "So, how did you originally find out that your sister needed a kidney?" I ask as I sit down in front of the exam room computer.

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Spring, Rocky Mountains, Reconnection, and Renewal

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

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I love spring. After the winter weather of cold temperatures, snow, ice, and gloom, spring brings us rebirth, rejuvenation, renewal, spring training and “The Meeting”. Robin Williams, the late actor, director, and comedian said it best: *Spring is nature’s way of saying, “Let’s Party.”* I can’t believe that in just one month’s time we will be gathering in Denver, Colorado, for the SGIM 2018 National Meeting. The meeting’s theme is “Health IT: Empowering Generalists to Lead Digital Innovation.” This month’s *Forum* whets our appetite for both the meeting and the theme with an exceptional mixture of articles.

First, Meeting Co-Chairs Lipika Samal and Saul Blecker give us the equivalent of a national meeting pep rally with their overture of the events and activities to be occurring. It looks amazing! I expect that when it’s all over Lipika and Saul will be boasting on the size of the meeting crowd compared to former meetings, and proclaiming it to be the biggest ever. Our “Flashback 40” piece takes us back 20 years when Rick Lofgren, then meeting chair, introduced clinical vignettes, hoping that they would catch on. Avital O’Glasser confirms that they did!

With regard to digital innovation, we have a report from the Clinical Practice Committee to make it easier for clinicians to improve care and to take control of their practice and professional happiness. The report, by Dr. Jim Bailey and his team on the CPC, describes the launch of SGIM’s *ImprovingCare* Web site whose focus is on practice redesign and improving the practice environment for general internal medicine and primary care. It is sure to have an impact on both patients and providers.

Our president, Tom Gallagher, takes on the challenging issue of sexual harassment in SGIM and organizations like ours. He reports on the Society’s important efforts to tackle sexual harassment in academic general internal medicine, including the encouragement of dialogue, clear expectations of our members, and support for those who have been affected. *We must* get this right.

The March issue rounds out with a recap from the Mid-Atlantic’s Regional Meeting, an update on Proud to be GIM, a Morning Report Case that I wouldn’t have believed, and the unique role that one general internist performs in transplantation medicine. Also in this issue, Dr. Denise Valero describes the road that led her to a career in medicine and how she is helping students overcome self-doubts that might arise from the prejudice of others. Finally, speaking of renewal, I mentioned several months ago, after formal and informal feedback from you, that *Forum* will be undergoing a “refresh.” Sooo—drum roll please—appropriately timed with the meeting, we will be introducing *Forum’s* new look next month. We believe the new look will be easier to read and navigate as well as fit in with other SGIM-branded media. I expect lots of you to stop me in the halls of the meeting next month and give me your candid opinion. See you in Denver!

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Sexual Harassment in Academic Medicine: How Should SGIM Respond?

Thomas H. Gallagher, MD, President, SGIM, and Jada Bussey-Jones, MD. Dr. Bussey-Jones is a member of SGIM's Council and is leading a Council work group on sexual harassment (jcbusse@emory.edu).



... academics, in general, and academic general internal medicine, in particular, are areas where the risk for sexual harassment is especially high. Fortunately, SGIM is ideally positioned to address this issue. A high proportion of our members and leaders are women, and we are lucky to have several national thought leaders on this topic amongst our members. A robust response to this critical issue will require we draw heavily on these resources.

We were starting to work our way through the typically packed agenda at our December two-day in-person Council Retreat when one member suggested we try to squeeze an additional topic into the meeting—namely that of sexual harassment in academic medicine and how SGIM should respond. All agreed it was an important topic, and we decided to have an informal discussion about it that night over dinner.

Most of the men on Council likely came to the discussion envisioning that the issue was how SGIM should respond to reports of harassment happening in the public sphere and at other organizations. What we heard instead were raw, personal, painful stories about how sexual harassment is as much an issue in academic medicine as it is elsewhere in society, and perhaps more so, given how the hierarchies in academic medicine can inhibit reporting. Knowing that some data suggests that professional society meetings are environments where sexual harassment is actually more common, we asked Kay Ovington, our deputy CEO who has been with the organization for 20 years, how many times a complaint has been filed relative to sexual harassment at our Annual Meeting. “Never” was the reply.

Several of my columns addressed the key role that culture plays in academic medicine, the importance of transparency, how speaking up about problems is critical yet challenging, how we often shy away from difficult conversations with our peers, and how easy it is to convince ourselves of things that turn out to be false. All of these issues converge when it comes to the topic of sexual harassment in academic general internal medicine. Much as we would like to think otherwise, academics, in general, and academic general internal medicine, in particular, are areas where the risk for sexual harassment is especially high. Fortunately, SGIM is ideally positioned to address this issue. A high proportion of our members and leaders are women, and we are lucky to have several national thought leaders on this topic amongst our members. A robust response to this critical issue will require we draw heavily on these resources.

There are multiple definitions of sexual harassment; for example:

1. “Unwelcome sexual advances, requests for sexual favors and other verbal or physical contact of a sexual nature that tends to create a hostile or offensive work environment.”¹

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The SGIM *Forum* is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM *Forum* is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Phuong Nguyen (ptnnguyen@gmail.com).

2. “Harassment is any form of unwanted or unwelcome attention that invades the physical and emotional spaces of others in a way that is frightening, insulting or disrespectful.”²

Sexual harassment is a form of discrimination prohibited under title VII of the Civil Rights Act of 1964 and Title IX of the Educational Amendments of 1972, which affect any federally funded education program or activity.³

The epidemiology of sexual harassment in academic medicine is disturbing. As summarized by lead author and SGIM luminary Carol Bates in her article “It is time for zero tolerance for sexual harassment

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Clinical Vignettes Debuted, and Still Displayed, at the SGIM Annual Meeting

Avital O'Glasser, MD, FACP, FHM

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Next month at the 2018 Annual SGIM meeting, scientific abstracts and clinical vignettes across multiple categories will be presented in poster and oral form. SGIM, JGIM, and SGIM Forum have a long tradition of promoting clinical vignette writing and dissemination, particularly as a means to promote case-based education, scholarship, and mentoring relationships.

As such, you may be interested to know that clinical vignettes first debuted at the 1997 Annual Meeting, joining scientific abstracts as a forum for learning and sharing. In digging through the *Forum* vaults for this month's #FlashBackForty, I found the October 1996 article reprinted here.¹

From the inception, the aim was to present "generally informative" rather than "showcasing rare or bizarre cases", with emphasis on the important role of the clinician-educator within the Society. A select number of cases would be selected for oral presentations—six oral selections were anticipated this first year.

Any #FBF would be static with just one article uncovered and shared. So, like a general medicine physician combing the EHR for clues and meaningfully useful information, I kept digging.

Alas, the July 1997 *Forum* article reflecting on the meeting, written by the one and only Dr. Elnora Rhodes, does not provide comments on how

this new experience went or the number of clinical vignettes presented.² However, the November 1997 *Forum* piece reviewing meeting evaluations noted, "The overwhelming majority of attendees felt that the clinical vignettes should be continued at future meetings."³

Indeed, the clinical vignette portion of the Annual Meeting took hold and took off in the coming years. In 1998, 40 oral clinical vignettes and 210 posters (includes clinical vignettes and scientific abstracts) were presented.⁴ After the 1998 Annual Meeting and in advance of the 1999 Annual Meeting, Dr. Eileen Reynolds reflected, "Feedback from last year's

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Clinical Vignettes Will Debut at the National Meeting

—Richard P. Lofgren

In the tradition of case-based learning, a new segment will be introduced during the 1997 National Meeting—the clinical vignette presentation. Our intent is to enhance the clinical program by creating a forum where members can present interesting and challenging cases that highlight important management and diagnostic points. It is expected that the vignettes will be generally informative, not showcasing rare or bizarre cases.

The goals of the clinical vignette presentations are to: 1) expand the clinical content of the national meeting and 2) further capture the interest of an important segment of the Society, the clinician-educator. Hopefully, the clinical vignettes will provide a greater opportunity for SGIM members to participate in the national meeting, by sharing their extensive knowledge of clinical medicine with

their peers and colleagues. Such presentations will provide tangible evidence of their scholarly activity and serve as a catalyst for greater "networking" of persons with similar clinical interests. In the process, we hope new and less active members will become more involved with our meeting and Society.

A "call for clinical vignettes" was included with a recent mailing requesting abstract and workshop submissions. Any SGIM member or associate member is encouraged to submit a clinical vignette for review, using the standard submission form (available from the SGIM office). Authors are required to provide a brief summary of an illustrative case and clearly state the primary teaching point(s). They may include one or two brief sentences of discussion at the conclusion of the case presentation. The submissions will undergo peer review similar to the abstract selection process. The vignettes will be rated as to the clarity of the presentation, the importance of the

teaching point and its application to clinical practice, and general interest of the subject matter.

A certain number of clinical vignettes will be selected for oral presentation at the national meeting. The number of presentations will depend upon interest, number of submissions, and available space. The presentation will follow the same general format used for abstract presentations. It is anticipated that the authors will spend about 5 minutes summarizing the case, followed by a 5-minute discussion highlighting the major teaching point and a review and synthesis of the pertinent literature, and finally, 5 minutes of questions and comment. Hence, during a 90 minute session, there will be six clinical vignette presentations, presumably covering a variety of topics.

Though cautiously optimistic about the debut of the clinical vignette, we are very excited about this new endeavor, hoping it will add to the vitality of the meeting and broaden the participation of our membership.

Culture, Collaboration, and Trust: 2017 Mid-Atlantic Regional Meeting

Jennifer Goldstein, MD, MSc, Jennifer Kraschnewski, MD, MPH, and April Fitzgerald, MD, MEHP

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The Mid-Atlantic (MIDA) region encompasses Delaware, Maryland, New York, New Jersey, Pennsylvania, Puerto Rico, and Washington, D.C. The regional conference historically had been held each year in March, but the 2017 meeting was moved from spring to fall in order to more evenly distribute the regional meeting workload for SGIM staff. In advance of the meeting, the MIDA region held a trainee Proud-to-BE-GIM (PTBGIM) event at Temple University on September 16th, 2017, and the first MIDA fall meeting was held at Christiana Care Health System in Delaware on November 10, 2017. It was a huge success!

This year's Mid-Atlantic theme of "Culture, Collaboration, and Trust" resonated throughout the day's keynote speakers, workshops, and presentations as nearly 170 members gathered in Delaware. Dr. April Fitzgerald opened the meeting, and Dr. Eric Bass shared his vision and commitment as SGIM's new CEO: "I'll always be one email away." Dr. LeRoi Hicks, chairman of medicine at Christiana Care, provided a warm welcome, including sharing his personal journey in medicine and his institution's value of "love," resonating with the meeting's important theme.

Replacing the typical keynote presentation, this year's leadership selected three outstanding presenters to give TED-style MED-talks. The resultant 18-minute presentations focused on each of the areas of the meeting's theme. Mandy O'Neill, PhD, assistant professor of business administration at George Mason University, gave a fascinating presentation on the critical role culture plays within an institution. She shared two key examples that highlighted how a

culture of love has led one healthcare system to have higher quality care, and how the opposite can be detrimental to institutional success. "How we treat each other is as important [to healthcare outcomes] as how we treat our patients," Dr. O'Neill opined.

Dr. Shreya Kangovi, executive director of the Penn Center for Community Health Workers, shared stories of success from her work with collaborative teams in Philadelphia. By engaging community health workers in clinical care, her team has experienced tremendous impact on patients who need assistance outside of the typical clinical encounter. One impactful story highlighted a community health worker's commitment to a patient that resulted in her taking him bowling, the activity he was doing when he last remembered really laughing. This patient's story and the impact the community health worker had on his quality of life was, admittedly, magical. However, Dr. Kangovi challenged us, "How do we do magic in healthcare with consistency? What are the ingredients for success? What is the recipe?" Her presentation highlighted how it truly takes a village to care for our patients.

The third and final MED-talk presentation was given by Dr. Paul Haidet, director of medical education research at Penn State College of Medicine, who spoke on the topic of trust. Dr. Haidet's integration of jazz music to exemplify collaboration beautifully illustrated the topic of trust, which can be challenging to navigate in medicine: "This is a story about interprofessionalism... and this is a story of trust. Power is not a zero-sum game. Flattening hierarchies elevates the power of all." Dr. Haidet concluded, "Trust is not an

antidote for failure... but it ensures we do not fail alone." The silence across the auditorium at the conclusion of his talk demonstrated the impact of these effective presentations on the members in attendance.

Our MED-talks were followed by the first poster presentation session. Poster presentations were divided into two sessions over the course of the day to maximize space available for posters and minimize poster board requirements. The first session highlighted clinical vignettes and medical innovations. The second session highlighted clinical vignettes and scientific abstracts. This year we had poster judges pilot online (as opposed to paper-based) judging forms, minimizing the number crunching to determine poster winners at the end of the day.

Two workshop sessions (morning and afternoon) were held to provide attendees an opportunity to advance their knowledge and skills in mentorship, health equity, interprofessional teamwork, and even hands-on skill development in ultrasound-guided IV access. Another innovation at this year's meeting was the pairing of the Regional Associate Members with the National Proud to Be GIM (PTBGIM) Members for a Story Slam over the lunch hour. Members in attendance witnessed raw and powerful stories about why being a generalist is one of the most challenging, yet rewarding, careers in medicine.

The afternoon concluded with oral presentations followed by the MIDA Business Meeting, Awards Presentations, and announcement of newly elected officers. Finally, Dr. Fitzgerald officially passed the MIDA

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You Can't Escape Your Past: The Challenges of Evaluating a Nonagenarian

Rachel Ombres MD, Christina Tieu, MD

Dr. Ombres (RO2Z@hscmail.mcc.virginia.edu) is an internist and assistant professor of medicine with the Division of General Medicine, Geriatrics, and Palliative Care, University of Virginia, Charlottesville, VA. Dr. Tieu (CT7QF@hscmail.mcc.virginia.edu) is a geriatrician and assistant professor of medicine at the same institution. (The discussant's comments are in italics.)

Mr. D is a 90-year-old man in an independent living community who presented to his primary care physician with weight loss. His medical history is notable for prostate cancer treated with radiation in 2004, atrial fibrillation, ischemic colitis status post partial colectomy, and an abdominal aortic aneurysm (AAA) status post an open infrarenal repair twenty years ago. Over three months, he lost 15 pounds in the setting of a poor appetite.

Clinically significant weight loss is often defined as a loss of 10 pounds or > 5% of usual body weight over a 6 to 12-month period. In older adults, the prevalence of unintentional weight loss ranges between 8-27% depending on comorbidities and is independently associated with an increased all-cause mortality.^{1,2} Poor nutrition and weight loss in older adults can arise from acute and chronic illnesses, as well as other unique risk factors such as cognitive dysfunction, functional limitations, poor dentition, medications, social isolation, frailty syndrome, and depression.¹ While a thorough geriatric assessment includes examination of these risk factors, the patient in this case meets criteria for clinically important unintentional weight loss and should be assessed for serious underlying pathology.

At this patient's first visit, a review of systems was negative for fever, chills, night sweats, abdominal pain, nausea, vomiting, or changes in bowel movements. His vital signs were normal and his weight was 125 pounds (BMI 17 kg/m²). On exam, he had moist mucus membranes, regular heart rate with an irregular rhythm, and no audible murmur. Pulmonary auscultation revealed normal breath sounds and abdominal exam showed a protruding rib cage but no tenderness, palpable masses, or distention. He did not have peripheral edema, rash, or adenopathy. Neurologic exam was unremarkable. He was alert and oriented and denied mood disturbances.

Clinically significant involuntary weight loss is most commonly due



CT of abdomen/pelvis with contrast shows postsurgical changes of surgical repair of infrarenal abdominal aortic aneurysm with widely patent aortobiliac surgical graft. Aneurysm sac contains large amount of fluid and gas. There is a defect of the anterior aspect of the aneurysm sac with fistulation to the adjacent D4 duodenal segment and surrounding fat stranding.

to an organ-related failure, chronic infections, and malignancies.¹ Because this patient has a nonspecific presentation, proceeding with comprehensive blood testing is generally recommended, including tests for inflammation (ESR, CRP) and chronic disease (CBC, CMP, TSH, cortisol). Tumor markers are generally not initially recommended. However, in a patient with a history of malignancy such as in this case, a PSA would also be appropriate.

Basic labs were obtained including a CBC, BMP, TSH, PSA, cortisol, CRP, ESR, LDH and ANA. Results were remarkable for ESR 38 mm/h and CRP 6.8 mg/dL.

Inflammatory markers are non-specific and, when elevated, require further history gathering, specifically addressing risk factors for chronic infection, malignancy, and autoimmune conditions.

One week later, Mr. D returned to clinic for reassessment. His wife reported the new development of fever of 101-102 degrees °F for the past five days. No other new symptoms had arisen. A travel history noted a trip to Boston, MA, four months ago, but otherwise Mr. D and his wife spent the majority of time at their home in a metropolitan area of VA. Exposure history, includ-

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SGIM PTBGIM Campaign Continues to Spread

D. Rani Nandiwada MD MS, Brian Uthlaut MD, and Nilan Schnure, MD

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The need to attract and train more physicians interested in practicing general internal medicine (GIM) increases. In 2015, SGIM created the Proud to Be General Internal Medicine (PTBGIM) committee as an effort to increase awareness about the flexibility and scope of GIM as a career choice for medical students and residents. A 2016 study in the *Journal of General Internal Medicine* by Long et al, indicated that residents do not choose a career in GIM due to concerns about inability to address patient's social needs, burnout, need for mentorship, and lack of exposure to dedicated outpatient experiences.¹ The PTBGIM campaign is working to battle these challenges through a series of grants to institutions, ranging in spectrum of size and scope, to help promote a culture of pride and awareness about GIM careers and opportunities. This past year PTBGIM has grown from sponsoring six institutions in 2015 to 20 institutions. In addition, a social media Tweet Storm #ProudtobeGIM was instituted for the first annual PTBGIM week starting January 23, 2017. With the help of Fenton marketing, a set of infograms was developed after focus group interviews and disseminated as part of the campaign highlighting the diversity and strengths of a career in GIM. Feedback from institutions that were awarded grant funds revealed an increased number of students and residents attending the national conference as well as a reinvigorated faculty cohort that were #ProudtobeGIM.

This past year, through grant funding, we supported events that reached out to more than 1,500 students, residents, and faculty nationwide. Supported institutions were

asked to use the material developed by the campaign and available on the SGIM Web site, including our #ProudtobeGIM video, supplemental slide decks, and infograms. In addition, institutions were encouraged to create a social media presence on twitter and Facebook. There was a huge diversity in event types with some institutions holding a single large event with career panels and story slams, while others devoted a full week to smaller events targeting diverse groups. The University of Texas Southwestern had the highest participation rate with more than 300 attendees for a week-long set of events with each day highlighting a different GIM career "phenotype." Oregon Health Sciences University hosted more than 200 attendees at a local event space where GIM faculty and trainees shared their own live music, story-telling, art work and their love for their career choice. Three grants funded highly rated "speed dating" events where trainees briefly met and talked one on one with GIM faculty who were in different career paths. Other groups held lunch events with TED style or table topic talks and several groups headed to micro-breweries and happy hours for interactive guided networking events.

To highlight the impact of these events, we have included a perspective piece from a new intern whose pivotal moment of choosing a career in GIM was impacted by the University of Pennsylvania's Primary Care Story Slam:

"A Pivotal Moment":

"I attended a 'Proud to be General Internal Medicine' story slam as a fourth-year medical student without a perfect sense of who I was or

what I should be proud of. True, I had some idea after completing residency interviews, but I felt uninspired. My inclination towards primary care had become a pro/con list. I was being too rational, trying to anticipate future needs of a career still in its infancy.

And so I found myself in a small conference room with an intimate crowd and few pretenses that this event would provide any more clarity than countless hospital tours and PowerPoint presentations had. The gathered residents and attending physicians soon launched into their short personal stories—the moment when they realized that this was the career for them, or the interactions that lent meaning to their daily challenges. Some were drawn from patients they had cared for since their days as a resident. Many were uplifting, a few evoked tears, and a surprising number set at funerals had both effects.

The focus was always a relationship, or a person, rather than any dramatic moment, and illuminated not just the nature of their work but also the character of those involved. Each story highlighted why that physician was proud to be in primary care—not why they wanted ME to do primary care. In hindsight, the power of the event lay in the realization that everyone had volunteered their evenings to relive these experiences that sustained them, not just for my benefit, but for all of theirs. I walked home with other primary care-bound classmates as we spiritedly debriefed. We had all witnessed how rewarding and meaningful such a career could be.

I tweaked my rank list that night for the final time.

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ImprovingCare Web Site Launched: Providing Access to Top Practice Improvement Resources Nationwide

Jim Bailey, MD, MPH, Baldeep Singh, MD, Suneet Dullet, MD, and Calie Santana, MD, MHS

Dr. Bailey (jeb@uthsc.edu), professor and director, Center for Health System Improvement, University of Tennessee Health Science Center, is chair of the Clinical Practice Committee (CPC). Dr. Singh (bdsingh@stanford.edu), clinical professor and clinical chief, Stanford Internal Medicine is chair of the CPC Practice Redesign Workgroup. Drs. Dullet (suneetdullet@gmail.com), assistant professor in internal medicine, University of South Alabama, Santana (csantana@westmedgroup.com), medical director, WESTMED Practice Partners, and Singh are SGIM ImprovingCare resource page editors for Quality and Safety, Improving Practice Finance, and Practice Redesign, respectively.

After more than 3 years of planning and hard work, we are proud to announce the launch of a new resource—www.SGIM.org/ImprovingCare—to help primary care physicians nationwide readily find the best practice improvement resources available. This initiative was born of the SGIM Council's encouragement to the Clinical Practice Committee (CPC) in June 2015 to make its primary focus practice redesign and improving the practice environment for general internal medicine and primary care. The Council asked the CPC to lead SGIM's efforts to support our members' work to transform primary care practices nationwide. It wanted us to help reposition SGIM as a national leader in practice redesign by doing more to reach out, engage, and support our members in ways that would help it lead local, regional, and national efforts to both improve ambulatory care, reduce physician burnout, and bring back joy in practice for primary care physicians.

We talked to our members to find out what support they needed most through key informant interviews, brainstorming sessions of CPC members, and surveys. Drs. Jennifer Mackinnon, Scott Joy, and Reena Gupta surveyed members about their practice improvement resource needs and found that our members were particularly interested in information about team-based care, care coordination, and the patient-centered medical home. But sadly, members reported that they were unlikely to look to SGIM.org for that information; when they did, helpful information was hard to find. SGIM members said that they would particularly like to see links to best re-

sources, evidence-based summaries, PowerPoint presentations, and practice improvement modules on SGIM.org. Our members told us that they needed direction to trusted resources for practice improvement to help them advocate for and effect real changes in their work environments. We heard that for general internists to find joy in practice it was most critical for them to be able to provide better care to their patients.

Thus, the idea of www.SGIM.org/ImprovingCare was born. The CPC knew that SGIM's greatest resource is its members. Our members are among the national leaders in evidence-based primary care; therefore, we knew our members could identify the best and most relevant information for general internists and other primary care providers working to transform care. All we really needed to do was get our own SGIM experts to contribute their favorite links, content, and workshop materials in order to have some great content. We went to work!

We quickly identified Practice Redesign, Quality and Safety, and Improving Practice Finances as general topics of the highest interest to our members. Through the leadership of the CPC's Quality and Safety Subcommittee, Practice Redesign Workgroup, and Improving Practice Finance Workgroup, we identified SGIM volunteer editors, associate editors, and resident editors to gather, curate, and edit content for the following three main SGIM Improving Care resource pages:

1. Practice Redesign Resources.

Designed to help practicing community and academic

internists find the best communities, resources, and quick links needed to help primary care practice leaders redesign their practice or resident practice. We chose to divide the Web page in the key categories that have driven practice redesign in Primary Care over the past few years including seminal concepts such as the Patient-Centered Medical Home, Team Based Care, Quadruple Aim, and Care for High-need, High-cost Patients. Each topic has been carefully designed to present the key articles that have been ground breaking in each of these areas, as well as key links to videos and toolkits. Given our mission of collaboration, we also have tried very hard to link much of our content to our partners at the AMA (www.StepForward.org), IHI, and the ACP. Since many of our members lead internal medicine residency training programs, we have emphasized content focused on the redesign of resident ambulatory clinics. If you would like to contribute to the resource page, please contact the page Editor, Baldeep Singh, MD at bdsingh@stanford.edu.

2. Quality and Patient Safety Resources.

Designed to give primary care physicians easy access to key quality improvement and patient safety resources and help them provide safe, effective, patient-centered, and equitable care to all the patients they serve. Quality improvement and patient safety plays an integral role in healthcare

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No Time to Waste

Denise Valero, MD

Dr. Valero (denise_valero@rush.edu) is a third-year internal medicine resident at Rush University Medical Center. She received her bachelor's degree in biological sciences from the University of Chicago and her medical degree from the University of Illinois at Chicago College of Medicine.

When I was asked to be a part of a panel to meet with 150 high school seniors from various backgrounds getting ready to start college, I wasn't sure what message I would convey. Many of these students were first-generation Americans and would be the first in their family to even think about pursuing a college degree. Most of these students expressed fear and anxiety that not all students embarking on the road to college experience. I understood their apprehensions and I felt I needed to relay to them my personal experiences. My lessons were learned the hard way, and I wanted to protect these students so they wouldn't have to waste their time on losing confidence as I often had. I just knew that whatever words came out at the podium, they would have to serve the purpose of helping these students stand in a more self-confident position than when I first started college.

Gaps exist not only in the number of minorities that enroll in postsecondary programs in comparison to the general American population but also in the percentage of how many of these individuals actually attain their degrees.¹ According to the National Student Clearinghouse Research Center and the United States Department of Education Office for Civil Rights, only about 20% of Latino Americans complete postsecondary programs.^{2,3} Part of the problems lie in the lack of support in the university setting and from equity discrepancies that are present in elementary and secondary education.⁴ I did not need to remind these high school seniors of the hindrances that contribute to this low percentage—they had first-

hand experience of economic challenges and lack of resources like adequate facilities and mentors. I did need to speak to them about the power that they possess to attain their goals despite their backgrounds, how people would underestimate them, and what they would be told they could or could not accomplish.

I am first generation Mexican American, and I grew up in a modest home in the South Side of Chicago. My parents came from humble means and had the limited opportunities that a sixth-grade education could grant them. When my parents immigrated to the United States in the 1970s, their ultimate goal was to ensure that their kids would attain an advanced education. It is with that mindset that they labored from dawn to dusk in the central California vineyards and orange orchards. It is that hard work ethic they instilled in my siblings and me that led us to achieve the ultimate American dream. My parents, who were regarded as just two field laborers, produced a registered nurse, a mechanical engineer, and two medical doctors. Despite our achievements, too many times we have been underestimated. Some awkward encounters were easier to laugh off, like when my dad was confused for being the gardener while mowing the lawn on our new home in the suburbs. Other incidents, however, were nothing short of exasperating, such as being asked whether or not I'm actually a doctor by strangers at social gatherings or being asked if I'm a legal citizen by a patient.

I have never been embarrassed of my upbringing and have always believed that I could achieve anything. Yet multiple times throughout

my education I have been made to feel inferior by my supervisors. For instance, a college advisor once stated to me that I would be accepted into medical school because institutions were being "paid" to accept poor Hispanic students like me. She failed to recognize my academic merit. On another occasion, an attending physician was visibly surprised that I could "speak well," given that English was a second language for me and I had a Chicago public school education. I have to admit that I have wasted time replaying these events in my mind and have let myself fall into self-doubt. Over the years, I have learned to let go of prejudice's effect on me. I remind myself that in the end I am the one that determines my fate.

When I spoke at the panel, I informed the students that there is simply no time for thoughts that will inevitably lead to doubting one's capabilities. I encouraged them to instead spend their time and energy on working towards their goals with complete dedication knowing that they had worked hard to deserve the opportunities that were being granted to them.

Whether or not we are the first in the family to attend college or whether or not the communities we live in will have faith in us, we must *never* let that hold us back or alter our self-image and worth. Whether we believe we can or cannot achieve a goal, we are right.

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PERSPECTIVE

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“Well, her husband was posting about it on Facebook, and I decided I had to call her. Her husband is a mess...” Her forehead creases. She tells me doesn’t speak to her brother-in-law, whom she blames for her sister’s poor health, and it was only in the last year that the two sisters reconnected. She worries that after the donation, her sister may continue her unhealthy choices. “What happens if *that* kidney stops working?” she wonders.

In addition to answering her questions, I have my own questions to answer during the visit. Is she psychologically well enough to take the risk of donation? Has she adequately explored how this might impact her job, her financial well-being and the people who may depend on her? Given her concerns, I may need to continue to counsel with her through the donation process. I give her my business card with an invitation to stay in contact with me with any questions along the way.

Coming from General Internal Medicine, I am somewhat atypical in the role of donor advocate, a task which is often performed by nurses or social workers. I have this role because of the efforts of my division chief to improve collaboration with Duke’s division of nephrology and transplant center. Each transplant center in the United States is required to have a donor advocate who is independent of the recipient’s care team. The donor advocate visits with every individual who is being considered for living donation, a process which results in about 6,000 living donations yearly.¹ Fewer than one-fifth of the people who make it to the donor evaluation clinic eventually become donors, so the advocate’s evaluation is an important part of narrowing the list. While striving to adequately assess the risk of each donor, my primary care experiences remind me repeatedly of the patients that I care for with renal failure who do not receive a transplant.

Earlier this morning in primary care, I saw Ruth McCammon. She is 66 years old and has been on dialysis

for about 18 months now after having first arrived at the hospital struggling to breathe, her chest and legs swollen with fluid. She still does not have an arteriovenous fistula for dialysis due to some medical mishaps as well as her fear of the procedure.

Ms. McCammon came to her visit via paratransit van service. She gives a weary smile as I enter. “The bus came late, but I was out there early.” I look out the window. It’s a cold winter morning. “I was talking with my neighbor, John, and he said the nicest thing to me,” she beams. “He said: ‘Ruth, I want to give you a kidney.’ He’s as old as me. I said to him ‘Nobody’s ever offered that to me, but you need to keep both your kidneys.’” Ms. McCammon’s grown children apparently never offered to donate to her.

Like her, many of my patients on dialysis have multiple reasons why they have not received a transplant: Some are elderly, and many do not have family who would be able or willing to donate. They come from racial minorities that are under-represented in the pool of living organ donors.² Finally, many of them are impoverished, with limited support structures in place. My management often consists of coordinating transportation concerns, reconciling medications with the pharmacy, and responding to requests for help from overburdened family members and caregivers. I don’t know if her providers even discussed transplant when she started dialysis given that they were managing repeated exacerbations related to her emphysema and diabetes. At the same time, Ms. McCammon was navigating an unstable housing situation.

In my two roles as a primary care physician and as a donor advocate, I need to understand the context of these two patients’ lives in their care. As a primary care provider, maybe I can be the one who helps Ms. McCammon see new possibilities—such as transplant or even just an arteriovenous fistula placement—for her end-stage renal disease. As a donor advocate,

I can help Ms. Brown sort out the ambivalence she feels about donation so that she can come to a decision that she will be able to look back on with a sense of peace. Understanding the medical facts is essential, but that’s only a small part of these complex discussions.

This larger picture includes understanding and recognizing both barriers and patients’ unique strengths and assets. Like Ms. Brown, transplant donors come from many miles away, often crossing state borders. The stories that they share are admirable, taking significant (and sometimes expensive) detours from their own busy lives to undergo medical testing and procedures that have no direct benefit to themselves. In each case, a prospective donor is making his/her valuable contribution to the wellbeing of another person. In thinking about Ms. McCammon and other primary care patients with renal failure, I try to understand how it is that they cope with the grinding experiences of managing end-stage renal disease. When I speak to her about getting a fistula for dialysis, her eyes flash and she crosses her arms. “No,” she says. She is understandably wary of procedures that she does not understand. Her strong sense of agency—frustrating to me in the moment—could be a valuable asset if she were to become a self-advocate for receiving a renal transplant. I believe that I can help both patients channel these existing strengths.

Being a primary care provider and a living donor advocate puts me at opposite bookends of the medical experience. As general internists, we are constantly trying to look beyond the surface of our patients’ stories in order to troubleshoot the barriers they face and help them utilize their strengths. This perspective is often different from our subspecialist colleagues and will add value as we forge clinical and research partnerships with our transplant centers. Chronic renal failure is increasingly a fact of life in our society.

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PERSPECTIVE

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Let's find new ways to contribute and collaborate. Rewarding opportunities await us.

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FLASHBACK 40

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meeting included, 'Vignettes remained the highlight,' and 'Quality of presentation and range of subject matter were excellent.'"⁵

By the time it came to announce calls for abstracts for the 2000 meeting, the number of "Submissions [had] more than doubled in number each year since their introduction."⁶ The 2000 meeting also introduced the "unknown clinical vignette" session, during which three top-ranked vignettes, chosen for their "content and mystery" were delivered in an audience participation manner to delve into the differential diagnoses.⁶ More than 200 vignettes were submitted for the 2001 Annual Meeting, the fifth meeting to feature them.⁷

The "cautiously optimistic" introducers of the clinical vignette portion of the Annual Meeting had every right to be "very excited" about its potential. More than twenty years later, this endeavor has continued to bring hundreds of engaged learners,

especially trainees, to this forum for learning, scholarship, and discussion. Scientific abstracts and clinical vignette abstracts across dozens of subcategories continue to be accepted, with "Innovations in Clinical Practice" and "Innovations in Medical Education" other currently accepted categories of submissions. SGIM now receives approximately 700-800 clinical vignette submissions annually, with the number of vignettes now exceeding the number of scientific abstracts for the last three years in a row. While it is too late to submit for next month's Annual Meeting, we hope that you will strongly consider submitting or encouraging your learners to submit to the 2019 Annual Meeting.

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MORNING REPORT

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ing history of environmental toxins and exposure to exotic or atypical infections was remarkable only for time spent in the U.S. Navy stationed in Western Europe 70 years ago.

The presence of a fever in an older adult is especially significant. As one ages, the physiologic ability to mount a fever may be attenuated. One study of 320 hospitalized patients with pneumonia confirmed an inverse relationship between body temperature and age.³ On average, there is at least a 1 °C difference in

temperature between 20-year-old patients and 80-year-old patients, making the presence of such a high temperature in this 90 year old man quite remarkable.³ In many cases, a fever in older persons may represent common infectious and noninfectious etiologies. However, the geriatric provider must also consider that older adults often present atypically with typical illnesses (such as endocarditis, intra-abdominal abscesses, and hyperthyroidism), and less common etiologies may be more common in this

age group (such as tuberculosis and temporal arteritis).⁴ This patient's recurrent fever, nonspecific history and exam findings, and elevated inflammatory markers should prompt the collection of blood cultures, computed tomography (CT) imaging, and a PPD to screen for tuberculosis especially given his history in the military.

Blood cultures, repeat ESR and CRP were obtained, as well as a transthoracic echocardiogram (TTE) to evaluate for endocarditis and CT

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FROM THE REGIONS

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gavel to Dr. Rosemarie Conigliaro, our 2018 Regional President.

As your former Mid-Atlantic Regional Leadership, we thank the region membership for their engagement and entrusting us to lead you over the past year. We would like to thank the regional leadership, volunteers, and committee chairs who made the day a success, including

Ms. Gina Spear, SGIM meeting manager; Dr. Lauren Hogshire, MIDA membership chair; Drs. Ricardo Correa and Tina Gupta; MIDA associate members; Dr. Ro Conigliaro and Dr. Mariecel Pilapil, 2018 MIDA officers; Dr. Rhea Powell, Dr. Tom Radomski, Dr. Cherinne Arundel, Dr. Sreekala Raghavan, Dr. Frank Cacace, Dr. Nancy LaVine, Dr.

Amar Kohli, Dr. Monica Yepes-Rios, and Dr. Manasa Ayyala, meeting committee chairs.

Best wishes to our new leadership, and we hope to see you at the Mid-Atlantic 2018 meeting scheduled for November 9, 2018, at the College of Saint Elizabeth, 2 Convent Road, Morristown, New Jersey!

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MORNING REPORT

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of chest and abdomen to search for occult infection or malignancy. Within two weeks, the patient's CRP had increased from 6.8 to 26.7 mg/dL. TTE did not show any significant valvular abnormalities, abscesses or vegetations. CT of the chest and abdomen (see figure on page 6) revealed findings.

Secondary aortoenteric fistulas are a rare but serious complication of abdominal vascular surgery. The annual incidence after elective and emergency procedures is 1% and 14% respectively.⁵ Mortality ranges between 30-60% with surgical treatment and 100% without.⁶ Median time between primary surgery to fistulation is approximately two years, although 1/3 of cases occurs five years or more after primary surgery. Most often, patients present with GI bleeding, abdominal pain, and shock.⁵ In this case, the patient presented only with weight loss and fever. He does have a history of prior AAA surgery, which puts him at risk for aortoenteric fistulation.

Vascular surgery was consulted and the patient was directly admitted to the hospital. Blood cultures grew Strep Anginosus and he was started on vancomycin and piperacillin-tazobactam. Treatment options including surgical vascular reconstruction with an extra-anatomic bypass and graft explant or lifelong antibiotics were offered.

This patient's age and comorbidities place him at high risk for perioperative complications should he pursue surgical reconstruction. In this case, it is essential to explore with him and

his family their understanding of his illness and expected treatment outcomes. Only after understanding their values and the goals for his care can the most appropriate treatment plan be recommended.

After discussing the potential risks and benefits of surgical reconstruction, Mr. D chose to pursue lifelong antibiotics in order to spend his remaining time with his family and avoid a prolonged hospitalization. He was prescribed levofloxacin, metronidazole, and amoxicillin and discharged home with his wife.

This is a case of a 90-year-old man with an atypical presentation of an unusual but potentially devastating complication of a remote surgery. It is common for older patients to present with vague, non-focal symptoms such as malaise and weight changes. Although a majority of these cases are due to non life-threatening etiologies, a high index of suspicion for infectious, autoimmune, and malignant diagnoses must be maintained. The clinician's dilemma is in avoiding costly, unnecessary testing in patients with non-life-threatening etiologies, while ensuring that those with conditions associated with high mortality and morbidity are diagnosed promptly, all within the appropriate context of a patient's and family's overall goals of care. Frequent follow up visits, efficient communication between the clinician and the patient's family or care providers, and high-quality patient education can help facilitate a prompt diagnosis.

This case also demonstrates the

importance of considering surgical complications in the differential of a targeted geriatric evaluation. Internists must be aware of their geriatric patients' surgical histories and potential post-operative complications, regardless of how long ago the surgery was performed.

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SGIM

PRESIDENT'S COLUMN

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in academic medicine," 52% of female faculty in academic medicine in 1995 reported they had personally experienced sexual harassment.⁴ Multiple other studies have suggested that roughly 1/3 of medical students and residents report having experienced sexual harassment. Thirty percent of women in a national survey of NIH Career Development grant awardees described being sexually harassed. A relatively small proportion of those who described having experienced sexual harassment had formally reported it. Prior work has also shown that workplace discrimination is associated with increased job turnover, career dissatisfaction, and contemplation of career change. Further, there are also well documented inequities in achievement and promotion in academic medicine.

Sexual harassment is a special problem in academic medicine largely because of its intensely hierarchical culture, a culture that is deeply entrenched.⁵ These hierarchies not only increase the probability of sexual harassment taking place but also severely dampen the likelihood of reporting these episodes due to legitimate fear of retribution which, in turn, impacts opportunities for career advancement and reputation. As Eileen Reynolds noted in her thoughtful *Forum* President's Column in October 2016 and her keynote presentation "Equity and Transparency in Leadership" at the ACLGIM retreat this fall, the reminders of this culture are simultaneously subtle and pervasive, ranging from a disproportionate number of male leader photos displayed on institutional walls to disproportionate use of first names of women faculty presenters. These and other examples suggest ongoing efforts are required to reach true equity and inclusion across academia.

The national response to the topic of sexual harassment has been swift and robust. Multiple organizations have published position papers and articulating codes of conduct and

zero tolerance policies. The National Academy of Medicine is undertaking a study on this topic, with a report due out in mid-2018. The National Science Foundation is considering framing sexual harassment as a form of scientific misconduct.

Academic meetings present a risk, and were labeled a "Danger zone" in a recent *Scientific American* article "Confronting sexual harassment and science"² The combination of being away from home, multiple social events involving alcohol, easy access to hotel rooms, and attendance at meetings by subordinates and superiors increases the risk of sexual harassment. Multiple high-profile episodes of harassment taking place at scientific meetings have been published, but no rigorous population-based data exists regarding the prevalence of sexual harassment at academic meetings. Some organizations are responding by developing formal programs to prevent sexual harassment at academic meetings, asking attendees and speakers to sign codes of conduct, and providing training to session chairs and moderators to stop harassment and bullying by or of speakers and during question-and-answer sessions.

How can SGIM respond to sexual harassment in ways that align with our priority of creating value for our members and recognize the resource constraints our organization faces? Dr. Jada Bussey-Jones, the chief of general medicine and geriatrics for Emory at Grady Memorial Hospital, is leading a Council workgroup examining this issue, and expects to pursue several avenues:

- Tap our internal resources: As above, SGIM includes several thought leaders on this issue of sexual harassment in academic medicine, multiple groups within the organization with expertise on this topic, and a membership that strongly supports the importance of promoting equity.
- Undertake a broader dialogue: The men on Council left the discussion with an entirely new

understanding of the nature and scope of sexual harassment in academic general medicine. We hope this was just the first step in promoting respectful and open conversations among all our members about this issue. A town hall meeting on sexual harassment is planned for this year's Annual Meeting.

- Unequivocally articulate our expectations for appropriate behavior: On the one hand, it's discouraging that a written policy stating the organization's zero tolerance for sexual harassment is necessary, but this is clearly the case. SGIM must develop a formal code of conduct that covers all aspects of the Society's activities, including the Annual and Regional Meetings. Clear mechanisms should be developed for reporting and investigating incidents of harassment.
- Supporting our members who experience sexual harassment: One idea that the Council workgroup is discussing involves how SGIM could train a cadre of members to be sexual harassment support resources, available to talk with interested members about their experiences both within the organization and at their workplace and suggest strategies for addressing these problems.

Even in the absence of prior reports, it's wishful thinking to imagine that SGIM is an environment that is free of sexual harassment. It is our responsibility to promote a better understanding of this critical issue among all of our members, develop mechanisms to ensure all who participate in SGIM activities understand the organization's expectations and address breaches of these expectations, and support our members who have been sexually harassed. We welcome your thoughts about the most productive path forward in this area.

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PRESIDENT'S COLUMN

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SGIM

FROM THE SOCIETY

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I realize now, on my first primary care outpatient block, how the story slam didn't just inspire me but primed me. I approach each new patient visit with hope and intrigue. Will this be someone I'm still caring for in thirty years? I am already anticipating the stories we may tell."

—Nilan Schnure, MD, Internal Medicine, PGY-1

Even without grant funding, we hope that all of our SGIM institutions

will participate in #ProudtobeGIM week each year on social media and with an event of any size or shape. We are excited to be able to fund another round of institutions in the upcoming year. Look out for announcements for other ways to get involved with the PTBGIM committee in the near future. Feel free to reach out to discuss ideas for local and regional events. To see our available resources, videos, slide decks, and information on how programs have

planned for these events, please visit our Web site at <http://www.sgim.org/career-center/proudtobegim>.

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CLINICAL UPDATE

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today. Whether you are new to these topics, an expert, or anywhere along this spectrum, you will definitely find useful resources on the page. There are links to tool kits, organizations, videos, books, and articles on key concepts in quality improvement and patient safety. If you would like to contribute to the resource page, please contact the page Editor, Suneet Dullet, MD at swdullet@health.southalabama.edu or suneetdullet@gmail.com.

3. Improving Practice Finances

Resources. Has a new faculty member asked you what MACRA is? Has a fellow internist in a new administrative role wondered how his/her practice can improve its revenue? Or maybe you've wondered about these topics yourself? Many internists feel ill prepared to face the difficult task of running a business and making a living in primary care. SGIM recognizes the importance of a healthy financial environment to the continued health of internal medicine practices around the country. If we keep primary care practices financially vibrant and getting reimbursed for the wonderfully complex work they do, we can keep our patients healthy, our costs down and our clinicians professionally satisfied. We are working to provide primary care leaders with the information they need to take advantage of emerging payment opportunities for true high-value primary and preventive care. Our Web pages feature major sections

on "Major Determinants of Practice Finance," "MACRA and the Regulatory Landscape," and "Reimbursement for General Internal Medicine." In order to maintain healthy finances, our members and others in the community need to understand the main pillars of reimbursement for internists and some strategies to improve reimbursement. The Improving Practice Finances Resource pages begin with a brief discussion about the main forces that affect finances. Then, we have a section on MACRA since that is the biggest force affecting practice finance currently and in the horizon. We have curated the best of content in practice finances produced by SGIM members as well as other organizations such as ACP and AMA. We hope to be a clearinghouse for our members of this crucial information for internists and the larger healthcare community. If you would like to contribute to the resource page, please contact the page Editor, Calie Santana, MD, at csantana@westmedgroup.com.

We expect that *ImprovingCare* will expand and adapt over time to add content and meet the further needs and interests of our members. The CPC Workgroups, Subcommittees, and Resource Page editors are committed to supporting and maintaining *ImprovingCare* as a long-term activity of the CPC. And we will continue to develop and grow our resources based on feedback from SGIM members and bring together

virtual communities of primary care providers to help solve problems. *ImprovingCare* will help general internists find more joy in practice by assisting them in providing better care to their patients.

ImprovingCare will give our members a forum that will magnify and focus the voice of our members as we advocate for our most important priority—the health of the people we serve.

Take the time now to visit SGIM's new information hub at www.SGIM.org/ImprovingCare. You will find the following:

- PowerPoints for download from some of the top practice improvement workshops presented at our annual meetings that you may adapt and use for regional and national presentations.
- Great practice improvement toolkits that you can use to begin transforming your clinical practice tomorrow.
- Videos and teaching materials that you may use to train medical students and residents to serve as the next generation of primary care providers and quality improvement champions.

Let our *ImprovingCare* editors know how you feel about the materials and links and what sort of information may be missing from the site. Help us make *ImprovingCare* the best resource hub on the Web for people who care about primary, preventive, and high-value care.

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BREADTH

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ANNUAL MEETING UPDATE

It's Almost Time to Reconnect, Recharge, and Recommit at SGIM18 in Denver!

Lipika Samal, MD, MPH, and Saul Blecker, MD, MHS

Dr. Samal (lsamal@bwh.harvard.edu) is an assistant professor of medicine at Brigham and Women's Hospital and the chair of the 2018 Annual Meeting. Dr. Blecker (saul.blecker@nyumc.org) is an assistant professor of population health and medicine at NYU School of Medicine and the co-chair of the 2018 Annual Meeting.

Our annual meeting is fast approaching. We are excited to welcome Saturday plenary speaker Stephen Cha, director of the State Innovations Group within the Center for Medicare and Medicaid Innovation. From the Primary Care/Social Medicine residency program at Montefiore Medical Center, to the Robert Wood Johnson Foundation's Clinical Scholars Program at Yale, to a career in the federal government, Dr. Cha exemplifies the role of the general internist in improving our healthcare system. He served as chief medical officer for the Center for Medicaid and CHIP Services and, before that, as senior professional staff for the Committee on Energy and Commerce under Chairman Henry A. Waxman. In that position, he drafted sections of the Affordable Care Act, the American Recovery and Reinvestment Act, and the Food and Drug Administration Amendments Act of 2007. The plenary session will be moderated by Joseph Ross, associate professor of medicine and public health at Yale University, who has known Steve since they were residents and then fellows together. What a way to celebrate the longevity of our GIM friendships!

As we announced a few months

ago, there will be innovative informatics-related content, including: a half-day informatics pre-course where SGIM faculty will present information relevant to general internists, a hands-on "tech alley" at the Innovations in Clinical Practice and Innovations in Medical Education poster sessions, and a Malcolm L. Peterson Honor Lecture presented by Microsoft's director of research, Eric Horvitz. We are excited to announce that Dr. Horvitz will spend the day at the meeting participating in a Shark Tank and visiting the ICP poster session. In addition, the SGIM book club has chosen *The Glass Cage* by Nicholas Carr to encourage a lively lunch discussion about the ways that computers are changing us.

Other new offerings this year will include a bioethics-focused field trip to UC Denver, which will include a tour of the exhibit, "Deadly Medicine," as well as a Grand Rounds presented by Dr. Patricia Heberer-Rice, senior historian at the United States Holocaust Memorial Museum in D.C., and Dr. Matthew Wynia, director of the Colorado University Center for Bioethics and Humanities. We have arranged a buprenorphine training session on Saturday, which can be combined with online content to

meet requirements for prescribing privileges. There will also be several special sessions on Saturday related to Women's Health. We also have two special TED Talk-style sessions: "SGIM MED Talks" on career development and careers in health policy. Please spread the word to all students, residents, and fellows that we have arranged a special trivia session at lunchtime on Thursday, as well as social events every day of the conference. Finally, the Denver Art Museum, located within walking distance of the hotel, will be the sole venue in the United States for the exhibit "Degas: A Passion for Perfection." Sign up to join us for a special tour of the show with other SGIM attendees on Friday evening. Of course, this is just one of many exciting things happening in Downtown Denver, one of the *New York Times'* 52 Places to Go in 2018!

There will be more content than ever. The hotel is in a walkable area. And, of course, SGIM will give you the opportunity to reconnect, recharge, and recommit to our shared mission. Be sure to keep checking our Web site for an updated schedule of activities: <https://connect.sgim.org/sgim18/program!>

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