HEALTH POLICY: PART I

PLANTING OUR FLAG—SHAPING PRACTICE AND POLICY THROUGH SGIM WHITE PAPERS

Mark Earnest, MD, PhD; Mark D. Schwartz, MD

We live and practice in turbulent times. Health disparities and inequities grow before a backdrop of social unrest, polarization, and periodic spasms of violence. The institutions, civic norms, and traditional forms of social capital that have provided stability in years past have eroded. Never in our lifetimes has there been a greater need for the steady hand and moral compass of the medical profession. Our voices and our leadership are sorely needed. Amid the chaos and rancor, we must provide the clarity of high-quality scientific evidence and ethically grounded reasoning and judgement. Amid the fear and welling emotion, intentionally stoked for narrow interests, we must be a firm, calm voice for the common good. Increasing SGIM’s output of high quality, policy-focused white papers is a critical strategy for achieving this end. This article challenges our members to draft new white papers for SGIM and we clarify the process through which SGIM approves new position statements.

SGIM has a long history of providing exceptional leadership in health and health care. For a small society, SGIM boasts a disproportionate number of national thought leaders, including numerous deans, department chairs, CTSA directors, and leaders of divisions of general internal medicine across the country. Many SGIM members have provided leadership to state and federal governments, among them: John Eisenberg, Carolyn Clancy, Andrew Bindman, Nicole Lurie, David Blumenthal, Laura Sessums, Steven Cha, Kavita Patel, Hoangmai (Mai) Pham, Preston Reynolds, Eugene Rich, Tom Tsang, Judy Zerzan, and Karen DeSalvo. Far more of our members are local and regional leaders, steering countless local efforts that improve the health of our patients and communities through myriad means. Leadership, however, is not limited to named roles and titled positions. On a daily basis, all of our members are called upon for wisdom and guidance from patients, peers, neighbors, and family. The time has come for us to leverage this wisdom and do more to shape the national dialogue.

Leading requires vision and clarity. Before we can speak with authority, we must objectively examine the issues, marshal the evidence, and apply a moral and ethical lens to the questions we face. Only after such a process can we speak with authority. White papers are one of the ways we have done that. Wikipedia defines a white paper as “...an authoritative report or guide that informs readers concisely about a complex issue and presents the issuing body’s philosophy on the matter.” The definition describes a white paper’s purpose: “... to help readers

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FROM THE EDITOR

THE SCRUM

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

Over the last year, I became a fan of rugby. Don’t ask me why. I still don’t get all of the rules but I can at least follow the ball. Rugby fans know that at this time of the year we are in the thick of the Six Nations Championship, a tournament that includes France, Italy, England, Wales, Ireland, and Scotland. Last year, I had the opportunity of seeing Ireland beat England in Dublin on their way to a Grand Slam (they essentially beat everyone else). Even though I still lack the knowledge to appreciate the nuances of the game and many of its rules (I can’t figure out what off-sides is regardless of the sport), I can still appreciate how teamwork and execution can be effective to reach a goal and win the game. I also used to be an American football fan. But the Jets and the NFL’s handling of chronic head trauma among their players had me rethink that.

Early on in my career, I often heard and described the Primary Care or Generalist Physician as the “quarterback” of a patient’s care. Interestingly, the focus was always on the physician as the only member of the health-care team responsible for coordinating the care of a patient. Rugby and American football have similar origins but, unlike American football, rugby is faster paced and members on the team have much less specialized roles. However, some of the positions are fairly similar: for instance, two members of the 15-member Rugby team, the scrum half and the fly half, carry out a similar role and are closest to a quarterback in American football.

In the era of the Patient Centered Medical Home (PCMH), I now believe that rugby is a more appropriate sports metaphor for delivering care than American football. Primary care physicians and hospitalists are more likely to work in teams with other professionals, some with specific roles like pharmacists and psychologists and some with complementary roles, such as nurse practitioners and physician assistants. In rugby, a scrimmage is called a scrum. To me, a scrum is akin to a huddle where healthcare teams typically convene prior to delivering care at the outset of care delivery. In the huddle, the role of the lead team member is often but not always that of the physician and can appropriately change given the patient or the clinical issue at hand. At the Zucker School of Medicine, our primary care internal medicine track trains residents as part of an interprofessional team. In our resident practice, the IMPACt Clinic, huddles are routinely used and organized such that the medical assistant, pharmacy, or physician assistant (PA) student take on the

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A new year is a time when many of us take to reflect on goals, both personal and professional. In the same way, we have the opportunity to think about our goals for SGIM. In past Forum articles, we shared some of the hard work that council, staff, and other leaders in SGIM have undertaken over the past several months to clarify our society’s strategic goals and set metrics for evaluating our progress. One key strategic goal is ensuring the organization continues to have the fiscal resources needed to thrive and grow. I am excited that SGIM presently is on solid and stable financial footing, enabling us to make thoughtful decisions about how to sustain and grow the organization’s finances.

There are several reasons for this confidence in that SGIM has:

- minimal liabilities/debt
- solid capital assets—we own our building and boast a fabulous dedicated staff;
- excellent products—our meetings, programs, member services, and reputation;
- six (6) months of operating expenses in reserve plus well-invested endowments;
- restricted investments that provide income to support multiple awards and programs; and
- a financial history of positive operating margins, and building our cash reserves.

ENSURING SGIM CONTINUED PROSPERITY

Giselle Corbie-Smith, MD, MSC, President, SGIM, and Mark D. Schwartz, MD, Treasurer, SGIM

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The Patient-Centered Outcomes Research Institute (PCORI) is an independent nonprofit, nongovernmental organization authorized by Congress in 2010 as part of the Affordable Care Act (ACA) legislation. The authors of the ACA sought to fund research that can help patients and their caregivers make better informed decisions about the healthcare choices they make. PCORI must be reauthorized this year to continue its important work, and SGIM will work with other organizations to support this reauthorization.

PCORI’s mission is to improve healthcare delivery and outcomes by producing and promoting evidence-based information from stakeholder-guided research. PCORI seeks to fund useful research likely to change practice and improve patient outcomes. A key priority is sharing research results with the public. The organization has also sought to influence research funded by others to become more useful to patients and other healthcare decision makers.

Since 2012, PCORI has funded hundreds of studies, including many to SGIM members, that compare healthcare options to identify which option(s) work best, particularly in light of patients’ individual circumstances and preferences. In a unique funding model, PCORI works closely with healthcare stakeholders—including patients and caregivers, clinicians, researchers, purchasers, payers, industry, hospitals and health systems, policy makers, and training institutions—to identify comparative effectiveness studies that address high-priority clinical questions and focus on outcomes that are important to patients.

PCORI has transformed patient-centered research in a variety of ways that are highly aligned with the priorities of SGIM researchers, educators, and clinicians. A principal innovation has been the engagement of patients and caregivers in research throughout the research process. In PCORI-funded research, patients are partners—rather than research subjects—who leverage their experiences and expertise to make research more patient-centered, relevant, and useful. Patients and caregivers are engaged throughout the research process, including study planning, implementation, and dissemination of study findings. In addition to the critical role of stakeholders in PCORI projects, PCORI has engaged stakeholders in identifying important topics for funding announcements, in the peer-review process, and in dissemination strategies to assure that the research they fund is relevant to the needs of all potential users and to assure that potential users learn about findings. Another area where PCORI, as a funder, has been innovative is in its emphasis on developing rigorous methodology standards. These standards maximize the likelihood that research conducted with PCORI funding is of high-quality and that research findings are valid and generalizable.

PCORI is funded through the Patient-Centered Outcomes Research Trust Fund (PCOR Trust Fund) that was established by the ACA. The PCOR Trust Fund receives income from the following three sources:

1. a statutory appropriation from the general fund of the Treasury;
2. transfers from the Centers for Medicare and Medicaid Part A trust fund; and
3. a fee assessed on private insurance and self-insured health plans (the PCOR fee).

Importantly, the funding does not come from annual congressional appropriations in the federal budget. In addition to funding PCORI staff and research projects, approximately 16% of the PCOR Trust Funds are directed through the Agency for Healthcare Research and Quality (AHRQ) to work with PCORI in disseminating patient-centered outcomes research and evidence. AHRQ seeks to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable and also to work with partners to make sure that the evidence is understood and used.

The initial authorization of PCORI from the ACA will expire on September 30, 2019. If Congress does not pass new authorizing legislation, the organization will cease to exist (the organization has reserved funds to close out ongoing work if it is not reauthorized).
What is needed for reauthorization? The key requirement is legislation from Congress to reauthorize PCORI and assure its funding. Recently, a group calling themselves “Friends of PCORI Reauthorization” has been established. Key leaders from this group are working with Republican and Democratic leaders in the House and Senate to identify individuals interested in filing legislation and promoting it in Congress. Because of the important role that PCORI has played in promoting and funding patient-centered research that is important to our members and patients, SGIM is participating in Friends of PCORI Reauthorization meetings and hopes that this process will lead to successful reauthorization.

References

FROM THE EDITOR (continued from page 2)

role of huddle leader when it is clear they are the one most knowledgeable about a patient and what are the goals of the visit. The rugby concept of multiple quarterbacks is a great metaphor for medicine.

In rugby, the scrum half and the fly half are good examples of interchanging leadership responsibilities on a team. The scrum half collects the ball and gets it into open play. He or she often has to get it over to his or her colleague, the fly half. The fly half is the playmaker in rugby. It is his or her job to read the state of play and make timely decisions: to run, pass, or kick the ball. All the while opposing players are running towards him or her (there is no blocking). In medicine, we as physicians often have other healthcare team members that we rely on when caring for patients. Medical assistants and other front-line staff get us in the game while pharmacists, psychologists, etc., help us read the state of play and aid in diagnostic and therapeutic decisions. All this happens with no time outs or commercial breaks.

What does this have to do with this month’s Forum? Mostly to highlight the point about how state-of-the-art primary care can be delivered. Forum never lacks for examples of team-based interprofessional care and education from SGIM members. Danielle Zipkin and her colleagues describe a tool to teach both EHR skills and interprofessional roles in the ambulatory setting. Recognizing the diverse nature of an interprofessional team, Dr. Zipkin and her co-authors show how they use the EHR to teach residents how to effectively collaborate and communicate with all team members and how to share tasks with a team of nurses, pharmacists, and social workers. This month’s issue also features a piece in which Dr. Nancy Keating reminds us that the Patient-Centered Outcomes Research Institute (PCORI) needs a reauthorization and how “Friends of PCORI” are gearing up to support it. The Health Policy Committee puts out a call for SGIM members to get involved and change practice, education, and research through the use of white papers. In addition, this issue presents a feature that I would love to see more of—a book review. Dr. Tiffney Leung gives her thoughts on the book Graphic Reproduction: A Comics Anthology by Jenelle Johnson. How to use coding and documentation to teach residents and a Perspective piece from a young faculty on attending the annual meeting makes for a great issue.

Go Team!!
SEEING OPPORTUNITY WHERE THERE ONCE WAS CHALLENGE: UNIFYING THE PURPOSE OF DOCUMENTATION FOR EDUCATION AND REIMBURSEMENT

Mary E. Lacy, MD, FACP; Lida Fatemi, MD, MPH; Justin Roesch, MD, FACP

With the advent of retroactive reimbursement and its necessary dependence upon provider documentation, clinician educators have often found themselves at an awkward crossroads during rounds. Students may present cogent and sensical problems, like bacterial meningitis presenting with altered mental status, only to have the attending retort, “Well, technically we have to document it as metabolic encephalopathy due to meningitis...” Much to the chagrin of students and residents, this dialogue is a microcosm illustrating the convoluted dynamic between documentation and practice. Larry Weed’s creation of the SOAP format in the 1970s was meant to serve as a scientific document and memory aid to help the clinician organize data and reflect their critical thinking. Simultaneously, the SOAP format afforded the clinician a concise way of portraying the illness trajectory and management over time. Eventually, insurance companies and Centers for Medicare and Medicaid Service (CMS) started using the SOAP note as a tool for generating reimbursements, thus subtly but irrevocably transmuting the purpose and content of the medical record. In conjunction with the advent of electronic health records (EHRs), documentation requirements for billing have substantially increased the physician’s time spent on the computer rather than with the patient, leaving even less time for education and ultimately contributing to physician burnout and suboptimal patient experience.1 It is not surprising then that a palpable tension has resulted from the dichotomous roles documentation is presently felt to serve.

Clinical documentation supports effective communication and provider collaboration, can act as an aid to facilitate processing of information, and is used for coding and reimbursement.2 Despite this importance, it is often relegated to the absent curriculum of undergraduate medical education and most post-graduate training programs. Within this void, trainees are expected to develop a secondary lexicon for medical documentation, which at times is seemingly at odds with or even antithetical to terminology described in texts or medical literature. Until recently, this bore little consequence for most students, as notes were often exercises in documentation but held little practical relevance. This was in part due to prior CMS guidelines that led to a misalignment between billing requirements and the goals of the educational system to engage students in the documentation process. In February 2018, CMS changed its policy, allowing medical student notes to count for billing.3 This change did not occur in a vacuum. For many years, multiple national medical entities, including the Alliance for Clinical Education (ACE), the American College of Physicians (ACP), and the Society of Teachers of Family Medicine have strongly advocated for medical students to be granted access to the EHR and subsequently to have the ability to document clinical encounters which may be used for billing purposes.4-6 New CMS guidelines no longer require clinicians to re-document large portions of a note which will reduce the burden on clinicians and improve preceptor recruitment. In many regions and settings, the onerous nature of redoubling documentation contributed to a shortage of high-quality clerkship preceptors. In fact, a summit held in 2016 to address a shortage of family medicine preceptors identified a primary tactic to address this problem should be working with CMS to revise student documentation guidelines.6 The 2018 CMS updates are expected to significantly decrease the administrative workload on faculty which will increase the number of physicians accepting medical students. A pilot study at the University of New Mexico (UNM) implemented new documentation requirements allowing for billing of student notes within both clinic and inpatient ward encounters during the Family & Community Medicine Clerkship.

Faculty were queried about their perceptions of the experience and the overwhelming response was favorable: continued on page 7
The Alliance for Clinical Education’s (ACE) charge to allow students to document within the EHR was leveled with the intention of enhancing a student’s contribution to the medical team while also promoting skill development through feedback to help focus content and clinical reasoning. In the same pilot study at UNM, a student survey after the experience noted “I felt being able to send notes and have them used for billing purposes gave me a larger sense of belonging on the team and felt my contributions were more meaningful.” Another student responded, “Sending endless notes into space that were never read and never looked at again was fatiguing.” Ultimately, all surveyed students reported agreement with the statement that “this process change helped me to be integrated into the care delivery team” (A. Rankin, MD, unpublished data, 2018).

The results of this pilot are promising for students and faculty alike. In particular, faculty were still afforded the opportunity to provide feedback on students’ clinical reasoning processes, including the prioritization and interpretation of clinical findings to support diagnostic considerations. Understanding this potential value, medical educators should maintain vigilance that billing requirements can be formulaic and offer little room for the ambiguity that exists in practice. Moreover, there is plausible risk of placing educational goals in greater tension with billing, and for the student role to be reduced to scribe, whose primary purpose is to complete billable documentation. It is paramount that we contemplate these dynamic benefits and risks if we are to achieve the goal of integrating medical education and documentation for billing.

Many institutions are trying to figure out how to implement these recent CMS guidelines. While some aspects related to their use remain under debate—such as whether exams by students need to be directly supervised or simply repeated—these guidelines present an opportunity for the medical education system to appraise and revamp the current process on education related to documentation. Medical education is approaching a crossroads wherein institutions will need to contemplate whether teaching documentation standards can be neatly integrated into the standing curriculum, whether it warrants the creation of an entirely new curriculum, or temporarily and perhaps less effectively, whether it should remain unaddressed and within the absent curriculum.

Ultimately, we advocate that national organizations such as SGIM and the AAMC help to develop clear recommendations for best practices related to student education on documentation. In the interim, we entreat each school to carefully 1) engage all stakeholders (students, residents, faculty, community providers, documentation and billing staff, etc.) for input regarding curricular content, structure, outcomes, and assessments, and 2) acknowledge how differences in terminology (e.g. altered mental status and septic metabolic encephalopathy) can be reconciled between documentation needs and clinical practices in a sensical fashion for learners. Appropriate implementation of these guidelines has the potential to reduce documentation duplication, improve physician satisfaction, increase preceptor recruitment, and enhance the student role on the medical team through legitimate participation.

References

SGIM
The electronic health record (EHR) is a way of life in clinical medicine. Building residents’ skills in navigating EHRs efficiently while imparting the granular details of managing in-basket messages not only represents a significant challenge but also brings tremendous opportunity to teach accountability, the role of the doctor as team leader, and the unique roles and responsibilities of each member of the interprofessional team. For instance, which tasks can and should be shared with the team of nurses, pharmacists, or social workers? Residents are learning how to navigate their future roles as team leaders by learning how to effectively collaborate and communicate with all team members. Recognizing this need, we developed a tool to teach both EHR skills and interprofessional roles simultaneously in the ambulatory setting.

The tool was developed organically in an educational ambulatory setting where formalized EHR navigation workshops were already being taught. During EHR training and subsequent clinical practice, resident questions continually concentrated on the management of follow-up processes in patient care, the workflow of in-basket management during and outside of clinic sessions, and the clarification of team members’ roles and responsibilities. As a result, it became natural and necessary to add the element of professional development to everyday teaching by developing a tool that can teach professional development, team roles, and the use of EHR simultaneously.

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By anchoring the tool in the ACGME milestones, which are most relevant to interprofessional teamwork and ambulatory clinical care, the tool can assess resident competencies as they relate to EHR domains by defining observable behaviors for each milestone. The tool focuses on the following milestones: Systems Based Practice (SBP1), Professionalism (PROF1 and PROF2), and Interpersonal Communication Skills (ICS2 and ICS3). For each milestone, the tool suggests competency benchmarks for both in-basket management and ambulatory encounter management, allowing for better assessment of these milestones as they relate to outpatient care (see figure). During the workshop, case scenarios, which were designed to illustrate various levels of competency in trainee’s responses to lab results and patient requests, were employed to demonstrate the use of the curricular tool and aid with faculty development. These cases and the curricular tool can easily be customized for different institutions, settings, and learners. The following figure on page 9 illustrates a portion of the curricular tool for illustrative purposes.

Professionalism is often noted as one of the more difficult competencies to teach, assess, and remediate. While the EHR can be the source of considerable frustration, incorporating the teaching of interprofessional roles into EHR teaching could improve learners’ engagement by linking the content to core skills in doctoring and team leadership. The curricular tool that we developed makes explicit the assessment of trainees’ professionalism in the context of their navigation of the EHR. With the use of this tool, programs can not only make the teaching of interprofessional teamwork within the EHR clearer but also can more easily expand observations of resident behaviors and practices to inform milestone assessments. In other words, we aim to open up the EHR space as another domain for data gathering on resident performance on milestones. Next steps will include dissemination of the tool and assessment of its value by gauging residents and faculty satisfaction, demonstration of skills by trainees as ambulatory team leads, and delivery of higher quality feedback to trainees from more frequent direct observations by faculty.

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Illustrative segment of curricular tool for teaching professional development and team roles while teaching the use of the electronic health record.

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BOOK REVIEW

BOOK REVIEW: GRAPHIC REPRODUCTION

Tiffany I. Leung, MD, MPH, FACP, FAMIA

Dr. Leung (t.leung@maastrichtuniversity.nl) is an assistant professor at the Faculty of Health, Medicine and Life Sciences and PhD candidate at the Care and Public Health Research Institute at Maastricht University in The Netherlands.

When I started reading Graphic Reproduction: A Comics Anthology, edited by artist Jenelle Johnson,1 the then news cycle in November included coverage of another book, former first lady Michelle Obama’s new memoir, Becoming. “I felt lost and alone and I felt like I failed because I didn’t know how common miscarriages were, because we don’t talk about them,” she had said in an interview.2 Graphic Reproduction accomplishes this—and more—through artful narrative, opening the emotional conversations so desperately needed about sensitive topics in reproduction, including the trials of infertility. This book, a collection of comics on reproduction, does so in an accessible and sometimes painfully honest way.

True to its title, the book is in the genre of graphic medicine, a growing field that “combines the discourse of medicine with the medium of comics,” according to Johnson. This visual approach has been applied to patient education and communication, as well as medical education.3 Furthermore, graphic stories are effective in depicting the experience of illness for patients and doctors, and for teaching humanism and empathy in medical education.

I found, as a childless female physician in my mid-thirties, one comic the most relatable: in a strip containing little dialogue, an anthropomorphized uterus literally tugs at her, with a hand-like fallopian tube, reminding her of a biological countdown.

Graphic Reproduction is a compilation of 13 comics intended to reflect on the complexity of reproduction, “a merging of personal and political, body and ideology, individual and institution, science and technology, joy and pain, nature and culture, sex and gender, humor and horror, seeing and saying.” The styles of art vary, as do the points of view and dialogue, which make for an easy read of each graphic story in any order over a period of several days or in one sitting.

In the introduction, Johnson describes graphic medicine for the uninitiated reader, then continues to briefly describe her own experience of infertility. She also describes the histories of each comic and illustrator and their social and political contexts at the times of their original publication, spanning from 1973 to 2017. She explicitly aims to be gender-inclusive in her selection of comics, including a story from a would-be father, and two stories about pregnancy for individuals with non-heteronormative gender identities (in “Pregnant Butch” and “Spawn of Dykes to Watch Out For”). Most of the comics do still focus on heteronormative relationships and family structures, but her inclusivity is especially distinguishing.

In the first two comics, the book launches unflinchingly into one of the most controversial topics in reproduction: abortion. The first comic feels undeniably dated in its colloquialisms and illustrated social and class stereotypes, which are to an extent excusable given the original comic was published in 1973. The aim was to describe the changes in federal law—Roe v. Wade had just concluded—by illustrating a group of women of different backgrounds who are seeking abortions for various reasons; they find support and sympathy among “sisters” in this educational comic on abortion. Interestingly, the comic was created in collaboration with a number of women’s health groups, most notably Planned Parenthood, which in November 2018 appointed emergency medicine physician Leana Wen, MD, as its new president.4 The second comic, shorter and originally published in 2015, reads more like patient-education material, illustrating and describing medical and surgical abortion procedures in simple language. A later

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comic intended to educate about postpartum depression, illustrates a clinical psychologist who breaks the fourth wall to speak to and educate the reader.

The most memorable of the graphic stories are those of infertility. The honesty and rawness of the stories told, some fictional and some autobiographical, channel an unfettered depth of despair associated with the death of an unborn child that is not acknowledged nearly enough as it needs to be. At the same time, a recurring theme is that such conversations need to be normalized to help those affected by such devastating loss to heal. In one comic, Endrené Shephard illustrates after a miscarriage, “As I opened up to others, they opened up to me...It turned out that I had joined one of the planet’s most miserable (mostly secret) societies.” In other words, women who experience miscarriages often grieve alone, and the self-perception of failure or inadequacy, which Michelle Obama also expressed, can be crushing. However, the reality is that miscarriages and infertility are far more common than the public is led to believe. In this way, despite the heaviness of the content, the choice of comics in this book offer a wide-open door through which to walk—not just peek—into the heartbreaking experiences of wanting but being unable to become a mother.

While some stories express a hollowing of the heart bored by feelings of incompleteness, others demonstrate a degree of lightness, usually in the form of a thin veil of sarcasm that tries only barely to hide the strange distortions of everyday life that are the consequences of invasive and costly procedures related to infertility treatments. “We started calling the frozen embryos the ‘JV team,’” says Johnson in an illustrated panel from her own comic. In another one-page comic on becoming mother, “Anatomy of a New Mom,” Carol Ann Tyler illustrates a caricature of a disheveled woman with “Unshaved legs (low priority)” and “the ‘Forget It’ zone” with an enormous “X” over the pelvic region, among many other annotations to the cartoon. Although published in 1988, the content here, and in all of the stories, is still evergreen.

I found, as a childless female physician in my mid-thirties, the comic by Paula Knight, to be most relatable: in a strip containing little dialogue, an anthropomorphized uterus (also gracing the book’s cover) literally tugs at her, with a hand-like fallopian tube, after her thirtieth birthday to remind her of a biological countdown beginning. Johnson, in her own comic, had written, “It seemed like every person I knew either had kids or was pregnant. Party conversations had shifted considerably.”

As inclusive as this book is, still missing are the stories of choosing not to have children, delaying having children, egg cryopreservation for a later date, and adoption. As a book on “Graphic Reproduction,” almost all of the comics revolve around pregnancy, presumably because this is the biological point of convergence in reproduction, regardless of fertility status or gender identity. Nonetheless, the pathways to creating a family in contemporary social contexts are much broader and I believe would warrant a second volume of this comic anthology.

Overall, the sensible selection and easy readability of the comics contained in this anthology are informative and satisfying to read. In a time when striving for gender equity has never been stronger and more vocal in the medical profession, family life is impossible to omit from the conversation. Consequently, at least one of these comics will be relatable to most readers. Even if personal experiences are not among the stories, there is still recognition that dialogue about these difficult issues is needed. This book can facilitate those conversations. In fact, a discussion guide and exercises are included at the end of the book.

I recommend Johnson’s Graphic Reproduction, a quick read that engages readers of all backgrounds in this thoughtfully constructed graphic medicine anthology.

References
Last year, after being chosen as one of the recipients of the Young Scholars in GIM Scholarship, I was eager to take full advantage of the numerous opportunities to improve my clinical knowledge and teaching skills and network with potential mentors. Among several others, I had circled a workshop called “Being Female in Medicine: Skills for Growth and Promotion” on my Society in General Medicine (SGIM) 2018 program. One slide from the presentation at this workshop really stood out to me. The presenters were discussing Angela Duckworth’s work “Grit: The Power of Passion and Perseverance” and how cultivating a sense of purpose is key to gaining the confidence to be successful in your career. This sense of purpose is developed by:

• “reflecting on how your work contributes to society,”
• “thinking about how you can change your current work to connect to your core values, even if in small ways,” and
• by finding a “purposeful role model.”

This slide resonated with me because I feel it truly reflects what SGIM means to me and what I have experienced at the Annual Meeting—a community of people with purpose and passion who take pride in how their work contributes to society and are excited to share this work with others.

I found inspiration in many places throughout the 2018 Annual Meeting. For example, the abstracts presented at the Thursday and Friday Plenary Sessions, in particular, the case report about the interdisciplinary team who was able to bring a patient struggling with heroin addiction to valve replacement surgery (“It Takes a Village...” by Dr. Fujita), were motivating in terms of their focus on and commitment to patient advocacy. The idea of providing hospital level care at home is innovative and eye-opening (“Hospital-Level Care at Home for Acutely Ill Adults...” by Dr. Levine), and I loved that a topic in Women’s Health, namely increasing patients’ awareness of their breast cancer risk/need for additional screening through educational videos (“...Personalized Breast Density and Breast Cancer Risk Notification” by Dr. Haas) was at the forefront of the Meeting. Additionally, I had the opportunity to discuss multiple interesting cases presented at the various poster sessions and Clinical Vignette Oral Presentations, and gained an understanding of the basics of caring for patients who identify as transgender as well as how to teach these skills to my fellow general internists (“Teaching Transgender Care to General Internists”).

On Friday afternoon, SGIM Distinguished Professor of Women and Medicine Dr. Suzanne Fletcher gave a phenomenal keynote lecture. She closed by discussing a story published in the New York Times that highlighted one of her medical school classmates, cardiologist Dr. Bernard Lown, who was recently hospitalized and asked an intern why he had to be woken up to have his vital signs taken every four hours. When the intern (who authored the article) noted that he “understood his frustration” but that there was nothing he could do, the physician-patient replied “Understanding is not enough. You should be doing something to help fix this system.” I felt a similar sense of commitment to innovation, advocacy and change reflected in the words of the various SGIM speakers and session leaders.

I am looking forward to attending the SGIM 2019 Annual Meeting. Previously, I attended as a senior resident preparing to start my first junior faculty position. This year, I will be attending with almost a year of teaching and precepting interns and residents in the ambulatory setting under my belt. In 2018, I attended several workshops centered on teaching and education, including “Public Speaking for Academic Physicians,” “Outpatient Teaching 2.0” and “Working Smarter: Tools to Enhance Learning and Feedback.” I learned fresh, innovative teaching and presentation techniques and had the opportunity to practice these skills in a non-judgmental setting. I am especially excited by the prospect of attending similar workshops in 2019, albeit now from the point of view of a new clinician-educator with many questions and cases to potentially discuss with the strong network of experienced medical educators that I met last year at SGIM. Moving forward in my career, I hope to continue to cultivate my skills as an educator with the knowledge that I am supported by and have access to an incredibly rich network of resources on both a regional and national level.
understand an issue, solve a problem, or make a decision.”

As noted in this definition, white papers strengthen SGIM’s leadership in a number of ways:

1. **They inform our membership about complex issues.**
2. **They provide clarity to our leaders and members as to our goals and interests and allow us to plan and prioritize our advocacy efforts.**
3. **They also enable us to inform and influence others beyond our society.**

In doing so, they strengthen the reputation of SGIM as a thought leader in medical practice and policy and increase SGIM’s influence with local and national policy-makers.

Currently, SGIM has only two white papers—one addressing the dysfunctions of current Evaluation and Management (E&M) codes may be the definitive document on the topic and the distortions in practice and workforce distribution that result from the dysfunctional way our work is valued and reimbursed.²

Nationally, SGIM is leading the effort by the Cognitive Care Alliance to achieve rationality and equity in payment for medical services between cognitive and procedural services and this paper is in many ways the cornerstone of that effort. The second white paper addresses GME reform, calling for dramatic changes in the accountability and transparency of GME financing to align with the country’s physician workforce needs.³ Both papers were endorsed by Council, and the GME report was published in JGIM.⁴ Each have enabled SGIM to sharpen our focus, hone our strategy, and improve our ability to leverage policy change. We need to do more.

As a society historically proud to “punch above our weight,” we have underutilized white papers. We have no statement on universal access to care or rational policies to address the opioid crisis. In 2013, Mark Schwartz and Harry Selker published a commentary on gun violence as a public health issue that was reviewed by the Health Policy Committee, but SGIM has not adopted a position on the issue.⁵ Other issues beg for comment, including:

1. **sustainable practice models to constrain cost growth in health care,**
2. **reducing the influence of profit in health care,**
3. **broadening medical practice to address social determinants of health,**
4. **expanding the healthcare team to include new and emerging professions including community health workers, health coaches, navigators, panel managers, etc.**

In broadening our reach in this manner, SGIM must address issues that are clearly in our professional purview. Any position SGIM adopts officially will need to be close to the mainstream thinking of our members. Such official position papers will need to be approved by the Health Policy Committee and Council. While the JGIM editors will be alerted as position papers are prepared, Council approval does not guarantee publication in JGIM. These papers will go through JGIM’s usual, rigorous peer review.

In addition to formal position papers, SGIM members contribute to the national conversation by publishing valuable thought pieces and papers related to practice and policy in JGIM and beyond. JGIM would welcome such manuscripts in the form of perspectives and comments.⁶

There are two established routes for SGIM to adopt an official position. The first is member-proposed. An individual or group can request that SGIM adopt a position by contacting the Health Policy Committee (HPC). If the HPC approves the request, it forwards the request to Council who must ultimately endorse it and invite the requestors to create a white paper. The second is to issue a call. The HPC or Council can issue a call for a white paper to clarify our position on an issue. In both cases, the HPC reviews and comments on drafts of the paper to develop the final draft that is forwarded to Council for review. Council may request revisions or accept it as is. Once accepted, it becomes SGIM’s official position on the topic.

We would like to close with a charge to our members: Let’s get busy. SGIM and, indeed, our nation, needs your passion and expertise. We are inviting you to consider what policy issues you would like SGIM to take a position on and what issues you would be willing to work on. If you currently serve on a committee or participate in an interest group or task force, think about how a white paper might advance the issues you are working on. If you are working on an issue that hasn’t found a home in a current SGIM committee or interest group, consider who might work with you to draft such position paper. For those developing papers for official endorsement by SGIM, the HPC will ensure rapid turn-around of drafts and work to get expedited review by Council. For every single issue that results in an official position for SGIM, there should be 10 developed as perspectives, commentaries, or health policy special topics for JGIM or other publications.

The call to leadership is clear. SGIM boasts a proud history of leadership, but we can do better. Pick
References

In spring 2018, the SGIM Council established the Financial Growth Workgroup led by Mark Schwartz (Treasurer) and Leslie Dunne (Director of Development and Project Management).

The Workgroup was charged with developing recommendations and strategies for generating ongoing revenue streams to support SGIM’s expenses and sustain our aspirations and growth. The Workgroup engaged members and staff representing a wide variety of key stakeholder areas of the Society including the Finance Committee, Development Committee, Ethics Committee, SGIM regional leaders, JGIM, and past fund-raising campaigns. We are grateful to those who offered their insights, wisdom, and sage advice during this process.

The group reviewed current, past, and potential revenue-generating ideas and organized them into five subgroups to focus the discussion.

1. General Operations Revenue, led by Hollis Day, focused on increasing revenue from growing our membership, the annual meeting, and JGIM;
2. Revenue Generating Programs, led by DC Dugdale, focused on developing sound and transparent business plans for our Career Development programs, such as TEACH, AHA, LEAD, and LEAHP;
3. Philanthropy, led by Martha Gerrity, focused on enhancing individual donations, growing our new legacy program, and endowments;
4. Exhibits/Sponsorships/Ads, led by Allan Prochazka, focused on updating our external funds policy and expanding such opportunities at our meetings within the bounds of the policy; and
5. Grants, led by Bruce Landon, focused on developing criteria for SGIM’s engagement in grant-funded opportunities.

The subgroups met regularly to generate and refine recommendations and strategies to accomplish them. The full group met monthly to harmonize their approach and align the recommendations with SGIM’s other strategic goals. An initial set of recommendations, that included dozens of recommended strategies, was prioritized and synthesized into a report that the Council reviewed at its December retreat. Each strategy was rated on its potential revenue and the cost to implement in dollars and staff effort.

The Workgroup presented the following recommendations to Council:

- **General Operations Revenue:** Revenue from membership dues and meeting fees is the largest source of income and the most efficient way to increase revenue. SGIM should invest in strategies to double the annual net growth rate of SGIM membership from 1.5% to 3% by increasing the number of new members and improving retention of current members.
- **Revenue Generating Programs:** Create a business plan that optimizes revenue and shows the detailed profit or loss of all major programs after accounting for all staff and organizational costs.
- **Philanthropy:** Nurture a culture of giving at SGIM by tripling the percentage of members who give regularly to SGIM from 5% to 15% and grow larger philanthropic giving to establish new endowments.
- **Exhibits/Sponsorships/Ads:** In keeping with external funds policy, increase the number of exhibits at annual meetings, solicit member feedback on the experience of exhibits, and expand sponsorship and advertising revenue at meetings and in JGIM.
- **Grants/Projects:** Develop a sustainable framework of criteria to guide SGIM’s selection of and response to grant opportunities.

The Council approved the report, endorsing its recommendations. We realize we likely will need to implement all recommended strategies to support our aspirations for growth, and success will require investment of money, staff, and member effort. Therefore, the Council asked the Workgroup to review the proposed specific tactics for each strategy, estimate the investment (time, people, and money) required to implement, and provide projections of potential revenue for the five areas to guide our decisions for investing in revenue growth over the next year and beyond.

I would like to thank the following members and contributors of the Financial Growth Workgroup:

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- Lee Lindquist
- Julie Machulsky
- Kay Ovington
- Daniel Pomerantz
- Allan Prochazka

As we continue developing this plan, we ask you, our members, to help us by contributing your thoughts on specific ways we can implement the recommended strategies and join us as we expand the membership committee and revive a robust development committee.
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