

ANNUAL MEETING UPDATE

UPDATES ON THE 2019 MEETING—YES, WE CAN!

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The timely theme for the 2019 SGIM Annual Meeting is “Courage to Lead: Equity, Engagement, and Advocacy in Turbulent Times.” This year’s meeting will, as always, encompass the breadth of general internal medicine, including health services research, medical education, population health, and excellence in hospital-based and primary care. In addition, this meeting will highlight the contributions generalists can make to advance health equity, patient and community engagement, and high-value care.

We intend the 2019 Meeting to be a venue to discuss how generalists can proactively lead collaborative efforts—within our clinics, health systems, classrooms, and communities—to advance health, well being, and equity.

As such, to support this year’s meeting theme, we are excited to introduce the following new and innovative programs:

- 1. Patient & Community Engagement:** We are inviting patients/community members to attend and participate in the 2019 SGIM Annual Meeting by co-presenting workshops, abstracts, and innovations they have partnered on with SGIM members. Sessions that include patient/community partners will be highlighted in the program. If you are currently involved in community-engaged research or collaborating with patients on an educational or healthcare delivery system innovation, we encourage you to include your non-clinical partners on the submission!
- 2. Advocacy 2019:** Annual meeting participants will be able to schedule in-person visits to Congressional representatives on Wednesday, May 8, before the meeting starts. SGIM will provide talking points and printed materials to leave with your representative. SGIM will also help you contact your Congressional offices to set up a meeting. We will be hosting an Advocacy 101 Webinar for interested participants on April 12 to help you prepare. No cost registration for the event is due April 2—you can add this when you register for the meeting itself.
- 3. Pre-courses:** This year, we will have two innovative pre-courses that embody the meeting theme: one will focus on caring for and advocating for asylum seekers and the other will focus on effective strategies to support community engagement. Join us on Wednesday afternoon to attend one of these timely sessions!
- 4. Special Symposia:** We will have 10 special symposia this year that cover a range of thought-provoking topics, including the contribution of mass incarceration on health disparities, how physicians can advocate for social justice, strategies to support a single-payer health system, and international approaches to addressing health equity. These symposia will feature the director of National Institute for Minority Health and Health Disparities, the former health minister of Mexico, the former president of Ecuador, the CEOs of Healthify and HealthBegins, and the Lancet Commission on Public Policy & Health. Register for the meeting now to engage with this all-star cast!

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SO MANY LANES TO CHOOSE!

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

This past October, there was a lot of commotion around the American College of Physicians' (ACP) position paper on gun violence¹, notably the National Rifle Association's (NRA) response to it.² The infamous "stay in their lane" tweet by the NRA has become a rallying cry not only for the overall medical community and our stance and role regarding the public health issue of gun violence but also other public health areas that don't necessarily involve a direct doctor-patient relationship. The entire medical community denounced the NRA's admonition and SGIM members were among its most energetic voices. In a prior editorial, I mentioned how generalists are among the leaders in advocating and addressing problems not directly linked to the delivery of medical care to adults, and gun violence is one of them.³ In that same editorial, I also commented about an article written by Beth Gillespie regarding SGIM's participation, along with other medical societies, in the Medical Society Consortium on Climate and Health.⁴ Several months prior to that issue, the U.S. Global Change Research Program Climate Science Special Report concluded that there is likely a link between climate change to existing weather patterns, droughts, and the environment.⁵

Most recently, in November, a further climate change report was released again confirming the dire consequences that are associated with the current rate of climate change and the impact it will have on the environment, finance, and health over the next century.⁶ I bring up gun violence and climate change to illustrate the influence that we as individuals and as a Society have on these debates being considered today. These are yet "other lanes" that we must occupy to fill SGIM's vision of "A just system of care in which all people can achieve optimal health."

How we occupy these lanes leads me to one of the articles in this month's *Forum*. For this year's meeting—Courage to Lead: Equity, Engagement, and Advocacy in Turbulent times—Drs. Brita Roy and Lenny Lopez have an amazing meeting lined up with a theme that could not be more appropriate for the time. Not only is the timing right but also the venue is perfect: Washington, DC! The program committee has taken advantage of this to promote content around patient-community engagement as well as meetings on the Hill. This year we will be able to show how we can move forward and stay in any lane we chose on the capital beltway in DC. To get us into the right mindset for the meeting in May, we have set aside a

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HOW DO YOU APPROACH A CHALLENGE?

Giselle Corbie-Smith, MD, MSC, President, SGIM

Creativity is not just the purview of musicians or other artists—creative problem solving is an excellent example of creativity. If you solve problems, pursue opportunities, or address challenges, you frequently engage in the creative process. As educators, clinicians, researchers, and leaders in academic general internal medicine, we are clearly faced with challenges all the time—how do you approach those challenges?



In medical school, many of us learned that typical responses to a challenge are fight, flight, or freeze. However, an additional uniquely human response is to innovate or engage in creative thinking. Creative thinking simply means looking at something in a new way. Gurus in the business world coined the term breakthrough thinking and have described a process by which innovation occurs through creative thinking. When I first started learning about this process, I was excited to know it is universal, meaning it is something we all engage in, albeit in different ways. Creativity is not just the purview of musicians or other artists—creative problem solving is an excellent example of creativity. If you solve problems, pursue opportunities, or address challenges, you frequently engage in the creative process. As educators, clinicians, researchers, and leaders in academic general internal medicine, we are

clearly faced with challenges all the time—how do you approach those challenges?

Research on the creative problem-solving process identifies distinct activities that use specific and unique skills that we all possess to come up with innovative solutions. In this month's *Forum* article, I hope to give you some background on, insights into, and resources for creative problem solving that we can use individually and collectively in our careers.

Alex Osborn, founder of the Creative Education Foundation, first developed creative problem solving in the 1940s, along with the term *brainstorming*.¹ Together with Sid Parnes, he developed the Osborn-Parnes Creative Problem Solving Process. In the creative problem solving process, you are asked to understand the difference between “divergent” and “convergent” thinking, and then learn to separate the two. *Divergent thinking* is the generation of as many potential solutions to a chal-

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The SGIM *Forum*, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the *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 Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Howard Petlack.

A QUALITATIVE REPORT OF RESIDENTS' IMPRESSIONS OF A HIGH-VALUE CARE CURRICULUM

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Nearly 30% of U.S. healthcare spending is considered wasteful and potentially avoidable, and physicians are responsible for helping curtail these costs.¹ Internal medicine (IM) programs are mandated to train residents in high-value care (HVC), but optimal methods for teaching these concepts are not established.^{2,3} We implemented a hospital bill review curriculum to teach IM residents about HVC in the inpatient setting. Previous approaches using patient bills and cost data to teach HVC have had mixed results, including inconsistent associations with reduced costs or improved patient care.^{4,5} Given the limited impact of prior interventions, we took a qualitative approach to better understand how this curriculum impacted residents' understanding of HVC concepts. Specifically, we aimed to explore residents' perceptions of the curriculum and expectations of how the curriculum would impact their clinical practice.

PGY1-3 residents participated in the curriculum while rotating on general internal medicine (GIM) inpatient services at the University of Pittsburgh Medical Center, where GIM teams consist of 1 attending, 1 resident, 2 interns, and 2-3 medical students. Each GIM team was provided with the hospital bill for a patient recently discharged from their service. The bill included all itemized charges from the patient's hospitalization, excluding physician charges. The charges represented the initial price requested from insurance payors. The bill did not include out-of-pocket costs or reimbursement amounts negotiated by insurance companies, as these were unavailable. Attendings received a curriculum guide and attended a faculty development session. Each GIM team met to reflect on and discuss their hospital bill. This exercise occurred monthly for approximately 30 minutes.

We conducted one-on-one semi-structured interviews with residents who received the curriculum during November 2014. Interviews of 10-15 minutes

in length were conducted by qualitative experts. Two investigators reviewed interview transcripts, developed a preliminary codebook, and refined the codebook iteratively as additional transcripts were reviewed. Thematic saturation was achieved after 10 transcripts. Investigators independently applied the final codebook to all transcripts using ATLAS.ti (version 7, Scientific Software, Berlin, Germany). Cohen's Kappa statistic was 0.86, indicating almost perfect agreement between coders. Overarching themes and key quotations were identified by investigators. The study was determined to be exempt by the Institutional Review Board of the University of Pittsburgh.

Twenty of 21 eligible residents completed interviews, for a participation rate of 95%. Most participants were early in their training: 60% were PGY1, 25% were PGY2, and 15% were PGY3.

Themes corresponded to the following two domains: Reflection on the hospital bill and reflection on clinical practice.

1. Reflection on the Hospital Bill: During the exercise, nearly all residents expressed surprise at the magnitude of charges, especially for commonly ordered studies like daily laboratory tests, blood cultures, and chest x-rays. For instance, one resident reflected: "Some of the charges were just surprising. I had some numbers in mind about the cost of an admission, say the cost of the room and bed. And my numbers were totally different from the number seen on the bill."

Residents also reflected on the lack of transparency surrounding healthcare costs. Residents appropriately struggled to understand the relationship between a charge on the hospital bill, the out-of-pocket cost to the patient, and the "true" cost of the test. Residents indicated that having access to

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out-of-pocket costs at the time of order placement would impact their practice more substantially. “I think what would ultimately dramatically impact things is if we had real time access to that data. [...] If you were online shopping. If you clicked on something and saw a price tag right away, I think that would much more influence my management.” Several residents reflected on how this lack of transparency made it difficult for patients to understand healthcare costs: “We talked about how difficult it is for us as physicians to really navigate these different costs and how confusing it must be or difficult for patients as well.”

- 2. Reflection on Clinical Practice:** Residents identified strategies to minimize costs associated with inpatient care. Some residents favored broadly ordering fewer tests. As one resident described, “We talked about limiting extra tests and being conservative.” Specific strategies included decreasing daily laboratory testing, limiting telemetry use, pursuing outpatient over inpatient testing, and discontinuing outpatient medications during hospitalization.

Residents also reflected on ways to maximize the value of testing. For example, residents identified testing that did not influence clinical management, and discussed whether the testing was avoidable. One resident stated, “We discussed how these labs affect our management. And if they wouldn’t affect our management in any way [...] it’s not necessary to check a certain lab every day.” Several residents reported that this discussion influenced their clinical practice: “Even that day I actually ended up ordering less labs for some patients just thinking, ‘Do I really need to order this? Am I really following it or is it just

something I was just ordering because?’ I think I ended up ordering less things for my patients for the rest of the rotation.” Residents also discussed the importance of considering indications for various tests. “We did talk about not ordering labs when they’re not indicated. Not doing a daily phosphorous or magnesium unless we need to, and telemetry was a big thing that we talked about.”

The hospital bill review curriculum was a focused intervention that fostered discussion of healthcare costs and reflection on clinical practice among IM residents. Residents identified examples of low-value care received by their patients and named strategies to reduce healthcare waste. Prior work indicates that providing residents with feedback on costs can improve attitudes towards HVC and reduce spending.^{4,5}

Through resident interviews, we identified several lessons unintentionally transmitted in this curriculum. First, some residents over-emphasized cost reduction without considering test appropriateness. For instance, residents discussed “being conservative” in testing and pursuing outpatient testing to reduce hospital costs. These strategies are unlikely to create less costly care and may result in failure to perform necessary testing. Residents were surprised by the magnitude of hospital charges and this ‘sticker shock’ may have led to a disproportionate focus on reducing spending.

Second, residents infrequently discussed the utility of higher-cost items, such as procedures or radiology studies, which are potentially costly and harmful. Instead, residents focused on lower-cost items, such as daily laboratory tests. Likewise, Sommers, et al, evaluated an HVC intervention for IM residents that included reflection on a patient bill and found that costs of laboratory tests declined while there was no change in radiology or total admission

costs.⁵ In our study, most residents were early in their training and may have lacked the medical knowledge or autonomy to drive decisions about high-stakes testing, leading to a focus on lower-cost items.

Using hospital bills to teach HVC to early trainees can be challenging, and we identified strategies to improve similar curricula. First, discussions must focus on ordering the *right* tests rather than *fewer* tests while decreasing waste. This can be accomplished through training on incorporating evidence-based medicine with HVC practice and discussion questions to achieve this focus. Second, increased cost transparency and cost availability at point-of-care would increase the educational yield of similar interventions.

This study has several limitations. One limitation of our curriculum is that we provided residents with charges rather than costs after insurance reimbursement. Unfortunately, post-reimbursement costs were unavailable and continue to be difficult to obtain. Nonetheless, this curriculum provided an opportunity for residents to reflect on all testing ordered for their patients during a hospital stay and discuss whether any testing was low-value. Participants were also early in their training and from a single institution, limiting generalizability. Finally, we did not measure the impact of the curriculum on spending, but this had been assessed in other studies.⁵

In conclusion, when provided with their patients’ hospital bills, residents reflected on HVC concepts and identified strategies to reduce healthcare waste. However, residents focused predominantly on lower-cost items, and some focused on cost-reduction without considering test appropriateness. To our knowledge, this is the first qualitative evaluation of a hospital bill review curriculum. Our findings may inform future curricular content in this important area.

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COPING WITH PEER-TO-PEER HARASSMENT AND DISCRIMINATION IN THE WORKPLACE: A PRIMER FOR HEALTHCARE PROVIDERS

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While physician burnout and related mental health concerns are getting increasing attention, it is crucial to examine the impact of discrimination and harassment at the workplace which are widely prevalent across disciplines, though under reported. In a survey of 445 physician responders, 63% reported having experienced some form of discrimination at work and only 11% reported an incident of discrimination to someone in their organization.¹ This may lead to a hostile work environment, increased burnout, job turnover, depression, and alcohol dependence among healthcare providers.^{2,3} Harassment of medical students and trainees has also been shown to affect their career choices.⁴

This is a follow up of a previously published article in *SGIM Forum*.⁵ In this piece, we review best practices and share resources for healthcare providers who may be victims of workplace harassment and/or discrimination by colleagues, and for bystanders who witness such incidences.

Scenario

A hospital medicine physician of Nigerian descent has been at his current job assignment for more than a year. He has noted that a physician colleague often jokingly corrects his pronunciation in front of others and suggests he take an English language course. Some colleagues laugh at the comments. The episodes have been getting more frequent, whereby the hospitalist avoids speaking up in departmental meetings due to fear of humiliation, and is contemplating leaving his current job.

How Should the Victim Respond?

Victims of harassment at the workplace often do not report the incidents due to fear of retaliation. However, anti-discrimination laws prohibit retaliation for filing a discrimination charge, testifying, or participating in any way in an investigation, proceeding, or lawsuit under these laws; or opposing employment practices that they reasonably believe discriminate against individuals. Additionally, in some states (e.g., California), an employer may not be liable for harassment by a nonsupervisory coworker unless the employer knew about the harassment and failed to remedy it. Therefore, timely reporting of these events is crucial.

The following are tips for a victim of workplace discrimination or harassment, compiled from available resources from the Equal Employment Opportunity Commission (EEOC) and American Association of University Women (AAUW):

- If subjected to a criminal offense, such as threat or act of physical aggression or rape, call police immediately; and report the incident to the state medical board at the earliest opportunity
- Document in writing the following:
 - Experience with the harasser—time, location, details, and witnesses
 - Experience reporting the harassment—time, location, details, and witnesses
 - Productivity at work during and after reporting
- If you are a victim of an act of harassment such as

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sexual harassment, bullying, or harassment based on gender identity, sexual orientation, religion, race, or ethnicity, consult the employee handbook or policies and follow the workplace harassment policy in place to report the incident

- If you do not have access to the policy, or if a policy doesn't exist, report the behavior to the human resources (HR) department or the person responsible for workplace investigations/complaints
- Federal employees should report a harassment incident to an EEO Counselor at the agency where the person works or may have applied for a job, within 45 days of the incident. The EEO Counselor will offer the victim options of either an EEO counseling or an alternative dispute resolution program. If these options fail to resolve the dispute, the victim can file a formal complaint with the EEOC office within 180 days of the incident.
- Victims are encouraged to contact the EEOC for insight and resources, or to file a discrimination complaint⁶. Reports can be filed (online or over the phone) with EEOC without the assistance of an attorney, within 180 days after the incidence. Victims are required to file a report with EEOC if they wish to pursue legal action against their employer for harassment.
- For medical students:
 - follow the university's complaint filing procedure, and/or
 - file complaint with U.S. Department of Education Office of Civil Rights (within 180 days of the incident)⁷
- For discrimination based on citizenship or immigration status, complaints can be filed with Immigrant and Employee Rights Section (IER) within 180 days.⁸
- If the victim feels comfortable, he/she can:
 - Inform the supervisor about the

incident and the steps you have taken to address it

- Confide in family, friends or co-workers for emotional support
- Review the state medical board's policy and report if the case fits its jurisdiction

How Should the Bystanders Respond?

The bystander effect has commonly been observed in events of violence or harassment, including at workplace, where a bystander watches without intervening, when a person is in need of help. In a survey of more than 200 employed female university students, 70% had observed sexual harassment of other women and 60% had observed gender harassment of others.⁹ Adding his/her voice to redirect the harasser, support the victim in the moment and during the formal complaint process, the bystander can catalyze culture change at workplace. Some bystanders fear retaliation including loss of job. However, it's worth noting that anti-discrimination laws prohibit harassment of or retaliation against employees who file discrimination charges, testify, or participate in any way in an investigation, proceeding, or lawsuit; or oppose employment practices that they reasonably believe discriminate against individuals.

The following are tips for the bystanders (including immediate supervisors) who witness discrimination or harassment at the workplace or get a report of the incident, compiled from available resources by the EEOC.

- Support the victim during the incident and afterwards
- Try to redirect the perpetrator, if possible
- Document in writing the incident you witnessed, including date, time and what you heard and witnessed
- Consult the workplace employee handbook, and follow the employer's harassment policy to report the incident.

- If you are a supervisor who was a bystander or received a report, do not begin an investigation, unless you are designated to do so by the employer. Instead, report the incident promptly to HR or the person designated to investigate these incidents at the workplace.
- If the bystander does not have access to the workplace policy and does not feel comfortable speaking to a supervisor directly, he/she may report the incidence to the human resources department or the person responsible for workplace complaints.
- If the victim wishes to stay anonymous, a witness or bystander can file a complaint with EEOC6 on behalf of the witness, online or via phone, within 180 days from the date of the incidence. The process doesn't require the assistance of an attorney.
- Review your state medical board's policy and report if the case fits its jurisdiction

Conclusion

While physician burnout reaches epidemic proportions and healthcare systems are looking at interventions to curb this epidemic, we call for healthcare leaders to review policies and workplace culture, to develop policies and promote a culture exemplifying zero tolerance for discrimination and harassment at workplace. We also call for healthcare leaders to develop victim and bystander support training programs, to empower victims to report and seek support in events of harassment and discrimination, and bystanders to actively support victimized colleagues.

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DIAGNOSTIC ERRORS IN INTERNAL MEDICINE

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Diagnostic error is defined by the National Academies of Sciences (formerly Institute of Medicine) as failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient. Diagnostic errors contribute to approximately 10% of patient deaths and medical record reviews suggest that they account for 6 to 17 percent of adverse events in hospitals.¹

One of the Core Competencies of hospitalists described by the Society of Hospital Medicine emphasize the importance of hospitalist to be able to minimize the hazards of diagnostic and management strategies, hence indicating their vital role in controlling error.²

Diagnostic errors may be subtle and difficult to measure in the hospital and outpatient setting. A slip could be as trivial as giving potassium supplements to a patient who is already receiving IV fluids containing potassium for hypokalemia and making the patient hyperkalemic enough to require ICU care. Although these errors may superficially seem to be of low impact, they have the potential for grave consequences. They account for poor quality of care, increased morbidity, and longer length of stay.

Diagnostic errors in primary care settings are important as well since the primary care provider's (PCP) office is usually the first patient contact for a disease symptom because of easy accessibility. Typically PCPs see high patient volumes and make quick decisions. In addition, PCPs have to accurately assess and balance diagnostic testing with often scarce and costly referral resources. Five dimensions are important when considering diagnostic error in primary care. These include patient provider encounter, diagnostic tests, follow up and tracking, referral and coordination with sub-specialist and patient behavior.³

Medical care is fraught with heavy interdependence on generalist and specialist care. Any overlook in the system, in part by a provider, can lead to diagnostic error. If, for example, a radiologist has made a perceptual or cognitive error in reporting an imaging study, it may lead to delayed diagnosis and poor outcome. Improving timely and correct diagnosis will enhance quality; reduce

Effective communication and collaboration among all members of the diagnostic team are required to improve healthcare quality and outcomes and reduce the incidence of diagnostic error.

mortality, readmissions and cost of care. It is our professional and moral responsibility to improve the diagnostic process. One of the important goals of the electronic medical record (EMR) is to enhance quality and safety of care. As currently used, EMRs are far from ideal, but EMRs have changed the diagnostic workflow and improved diagnostic accuracy. At the same time it has also raised many concerns and problems.

According to the National Academies of Sciences report failure to communicate a patient's health problem, is a subcategory of diagnostic error because patients and their families are considered part of the diagnostic team.⁴ Effective communication and collaboration among all members of the diagnostic team are required to improve healthcare quality and outcomes and reduce the incidence of diagnostic error.

ACGME requires residents to know how to report patient safety events, including near misses. Residents have the opportunity to participate in disclosing such events to patients, real or simulated. The Clinical Learning Environment Review (CLER) Program is designed to provide U.S. teaching hospitals, medical centers, health systems, and other clinical settings affiliated with ACGME-accredited institutions with periodic feedback that addresses six Focus Areas including Patient Safety and Health Care Quality. Many teaching hospitals have instituted programs to address this specific area which will have a direct effect on diagnosis and management errors.

Current trends of major academic centers collaborating with smaller medical centers as a referral base have led to increased hospital-to-hospital transfers. As a result diagnostic discordance was common (85.5%) during inter-hospital transfers and was associated with

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READING POST-CALL POETRY

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Author's note: Years ago, I came across an essay by Danielle Ofri in *Poetry Magazine* in which she described reading poetry to medical students and residents on the wards at Bellevue Hospital. Nowadays, when I ask my learners for feedback at the end of each rotation, hardly anyone compliments me on my chalk talks. Almost everyone offers appreciation for the poetry. The following poem is based on a true story.

In the footsteps of Danielle Ofri

The young physicians file in apprehensively inspecting
scattered chairs laminate tables a lone sofa splashed
with sunlight. Despite the shade of fatigue their minds

are constantly computing navigating algorithms mastering
games. Which is why I gave them warning after making rounds
and slashing the day's check boxes we'll pause for post-call

poetry. The word itself against the starkness of the wards is startling
so we begin with something easy lines straight and free flowing
no masking the poet's intention a call to listen generously.

The confident resident used to speaking with authority
speaks with authority and buoyed by his endorsement the others are
engaged. I raise the stakes let them steep in metaphor riddle them

with syntax just beyond our reach. We will no longer tolerate
a hierarchy of meaning one resident conveys from the corners of
her eyes seeming pleased. I sip Doctor Pepper deliberately.

The final poem conjures a landscape so distinct it suggests
an alternate universe a dazzle of light tincture of sea spray
that prickles the senses precisely. For thirty rarefied seconds

nobody speaks. We soak in the sun and stretch like cats in our seats.
Before we break our MD PhD, lean, bespectacled twists as if to leave
instead unfolds a sonnet that he penned and clears his throat to read.

IS THE BOW TIE A LESS FORMIDABLE FOMITE THAN THE NECKTIE?

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Today's physicians and medical students make decisions about their attire in a variety of clinical settings every day. One factor likely affecting their choices is the perception that patients care how their doctors dress. In this article, we review the literature on patient preference for physician attire. For doctors making a choice in neckwear, another consideration is the concern that neckties are a potential source of healthcare-associated infections. Bow ties, a less common neckwear style, might represent an important alternative to the necktie.

The largest study to date to evaluate patient preference for physician attire was published in 2018 and involved more than 4,000 adult patient responses from a wide geographic area of the United States.¹ This survey of male and female patients (mostly over age 55) included photographs of both male and female physicians dressed in seven forms of attire. A composite of patient preferences for their doctor's appearance was calculated across five domains: knowledgeable, trustworthy, caring, approachable, and comfortable. The attire in the photographs ranged from casual to formal (with or without white coat). The three more formal attires depicted by a male model included a necktie, though this was not noted as a key component of the study. Bow ties were not included in this study. Overall, 53% of patients surveyed replied that physician attire was important to them. Formal attire with a white coat was the preferred uniform for a physician in both the hospital and the primary care clinic. This study highlights that despite changes in fashion across society and the rise of "business casual," patients still have a preference for more traditionally formal dress from their doctors.²

Neckties, given their lack of routine washing and potential for inadvertent occupational contact, could be a significant fomite for doctors in the hospital. A systematic review published in 2018 evaluated the available literature on this topic.³ These authors included and analyzed six studies in their review, but were unable to perform a meta-analysis due to the lack of robust data. The authors concluded that neckties worn by doctors might be contaminated or colonized with nonpathogenic bacteria, but that limited evidence exists that they are colonized by more virulent bacteria or are able to transmit bacte-

ria in a controlled experimental setting. These authors found insufficient evidence to support a policy restricting neckties, such as the United Kingdom's "bare-below-the-elbow," dress code program.³

One study cited by this systematic review, a 1993 multi-center randomized double-blind crossover trial in the United Kingdom⁴, addressed bow ties specifically. The authors postulated that bow ties were more hygienic from an infectious diseases standpoint as compared to neckties. They recruited physicians from two teaching and three general hospitals in Wales and England. Study participants wore one tie for three days in one week and the other tie for the same period in a second week. A sterile saline soaked swab was taken from the tip of the participants' ties at the end of the first and third working day and assessed for bacterial growth. Using a semiquantitative system, the specimens were classified if there was bacterial contamination or not, but the type of bacterial growth was not analyzed. Bow ties were significantly less contaminated on the first day (which was statistically significant); however, on the third day there was no difference in the level of contamination. The results were limited by the small number of physicians who participated ($n = 12$) resulting in a total of 54 swabs that were analyzed.

Intuitively, it would seem that bow ties are likely more hygienic and less likely than neckties to transmit organisms, but the bow tie cannot be strongly recommended over the necktie based on this study. Further studies using a larger physician sample size and more advanced microbiologic techniques might provide additional data to support the bow tie over the necktie. In our experience, tying bow ties is not particularly challenging, and patients, colleagues, and staff tend to find them memorable. In terms of infection prevention for patients, adhering to standard precautions such as hand washing is likely to play a larger role than one's choice in neckwear.⁵

While the bow tie is sometimes perceived as a traditional or overly formal neckwear choice, it has been embraced by diverse communities. For example, the Ties to Love™ campaign promotes bow ties on Fridays in support of the gender non-conforming and trans community.⁶ We would encourage the use of bow ties instead of neckties

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for physicians who are intrigued by the potential for infection reduction, but also understand that a patient's satisfaction might be linked to his/her doctor's attire.

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The authors in formal attire with white coats (and bow ties).

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SGIM MID-ATLANTIC MEETING RECAP

Rosemarie L. Conigliaro, MD

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The day dawned cold, gray, and cloudy in Morristown, New Jersey, for the 2018 SGIM Mid-Atlantic Regional (MAR) Annual Meeting with the theme of “Clinical integration: Alignment across the Care Continuum.” Our location was the beautiful campus of the College of Saint Elizabeth, named for Elizabeth Ann Seton, the first American woman to be canonized as a saint in the Catholic church. The hosts were from Morristown Medical Center, a member of the Atlantic Health System, and the meeting chairs were Brenda Matti-Orozco and Gina Lacpra, aided by their colleagues, David Kuo and Rebecca Griffith. The venue was spectacular, a beautiful educational center in a rural setting replete with fall colors. As members drifted in and ate breakfast, the noise and energy in the lobby grew.

The program began with a welcome by the outgoing MAR president, Rosemarie (Ro) Conigliaro, followed by an update from SGIM’s CEO, Eric Bass. Eric reviewed for us SGIM’s new mission and vision statements, how we got here, and outlined a roadmap for where we (National SGIM) are going. In his review, Eric touched on the many programs and opportunities which involvement in SGIM provides for its members, and underscored SGIM’s importance on the national stage as an advocate for both its members and our patients in these turbulent times. This was followed by a thought-provoking talk by our keynote speaker, Dr. Ed Young, from the Mount Sinai Health System, who is boarded in both IM and Informatics. Congruent with our meeting theme, Ed’s talk was titled “Working Together with Data for Patient Care and Clinical Integration: Promise & Pitfalls.” He spoke about interoperability, and the potential as well as pitfalls of IT in this age of runaway data and Health Information Technology. Ed reminded us that use of patient data requires consent, that consent needs to be simple, consistent, and flexible, that data ultimately belongs to the patient, and that we all have a responsibility to make data both more useful and safe.

Our day continued with the first poster session of approximately 50 posters, held a short walk to the College library, which featured clinical vignettes, clinical practice and medical education innovations, and scientific abstracts. The first workshop session featured a standing-room only session by Hofstra faculty on Individual

Development Plans for goal setting and career development, as well as sessions on diabetes management from a psychosocial viewpoint, and cultural competency. Lunch included networking opportunities and mentoring tables, where senior SGIM members welcomed table visitors to discuss and answer questions about careers in clinical-education, clinical-research, clinical-administration, hospital medicine, primary care and GIM fellowships and other training opportunities.

The afternoon workshop session included a practical approach to prescribing the myriad new diabetic medications, featuring pearls from clinical pharmacy students, and a much-sought-out handout. The afternoon poster session now required a dash through the rain to reach coffee and the next set of 50 posters as well as poster tours, and more judging. The rain did not dampen the energy and enthusiasm of the group, as evidenced by many members engaged in intense conversations. After the last poster session, the final session of the day showcased the top rated abstracts as oral presentations of Clinical Vignettes, Educational Innovations, and Scientific Abstracts.

Attendance was outstanding, with a total of 186 participants, from all over the region except Puerto Rico. New York, New Jersey, and Pennsylvania were the most represented, with attendees from the other Mid-Atlantic states (Delaware, Maryland, DC) as well as from the Southern, Midwest and New England regions, and even one attendee from California! Our meeting boasted 43 student and 64 trainee attendees, so we were successful in our goal to involve associate members. Overheard conversations included ideas for future workshops, suggestions for publications of posters, and advice and input on career options. One member, for whom this was not their first meeting, told me “I met so many new people this year!”

Our meeting was a great success, thanks in no small part to the Leadership Council and the Committee chairs, including great coordination and scheduling by Mariecel Pilapil and Paul O’Rourke, who served in multiple capacities as well as all our poster judges, tour guides, session moderators and submission reviewers. In addition, we could not have pulled it off without the Herculean efforts of Allison Barrett, who stepped in as

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our staff assistant and even began training our new assistant assigned to our region, Tabina Lee-Noonan. Finally, Kay Ovington, SGIM's Deputy CEO, never let anything fall through the cracks, even emailing us at 10 pm with reminders and follow-up information.

Awards were announced at the end of the day, and included the following: Excellence in Clinical Education, Frank Cacace from Hofstra/Northwell; Excellence in Clinical Investigation, Eva Tseng from Johns Hopkins; Advocacy and Community Service Award, Nisa Maruthur, also from Johns Hopkins;

and Leadership in GIM Award, Jen Kraschnewski from Penn State. Also announced were our newly elected officers for the 2020 meeting: Jen Goldstein, President-elect; Patricia Ng, Secretary-elect; Manasa Ayyala, Membership-chair-elect, and Clark Veet, Associate Member-Elect. Ro passed the gavel to Tom Radomski, who will assume the position of president and lead the planning for the 2019 meeting, which Tom announced will be in Pittsburgh, PA. Having lived in Pittsburgh for many years, and familiar with its reputation for being one of the nation's least sunny cities, I expect the weath-

er to be about the same. However, I expect the 2019 MAR meeting to be even better than this year, since our goal is to continually improve the quality of our regional meeting, and to embody at the local level the values and mission that SGIM is to all of us as academic general internists.

By now the rain was torrential, as participants filed out to their cars to begin their journeys back to their hometowns. They left energized, engaged, and ready to take on the continuing challenges of providing excellent health care to our patients across the Mid-Atlantic Region.

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IMPROVING CARE: PART I (continued from page 8)

increased inpatient mortality. At the same time, State Health Information Exchanges have decreased diagnostic discordance and improved patient outcomes.⁵

Cognitive mistakes are behind many diagnostic errors. A recent study showed that physician burnout is likely an independent factor for medical errors than system level factors.⁶ Thus, handling burnout and improving wellness initiatives are likely to reduce diagnostic errors. Subtle clinician biases are yet another cause of diagnostic error, which may not be evident to physicians particularly in the setting of shift work and frequent handoffs, when they may not have the opportunity to review and receive feedback for their diagnoses over time. Computerized decision support mechanisms are helpful but have not yet proven to be a reliable method to improve overall diagnostic accuracy.

Reducing diagnostic errors is a complex process. Lack of measures of diagnostic accuracy remains a big challenge. Current quality measures do not take diagnostic accuracy into

account. However, collaboration at all levels is needed to achieve gains. This will involve instituting or the strengthening of educational agendas to improve the metacognitive abilities of clinicians, fostering intuitive reasoning and increasing awareness of the role of systems in the diagnostic process.⁷ System-wide EMR standardization, proper Health Information Exchange, and closely working with governmental and professional agencies will likely reduce diagnostic errors and promote a quality and safety culture in our medical centers.

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themed April issue of *Forum* dedicated to Advocacy. If you haven't yet submitted your work, there is still time—the deadline is February 10, 2019.

A rundown of this issue includes understanding residents' impressions on high value care, coping with peer-to-peer harassment, a primer on diagnostic errors, some poetry, and a recap from the Mid-Atlantic region. And this month's fashion advice comes from that hot bed of trendy couture, the Bronx. Happy driving!!

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ANNUAL MEETING UPDATE (continued from page 1)

5. **Provocative Plenaries:** During the Thursday plenary session, the President's address will be delivered as a TED-style talk. Then, we will feature "lightning talks" by two of our SGIM members who excel in equity, engagement, and advocacy. Each will deliver a brief, dynamic, stimulating, speech that features their work to promote health equity through education, research, and/or policy. Get ready to be inspired!

We are also pleased to announce that the Malcolm Peterson Lecture will be delivered by Camara P. Jones, MD, MPH, PhD, former president of the American Public Health Association and senior fellow at the Satcher Leadership Institute, Morehouse School of Medicine. She is a family medicine physician whose work focuses on the impact of structural racism on the health and well-being of the nation. In addition, we are excited that Vivek H. Murthy, MD, MBA, 19th Surgeon General of the United States, will be joining us for the Saturday plenary session to deliver a short speech and engage with us all in an open discussion. He is a general internist and hospitalist

who has focused on addressing the opioid epidemic, fostering emotional well-being, and promoting walkability in communities across the United States during his tenure as surgeon general.

Finally, in order to engage our trainees and create more opportunities for networking and collaboration among all of our members, we will be coordinating poster "walk & talks." During each poster session, the top 10 most highly rated posters in a specific category may be toured by a relevant Commission or Interest Group. We hope these poster walk & talk sessions result in establishing new connections and engaging discussions among SGIM members of all stages of training and tenure.

As a large group of general medicine physicians, together, we have a unique opportunity to promote health across a myriad of communities through clinical care, research, education, and advocacy, from a non-divisive vantage point during this especially tenuous political time. Let's use our time together in Washington, DC, between May 8-11, 2019, to energize, organize, and collaborate on ways to achieve this audacious goal.

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lenge as possible; in other words, thinking very broadly. *Convergent thinking*, on the other hand, is narrowing down the possible solutions by critically evaluating the options and choosing the most promising one (or ones). Research has shown that meaningful solutions are most often generated through the use of both divergent and convergent thinking, although not when used simultaneously. One is not better than the other; both are necessary for viable solutions.

The Creative Education Foundation (CEF) describes the following four core principles of the creative problem solving process:

1. Divergent and convergent thinking must be balanced.

There needs to be a clear understanding of how divergent and convergent thinking differ. Each way of thinking needs to be done separately, meaning that people need to be able to consciously shift between the two ways of thinking. The key is knowing when to practice each one, and how to balance them effectively.

2. Ask problems as questions.

Rephrasing problems and challenges as open-ended questions with multiple possibilities makes coming up with solutions much easier. Problem statements tend to generate limited responses, or none at all.

3. Defer or suspend judgment.

Judging solutions “on the fly” tends to shut down idea generation or divergent thinking. The appropriate and necessary time to judge ideas is during the convergence stage, not the divergent one.

4. Focus on “Yes, and,” rather than “Yes/No, but.” Language matters when you’re generating information and ideas. “Yes, and” affirms people’s ideas and encourages them to expand their thoughts. Using the word “but”—preceded by “yes” or “no”—typically ends conversa-

tion, and often negates what’s come before it.

We engage in the creative problem-solving process (probably without realizing it) every day as we face challenges big and small, and we all have preferences for how we engage in the process. I first learned this when I participated in different leadership programs, and now have integrated these ideas into much of my current work. Research around creative problem solving helps us understand these four distinct and sequential steps within the process.

The following four steps engage either divergent or convergent thinking:

Step 1. Clarify/Identify your goal, desire, or challenge.

You may assume, incorrectly, that you know what the problem is and immediately begin to implement solutions. Such assumptions may lead you to solving the wrong problem and in some cases making a given situation worse. Convergent thinking is useful for identifying the problem. When you have clarity around the problem, collect information about it and ask questions that will generate solutions.

Step 2. Ideate. To ideate is to form an idea of, imagine, or conceive. This is the divergent thinking step in the creative problem-solving process.

The goal is to generate (brainstorm, ask what if we...) multiple potential solutions that respond to the challenge questions from Step 1.

Step 3. Develop. The development stage requires a switch to convergent thinking. The goal of this stage is to critically evaluate all potential solutions and converge on the most viable one (or ones). Consider whether potential solutions meet your needs and criteria, and decide whether they can be implemented successfully. Examine strengths and weaknesses of each and determine which solution is the best “fit.”

Step 4. Implement. This is the action phase of creative problem solving. Identify resources needed, determine actions you will take to implement your solution(s), decide who will do what by when, ensure all involved in the solution understand the plan and accept it, and push the “go button.” Continuous monitoring of implementation activities and evaluation of whether your solution is actually solving the problem will help ensure success.

Each of these steps requires unique skills that people already possess. However, most of us prefer some modes of thinking over others. For example, we may naturally tend to use divergent thinking rather than convergent, or prefer action rather than discussion. As I learned more about the creative problem-solving process, it was eye opening for me to understand my preferences for Steps 2 and 4—ideating and implementing.² I realized that I tend to overuse these preferences, often coming up with lots of ideas and moving to implement them without having clarity on the problem I was solving or working with a well-developed plan on how to move the idea forward! This helped explain a lot of the frustrations I had as a team leader and helped me understand my colleagues’ preferences that were different from my own. The reality is that each of the steps is critically important. Using the principles of the creative problem-solving process has given me some really important insight and an important tool that I have used in my work whenever I’m facing a challenge.

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