

PERSPECTIVE: PART I

WAITING FOR A HURRICANE

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A few years ago, as a forecasted hurricane was bearing down on the Atlantic coast, I called to check on my nephew who lives on the Georgia Coast. We talked while he walked his dog on the beach—he sent me a picture of the two of them. It was beautiful day. Other than the forecast, life around him looked pretty normal. He had made no firm plans yet as to what he was going to do. “We’ve got some heavy surf, but not much else. We’ll see what happens.”

I couldn’t help but think back to that moment over the past week. We are all waiting for a hurricane. As the week started, Colorado had just a few dozen confirmed cases. Our hospital had one suspected case in house. It was sunny outside.

Yet, in response to the forecasts, we were no longer walking on the beach, we were nailing up the plywood.

We sent the bulk of our providers and staff home to work and converted most of our appointments into virtual ones. We rushed to make sure everyone knew how to conduct virtual visits and to figure out how to choreograph the work of supporting staff and providers located in different locations. We distributed protocols for PPE and discussed and re-discussed our triage protocols as the ground shifted around us. We set up communications plans and a back-up org chart and started reaching out to volunteer and retired physicians to see who might help if we needed them. We did all of this to a soundtrack of pings from our e-mail accounts, heralding updated versions of the announcements and guidelines we had received and read just a few hours before.

“I realized my biggest source of anxiety now was whether he, and millions of other Americans, would believe they had that power right now—the power to change the course of this hurricane.”

My personal inbox was also receiving a steady stream of replies to an e-mail I had sent to friends and family over the weekend. To soothe my rising anxiety, I sent a note pleading with everyone to take the threat seriously. I included specific steps I hoped they all would take. The steady trickle of responses was mixed. For every 5 or 6 thank yous or requests for advice, there was a conspiracy theory counterpoint or a Chicken Little accusation. On Monday, my nephew in Savannah posted a picture of himself and his wife at a St. Patrick’s Day parade,

steps from the beach he had walked before the earlier hurricane hit. My heart sank.

Around me, in Colorado, things were changing. Our governor

was taking charge. Restaurants were closing to in-person dining. Schools closed. Business were sending workers home. “Stay home” was the clear message.

I took our first doc-of-the-day shift on Tuesday. I drained an abscess, diagnosed a new case of gout, and gowned-up for a patient who had worsening respiratory symptoms that I screened for Covid. In between, I fumbled through a series of virtual visits, making calls, and dispensing some prescriptions that a week ago I wouldn’t have considered if the patient weren’t sitting in front of me. I finished the day acutely aware that in the weeks and months ahead our patients will need our help with a long list of problems that have nothing to do with Covid.

I slept poorly that night as I had the night before—my mind working through various scenarios

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FROM THE EDITOR

NESSUN DORMA!

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

*"Nobody shall sleep!...
Nobody shall sleep!
Even you, oh Princess,
in your cold room,
watch the stars,
that tremble with love and with hope.
But my secret is hidden within me,
my name no one shall know...
No!...No!...
On your mouth, I will tell it when the light shines.
And my kiss will dissolve the silence that makes you mine!...
(No one will know his name and we must, alas, die.)
Vanish, o night!
Set, stars! Set, stars!
At dawn, I will win! I will win! I will win!"*

—*Nessun Dorma* from *Turandot* by Giacomo Puccini

I am at a loss for the words that can adequately describe these last several weeks. I know all of you have been deep in the throes of this pandemic. I know you lost patients. You may have lost colleagues or loved ones. This is unprecedented. This is historic. I think it's fair to say that most of us have never had nor imagined an experience like this. But general internists are made for this. We have the capability to clinically function on many facets of the care team to support the front line. Our skills in research, education, and leadership also make us critical to our organizations in coordinating the overall short- and long-term response at the health system, community and national level.

Before the crisis hit New York City, I had been following and continued to follow the situation as it unfolded in Italy. Among the news coverage reporting numbers of cases, mortality and Italy's health care system's response were stories and videos of opera singers singing from their balconies while quarantined. For some reason, the song that was most commonly sung in these videos was the aria *Nessun Dorma!* from Giacomo Puccini's *Turandot*. I wondered why? Was this purposeful or just a random performance of a popular song in Italian culture?

The story of *Turandot* is an apt metaphor for what we've been going through—it is one of confidence, determination, and resolve in the setting of overwhelming odds. In Puccini's opera, *Turandot* is a beautiful and cruel princess who challenges her many suitors to answer three questions. If they are wrong, the punishment is death. No one has ever succeeded.

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SOLVING PROBLEMS AND LOOKING TO THE FUTURE: LIFE DURING THE COVID PANDEMIC

Jean Kutner, MD, MSPH, President, Society of General Internal Medicine

Just when we all most need the renewal and camaraderie provided by the SGIM annual meeting, we find ourselves needing to find new and innovative ways to stay connected to each other and to our overarching missions as a field and as an organization.

“At some point, everything’s gonna go south on you...everything’s going to go south and you’re going to say, this is it. This is how I end. Now you can either accept that, or you can get to work. That’s all it is. You just begin. You do the math. You solve one problem...and you solve the next one...and then the next. And if you solve enough problems, you get to come home. All right, questions?”

—*The Martian*, 2015



This quote resonates within me as I write this, my first *Forum* column as president, in late March 2020, deep in the midst of the COVID-19 outbreak. Instead of putting the final touches on what was to be a spectacular meeting, SGIM staff and Council have spent the past several weeks weighing alternative options as it became apparent that we would not be able to hold this annual meeting. Simultaneously, all of us are facing significant professional and personal upheaval: Student and resident educational experiences have been upended, research disrupted, etc. Our approach to clinical care has also drastically changed. On the per-

sonal front, children are home from school and social interactions are curtailed. Instead of looking forward to spending time together at the SGIM Annual Meeting, learning and connecting, we are deep in the throes of the impact of COVID-19 related activities. Just when we all most need the renewal and camaraderie provided by the SGIM annual meeting, we find ourselves needing to find new and innovative ways to stay connected to each other and to our overarching missions as a field and as an organization.

How do we carry on in the midst of such change and uncertainty? To quote *The Martian*, “you solve one problem...and you solve the next one...and then

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ELECTIVE IN ACADEMIC HOSPITAL MEDICINE FOR INTERNAL MEDICINE RESIDENTS

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As Hospital Medicine has grown as a specialty in recent years, academic institutions are shifting more and more attention to training residents in this discipline. As a result, an increasing number of training programs have begun to offer electives for residents in this field.¹⁻³ Among the institutions that have publicized their elective descriptions, significant variability exists regarding clinical experiences, extent of administrative and non-clinical opportunities, and elective duration. According to the Hospitalist Elective National Survey, the most recent data show that the majority of programs that offer such rotations are now incorporating non-clinical activities such as teaching, research, and quality improvement (QI)/patient safety. Most elective descriptions that have been publicized are often offered only in four-week blocks³. Few opportunities exist for residents to complete a shorter, two-week elective that provides non-clinical and perioperative experiences as well as the traditional clinical rounding roles. We have created a unique elective in Academic Hospital Medicine that addresses both clinical medicine and value-added services relevant to hospital medicine physicians in a two-week timespan. This article disseminates information on our elective to Hospital Medicine programs and physicians with similar goals of exposing trainees to the careers of academic hospitalist physicians within the confines of limited resident elective time.

Senior internal medicine residents at Duke University Hospital (DUH) have the option of taking a two-week elective course in Academic Hospital Medicine. The resident on the DUH Academic Hospital Medicine elective manages acutely ill patients as a member of the Hospital Medicine service. The following two major learning areas are emphasized:

1. Clinical Roles:

- a. Inpatient acute care of general medicine patients, including independently developing and executing the plan of care and communication with multidisciplinary team members, with education on topics including effective clinical documentation and discharge planning.

- b. General medicine consultations for management of perioperative risk assessment, arrhythmias, hypertension, diabetes, delirium, hypoxemia, and other common inpatient questions.
 - c. Observation of transfer request calls for experience in triage of potential patient transfers from referring facilities.
 - d. Participation in the Rapid Response Team (RRT) with expectation to lead clinical decision-making with support of the supervising attending during clinical decompensation and emergencies.
 - e. Procedures including paracentesis, thoracentesis, lumbar puncture, arthrocentesis through direct observation and practice.
2. Administrative and Academic Roles: One-on-one pairing with hospitalists for direct observation of their non-clinical roles, focusing on quality improvement, hospital administration, and patient safety for a unique perspective on future career opportunities.

In addition to the required end-of-course residency program evaluations, we have collected the following three separate surveys from our participants:

- **Pre Survey for Residents: assesses their baseline comfort with a variety of Hospital Medicine topics and career preparedness.**
- **Post Survey for Residents: assesses their change in comfort as an effect of the elective.**
- **Post Survey of Faculty: surveying faculty after the rotation helps capture any impact on their job satisfaction as this elective intervention requires additional effort from faculty members.**

We are collecting data from participating residents and faculty members over the academic years 2017-2018, 2018-2019, and 2019-2020. We anticipate 14 total residents and 46 faculty members over this time period. We hope to conduct a robust evaluation of this new educational elective using this data. Results will inform

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continued future improvements and refinements to the curriculum.

Our data thus far is comprised of responses to surveys during the academic years 2017-2018 and 2018-2019. We have received feedback from 11 residents during this time. Our qualitative feedback from residents to date is overwhelmingly positive and reflects increased confidence and knowledge related to both clinical and non-clinical roles. Recurrent themes emerging from the comments include the following:

1. Significant learning benefit from the unique and exclusive experience of administrative shadowing and QI meetings and
2. Valuable learning/teaching opportunity to perform general medicine consults and educate other specialty physicians and advanced practice providers.

Potential areas of improvement addressed in resident comments include the following:

1. More guidance for residents on the General Medicine Consult service for maximum benefit.
2. Option to spend more time on General Medicine Consults/procedures/RRTs rather than primary inpatient care of hospitalized patients which is already heavily emphasized in residency training.
3. More observation of patient transfer request calls in order to fully understand this process and the health system's clinical mission.

Regarding faculty perceptions, we have obtained 40 responses to our surveys to date. Quantitative data shows that 52% of respondents strongly agreed that they enjoyed working with a resident on a non-clinical role; 70% strongly agreed that they would like to work with a resident on the elective again; and 64% agreed that the experience provided valuable teaching opportu-

nities. Qualitative feedback from the faculty is generally positive and supports the idea of resident exposure to the hospitalist career. Suggestions for improvement include providing more intentional preparation for the faculty member to align with resident learning objectives, as this elective has a unique purpose that differs from the usual teaching attending role. Faculty also expressed an interest in viewing resident perceptions/feedback on attending the administrative meetings and conferences.

The sustainability of Hospital Medicine lies in the many opportunities that hospitalists have to contribute to a safer, more effective, patient-centered environment, and it is important to recognize that such opportunities exist outside of direct patient care. By exposing residents to value-added experiences in Hospital Medicine, we hope to create the necessary foundation for those interested in this career path and to perpetuate the values of the field among future generations of hospitalists. We feel that our elective offers a unique experience for residents interested in Hospital Medicine by providing direct, individualized exposure to non-clinical roles including quality improvement, hospital administration, and patient safety alongside the opportunity to practice clinical medicine in a more autonomous setting than offered during traditional resident rotations. Our elective also has the advantage of addressing these various aspects of Hospital Medicine in just two weeks, making it possible for the resident to partake in this experience alongside other elective pursuits that may be a part of the learner's individual educational plan. Additionally, we feel that this elective provides a unique supervisory teaching role for hospitalists aside from the traditional Hospital Medicine-based teaching services. Opportunities for improvement based on our preliminary data include potentially adjusting

the elective to weigh more heavily on clinical experiences outside of General Medicine inpatient care, providing a more robust resident curriculum for the General Medicine consult service (which we plan to achieve by formalizing their consult training using available curriculum modules), and allowing more opportunity to observe triage and decision-making surrounding patient transfer requests from referring facilities. For our faculty participants, we plan to emphasize the uniqueness of the resident learning objectives of this elective compared with those of more traditional general medicine rotations in order to shape the experience into a more valuable teaching opportunity and ultimately benefit job satisfaction. We will continue to collect qualitative and quantitative data during the academic year 2019-2020 and address additional areas of opportunity to refine the curriculum as they arise, embracing the principle of continuous quality improvement.

In the meantime, we feel confident that through this elective in its current form, we continue to expose learners to the value added by an academic hospitalist to patient care and the health system while simultaneously empowering them to direct their educational experience.

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WRITING TO MAKE SENSE OF IT ALL: GRAPPLING WITH COVID-19 WHILE FAR FROM HOME

Anonymous

Bangkok, Thailand, 24 March 2020

Writing has long been a struggle for me. The discipline and steady focus that writing demands, coupled with unperturbed stretches of time, pose formidable barriers. But more difficult to surmount is my poorly managed anxiety that writing distracts from the “real” work of teaching and caring for patients. How is it that I find the time and attention now, in the midst of a dizzyingly accelerating pandemic, to write?

This is a paradox, one of many born of this global uncertainty. For our communities, “gnawing anxiety vs. under-reaction.”¹ For healthcare providers, commitment to our patients despite serious concerns for the safety of our coworkers, our families, ourselves. At a time when healthcare workers face the gravest public health challenge of our careers, the routines and safety nets we have put into place to support our work have evaporated. New ones are already taking their place. Now, when my morning alarm rings, I reach for my phone to silence it and immediately move it from sight. I resist the urge to look at the news ticker for the latest statistics or my inbox with its onslaught of urgent updates. I take a breath and sit, silently, to collect myself before the day begins. I remember, as I open the curtains and feel the golden edge of the morning sun, that the rest of creation is undisturbed by the human consternation about COVID-19. I then turn to writing, which I have discovered is essential to focus my thoughts and unburden my concerns.

Can writing save me from the growing guilt I feel, as I bear witness from afar to the apprehension my hospitalist colleagues face as they wait, hospital emptied and echoing, for the wards to fill beyond capacity? I write, now, as a confession. I was scheduled to be on clinical service these past two weeks, covering night shifts for our busy adult hospitalist service. But I am not writing this from the hospital. Instead, due to mounting travel restrictions in the country where I work for most of the year—Thailand—I made the difficult decision to cancel my flight back to the United States last week. For the first time in my career, I prioritized the immediate needs of my family over those of my patients and team. One week on, I remain torn: with Bangkok under partial lockdown and travelers from the United States facing near-impossible barriers to entry, I know I would have left my young

children stranded here without me for weeks, if not months. At the same time, I grieve the lost opportunity to join with my team members as they prepare for the weeks ahead. I fear for their health and safety and for the health of the communities we serve.

In response, I grasp for opportunities to work, to be of use, from this vast distance. Even as the grim statistics of deaths and inadequate supplies mount, there are flashes of hope. Within the space of two weeks, remote working options that I have pursued for years have become the new norm. Committee meetings are held by Zoom, teaching is conducted fully online, home-based care options proliferate, and logistical barriers to telemedicine are being eliminated. Our university’s teaching, research, and clinical communities are uniting energies in profoundly supportive and creative ways. Many of these changes will, I hope, persist long beyond the direct effects of this virus. Our habitual modes of providing care and instruction have been shaken, and I have hope that we will emerge from this experience with fresh perspectives as to which are most essential to our practice.

But for now: I work from my home, and reflect, and write. As all of Bangkok shelters in place, I mentally occupy the hallowed space of a hospital half the world away. I am humbled and awed by the preparations that have already been put into place and the enormity of the work that remains to be done. I write in solidarity with my colleagues as we anticipate a need that threatens to overwhelm our capabilities—and that demonstrates, as never before, the strength of our united efforts. I hope, along with them, that we will collectively meet the challenge put to physicians so long ago by Hippocrates: to “cure sometimes, treat often, and comfort always.”

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SGIM EDUCATION COMMITTEE RESPONSE TO ACGME IM2035

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On behalf of the SGIM Education Committee.

The ACGME asked SGIM to provide our organization's perspective of the Review Committee for Internal Medicine's (RC-IM) revision and redesign for the Program Requirements. In the ACGME's process, they participated in an Alternative-Futures Scenario Planning exercise to help the committee proactively and creatively anticipate future practices of the specialty, the internist, and the patients. SGIM's Education Committee drafted the response to the ACGME about their three proposed paradigm shifts of the future, IM2035. Please see our following response:

Dear Drs. Desai, Cable, Lieh-Lai, and Vasilias:

Thank you for the opportunity to comment on the ACGME's three proposed paradigm shifts produced by the Review Committee for Internal Medicine through Alternative Futures Scenario Planning.

The preamble describing the internist of the future who is a patient-centered master diagnostician committed to providing cost-conscious, interdisciplinary team-based care resonates with us. We are excited to see that the internist will be the team leaders of interprofessional members who are practicing at the top of their licenses. Internists will also possess skills such as data management science, excellent communication skills, high integrity and ethical standards, and high levels of emotional intelligence used to promote wellness in their patients, their teams, and their communities. This is an aspirational person to be. In thinking about the future internist, we propose that she should also be adept at health systems science and be change agents when necessary. Furthermore, as internists master data management science, we would like internists to continue practicing evidence-based medicine to ensure our patients are constantly receiving data driven care. In the proposed vision of the internist, she is clearly the team leader. However,

in a future where all interdisciplinary team members are high performing, there may be times when it is more appropriate for another team member to take the lead. Therefore, internists must collaboratively engage with team members for the best interests of our patients.

This aspirational vision has influenced the following three paradigms that will be assessed for strengths, weaknesses, opportunities, limitations, and unintended consequences:

Paradigm Shift #1: Competency-based Medical

Education: This paradigm allows residents to individualize their careers early in training. For example, if a resident chooses to pursue Primary Care, she can prioritize rotations more relevant to her career and allocate more time to the ambulatory setting. This will allow for efficient education for each resident, streamlined pathways to underrepresented fields of medicine, and accelerated tracks to geographically underrepresented areas in medicine. Furthermore, it can allow trainees to move at their own pace through training, either through earlier specialization or a longer time needed to train. An unintended consequence might be loss of generalism as trainees forego broad exposure to a more focused approach. As residents go through training, they often change initial career plans based on clinical exposures they receive during residency. Would that flexibility still exist if there is early differentiation? We would also need reliable evaluation methods to assess if residents are ready for the next step. This paradigm can lead to many opportunities like the creation of hybrid programs, for example: IM-palliative care, IM-geriatrics, IM-addiction medicine, and others. It could allow integrating advanced degrees like MBA or MPH into training to better teach skills in leadership, population health, data management science, and quality improvement. Furthermore,

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DIAGNOSTIC UNCERTAINTY IN THE AGE OF COVID-19

Clark A. Veet, MD

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As the world faces uncertainties in the midst of the COVID-19 global pandemic, domestic panic has replaced the cautious curiosity once reserved for the otherness of an outbreak burgeoning in a distant continent viewed safely through headlines. Americans now have the charge, and time, to reflect seriously on this illness via social distancing, work disruption, and the absence of many springtime stalwarts including sporting, academic, and cultural events. Mainstream and social media have highlighted stories of sadness and optimism in this chaotic time, yet a prevailing theme is uncertainty. Much of this uncertainty relates not only to the medical outcomes of those infected but also to whether or not one actually is infected. The expectation of timely and accessible diagnostic testing has been a concern of many front-line practitioners and is shared widely via local discussion and social media. The panic caused by the inability to obtain testing is an unexpected side effect colored by the existing American healthcare landscape. If early, rapid, and affordable testing directed by Internists were available for seemingly low risk patients, we would likely have less frenzy and perhaps a better grip on the current scope of this disease.

For many Americans, the HIV epidemic stands as a testament to the convergence of modern epidemiology and public health leading to widespread testing and screening recommendations. However, the development of a reliable diagnostic test took two years from observation of the syndrome now known to cause AIDS to identification of the agent, HIV.¹ In decades since, due to international investment in outbreak surveillance and advances in testing including polymerase chain reaction (PCR), we now have the ability to identify pathogens and develop diagnostic tests much more quickly. Informed by similar viral infections, including the SARS-CoV-1 outbreak in 2003,² the scientific community in Wuhan, China was able to detect the novel respiratory viral syndrome known now as COVID-19 and transition to agent identification and diagnostic testing in mere weeks.³

“Internists are uniquely situated to both recommend appropriate care and discourage unnecessary testing; to order a treatment and to defer to specialists. We are often at the crossroads of diagnostic uncertainty and have a role to play in COVID-19.”

Amazingly, testing has included whole gene sequencing and targeted PCR allowing for near real-time tracking of disease. As containment gives way to disease mitigation in the United States, it is prudent to reflect that while such rapid testing was offered to the U.S., the CDC opted against using existing WHO technology for testing.⁴

Part of the problem relies on the changing nature of diagnostic testing in the U.S. healthcare system. Patients have previously seen their primary care practitioner to be assessed for many acute complaints. Generally, a practitioner evaluates the patient and, guided by physical exam and clinical reasoning, orders a diagnostic test if indicated. As a practicing General Internist with predominantly

urgent care outpatient clinical duties, it is common for a patient to begin an appointment with a request and preconception of what testing is desired or needed. Many tests, such as thyroid function and blood count

testing for fatigue, are reflexive, cheap, and clinically reasonable. Others, including advanced imaging for low-risk back pain, have plagued doctors and health systems and are markers of high cost, low value care. Nonetheless, front-line practitioners often realize that without testing, patient trust and satisfaction may decrease⁵ or that patients will seek out alternatives, including other health systems or direct to consumer online testing. With persistence and time, most low to moderate risk diagnostics tests will eventually be obtained—including existing respiratory viral panels for syndromes similar to COVID-19. In part due to consumerization in healthcare, most Americans expect there to be a test for any ailment, however unreliable or expensive it might be. Therefore, when a furtive physician shrugs her shoulders and points their suffering patient toward a faceless COVID testing website or hotline, there is a palpable loss. The seriousness of the situation sets in and the once smiling but febrile, coughing patient now feels worse, distanced from a former ally in medicine, and faced with prospects of a grim disease and the hope for an answer.

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The lack of locally available testing sends mixed messages to the public and healthcare providers alike. On one extreme, patients may incorrectly assume that if testing is not recommended for asymptomatic individuals, then the disease is either innocuous or unable to be spread without symptoms—potentially reducing adherence to social distancing. Conversely, patients may fear a test available exclusively through the CDC is a “government” initiative, with concerns about political motives or rationing. Moreover, even when a patient’s longstanding clinician recommends testing, barriers to obtaining a test may erode trust. By contrast, other countries, including South Korea, provided early convenient testing for free, often from the confines of the patient’s own vehicle.⁶

As weeks go on, testing will undoubtedly become easier and quicker. Similar to many other health systems, my institution has recently developed an internal test for SARS-CoV-2 with a designated testing protocol and a remote specimen collection facility away from busy primary care offices and emergency departments. With testing coordinated by local infection prevention experts, this feels like a tremendous success. It is a relief that I can now confidently identify the process map of testing and name the people involved. At the very least, I can turn my attention back toward the sick patient at hand

and provide the best possible care with the knowledge I have.

This reflection does not aim to pass blame or point to a person or group responsible, but rather to shine light on the role that front-line practitioners face in addressing difficult problems. Internists are uniquely situated to both recommend appropriate care and discourage unnecessary testing; to order a treatment and to defer to specialists. We are often at the crossroads of diagnostic uncertainty and regularly succeed in the art of conveying these dilemmas to the person in front of us in a very real, patient-centered way. This is a valuable service we provide as part of the healthcare team. If, and when, the next diagnostic challenge arises, we hope to be present at the start of the conversation with accessible diagnostic testing and the support of the system at large to help guide our patient.

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and making lists. How would we manage a huge patient surge? Which passwords and accounts would my wife need to access if something happened to me? Could we afford college tuition for both kids after our daughter finishes high school next year? Is our will up to date?

As the week came to an end, the surf looked a little heavier, but no storm yet. Five members of my department were on quarantine with

confirmed cases of Covid. The hospital had six suspected cases and the state was reporting its sixth death.

I kept thinking back to my earlier call with my nephew before the hurricane. If he had talked then about his power to change the hurricane’s course, I would have forcefully urged him to get help. I realized my biggest source of anxiety now was whether he, and millions of other Americans, would believe

they had that power right now—the power to change the course of this hurricane. My greatest worry is that not enough of them believe that, collectively, their sacrifice and inconvenience will be enough to downgrade the coming storm from a category 4 to several weeks of bad weather. I pray they do.

In the meantime, I will continue to nail up the plywood and prepare, in case they don’t.

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BEHAVIORAL HEALTH AND NEEDS ASSESSMENT AT A HOMELESS SHELTER

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What does a homeless person need? A home.

Chronically sheltered homeless individuals, a vulnerable and marginalized population, disproportionately suffer from preventable diseases such as metabolic syndrome. They experience high rates of psychiatric illnesses, such as mood disorders, psychotic disorders, PTSD and drug addiction, and high-risk sexual behaviors. Interventions have historically been limited in this complex population, who deserve our attention. There are further complexities when a homeless person is marginalized by race, which may pose additional biases and barriers to care. For instance, the vast majority of inner city and homeless individuals in Rochester, NY, are African-American men—a symptom of a history of racial imbalance.¹ In other cities, the distribution may be different, with veterans, undocumented and uninsured immigrants, or Puerto Ricans (post-Hurricane Maria) constituting the majority of the homeless population. The unique needs of any group ought to be considered when designing an intervention.

In 2018, as a fourth-year medical student at the University of Rochester (home of the biopsychosocial model), I conducted a needs assessment at the House of Mercy (HOM), a recently upgraded 82-cubicle facility that became the largest homeless shelter in Rochester.

The assessment was performed to guide future interventions for dietary change and social engagement—two important determinants of health. It required me to become acquainted with residents, prepare lunch with volunteers and staff (many of whom are former residents) to understand their nutrition challenges, and survey current and former residents (many of whom stop by for meals and socialization) on the topics of perceived social engagement and dietary habits. I led an intervention—a weekly focus group for women, a subminority at HOM—using motivational interviewing to discuss past traumas, body image, and nutrition (including diabetes education). The group discussions were held in a quiet staff conference room, safely tucked away from the hustle and bustle of the common area of HOM. These ladies trusted me and spoke up when prompted, but they seemed less eager to connect with their peers. I empathized when a few women suggested that they wished HOM were segregated by gender, stating they

felt uncomfortable sleeping near men at night.

Many beneficiaries of HOM were willing to engage in discussion—I spoke with roughly half of them regarding their health needs and barriers. I was surprised to learn that some of them had been living at HOM for multiple years, the majority felt strongly supported by staff, and all were isolated from family or had none to speak of. A number of them expressed difficulty attending doctors' visits—largely secondary to few options for transportation and lack of a smart phone. Many whom I queried reported high consumption of meat and sugar, compounded by largely sedentary lifestyles. Resoundingly, they agreed that sugar addiction was a reality. Some expressed interest in access to healthier food, while others were more skeptical—many cited the development of diabetes as a factor that would motivate dietary improvement.

Evoking the “Stages of Change” model, some of these individuals may be in the pre-contemplative stage for dietary change. Their presumed stage must be understood in the context of recurrent trauma. Therefore, it is the role of healthcare providers and social workers to foster change. While motivational interviewing is the therapeutic modality most linked with sustained behavior change, the success of this intervention has been limited in a study of homeless young adults.² Additionally, a systematic review demonstrated that application of the Knowledge-Attitude-Behavior model for understanding sugar intake is likewise limited,³ suggesting that there are other factors to consider.

This begs the question—would efforts at dietary behavior change be futile in the context of chronic stressors? Could unlimited funding to provide options for a healthier diet improve the health of this complex population, without addressing their homelessness? HOM relies largely on food donations from grocery stores, which poses nutritional limitations—these donations mostly consist of pastries and fruit, and these were placed as snacks whenever available (in addition to three full meals). I was surprised to see a soda vending machine on site; staff anecdotally mentioned that this improved beneficiaries' moods, and when soda was

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ZOONOTIC INFECTIONS

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Pandemics have been a recurring theme in the fabric of human history, with the deadliest since the Bubonic Plague being the 1918 Spanish flu pandemic, which killed up to 100 million people. This was prior to the advent of mechanical ventilation, seamless air travel as a mode of transoceanic disease transmission, and anti-vaccine culture. Amidst the coronavirus COVID-19 pandemic, I have taken an interest in how humans acquire diseases from animals. Namely, is there anything we can do to prevent the next outbreak?

Pandemic respiratory illness in humans is typically zoonotic, and differs from the common cold or seasonal flu due to a higher morbidity and mortality rate, largely due to pulmonary involvement. Certain animals are more implicated in zoonotic diseases than others. Birds and pigs are typically reservoirs for pandemic influenza. The risk of transmission is heightened when there is a high density of animals in a confined space, and animal caretakers are particularly vulnerable, as these pathogens are endemic on farms. Additionally, the migration of wild birds is a vector for long-distance spread. Often overlooked are bats—the only mammals that fly, known for their longevity, and hosts to numerous zoonotic pathogens. This includes deadly viruses such as Ebola, Marburg, rabies, Nipah, MERS and SARS.¹ For some of these viruses, disease is propagated via bodily fluids of animals or humans, making transmission slightly more difficult than airborne pathogens. Human encroachment into forests and other bat habitats is thought to play a role in the spread of these diseases, which is typically facilitated by bat hunting, or human contact with infected animals acting as intermediate hosts. Some diseases can also be transmitted by handling bat dung (also known as guano) or fomites such as fruit. Bats themselves are relatively unfazed by these diseases due to their enhanced macrophage and pro-inflammatory response to pathogens and quick ability to dampen inflammation thereafter.²

China has been a hotspot for virulent pathogens in recent years. Due to SARS-CoV-1 and avian influenza H7N9, the Chinese government temporarily shut down wild animal markets in 2003 and 2013-14, respectively. Key scientists agreed with this decision, including Kwok-Yung Yuen, a virologist at the University of Hong Kong who co-discovered the SARS virus. In *Nature*, he stated that this “reinforces the notion that we should not disturb wildlife and never put wild animals into markets”.³ “Respecting nature...is the way to stay away from the

harm of emerging infections”.³ Scientists also warned that a “deadly outbreak [such as SARS] could emerge again”.³ After the outbreaks ended, the markets were re-opened. With suspicion that illegal trade of the endangered pangolin could be at the heart of the COVID-19 pandemic,² the wet markets have again been shut down—hopefully this will be permanent. Prior to this pandemic, I had never heard of the pangolin, which I learned to be the world’s most trafficked mammal. When I saw pictures online, I was immediately mesmerized by this majestic scaly creature which resembles a cross between an artichoke and a small dinosaur. In traditional Chinese medicine, the scales are thought to have therapeutic properties, and the meat is considered a delicacy. Interestingly, research has shown that the scales are mostly made of keratin, so one might wonder whether eating one’s own skin/hair/nails would have a similar effect. In certain African traditions and rituals, bushmeat consumption continues—this includes primates and pangolins. Pandemics are a reminder that our cultures are rich and beautiful, but all humans will be affected by pockets of unsafe practices. Furthermore, poverty may drive many of these behaviors.

We live in an age in which we are disconnected from our food sources, and food may now be obtained from across the globe. Few people raise their own animals, and even fewer people slaughter these animals for personal consumption. Mindful consumerism will require us to step away from the industrial meat model. Human touch is lost in automated, high-volume slaughterhouses. In some religious traditions (Islamic and Jewish), the slaughter must be done with a knife, and with a deep respect for the sacrifice of the animal’s life. Additional care is taken to ensure that the animal does not perceive its upcoming demise. The carotid arteries and jugular veins must be severed to promote complete exsanguination, as blood is considered inappropriate for ingestion. Moreover, the spinal cord is not severed; this could theoretically prevent prion disease, which is rare but fatal. Prions may not be destroyed by normal sterilization techniques or cooking. The practice of using brain and spinal cord from cows and other animals as animal feed was banned by the US FDA in 1997,⁴ thereby preventing transmission of bovine spongiform encephalopathy (also known as mad cow disease) and the human version, called variant Creutzfeldt-Jakob disease. However, this practice

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competency-based medical education can lead to incentivizing fields that need further representation, benefiting primary care and ambulatory-based fields. However, individualized scheduling for an entire residency program will be extraordinarily challenging. For heavily selected specialty fields, rotations might have too many learners. For less popular rotations, faculty may not have access to learners for evaluations needed for promotions. Academic institutions might reduce teaching faculty or push them towards clinical duties. Since training would be so individualized, the standard Internal Medicine residency program would cease to exist, making accreditation difficult.

Paradigm Shift #2: From AIRE to There: In this paradigm, collaboration across programs would reduce workload on individual programs and individual program directors in developing ideas from professional societies or accrediting bodies. This model would allow for centralization of data and provide outcomes data for novel curricular innovations over multiple institutions. Through AIRE to There, residents could potentially enter the workforce earlier through shortened pathways with earlier access to increased pay. For example, an IM-geriatrics combined program could graduate geriatricians in a shorter timeframe than traditional IM residency followed by geriatrics fellowship. One of the limitations of program is that students would not know the rigor of a program until completion. Furthermore, if residents in a program are enrolled in a national study, who would be responsible for evaluating that resident and assessing advancement? Who would decide when the resident had achieved competency and then feed that information back to an accrediting body? Comparable to the prior paradigm, residents might lose the flexibility of changing their careers either during residency or afterwards.. Again, if residents are participating in experimental experiences for training, this could push the borders of what we currently conceptualize as the standard of training. Residency curricular changes would be driven by larger scale data that is multi-institutional. However, if a certain training is studied and found to be flawed, would the participants who completed that pathway have to repeat training? Would their training become invalid? Also, novel programs could be difficult to imbed into existing residency programs. An unintended consequence could be if some residents enroll in certain experimental programs, this might affect their peers' schedules and the rotational staffing of the hospital. It is unclear who would be creating the curricula, who would be responsible for enrolling, monitoring, and studying the impact of these programs. We are concerned that many programs would not be able to support these ideas. If criteria to enroll exist and a program decides to opt out, would that program be less attractive to students and be another comparator between residency programs?

Paradigm Shift #3: from NAS to LAS: In this paradigm, an ongoing iterative approach promotes the use of continuous data to initiate change. Similar to paradigm #2, it allows for sharing outcomes data on a larger scale to promote process improvement for residency programs. However, we are concerned that data that is continuously collected from our learners might be overwhelming. Residents and programs may need some reprieve from continuous data collection and reporting in order to maintain their wellness. Furthermore, the logistics of this level of data collection seem overwhelming. Will this data be locally mined or will it be reported to the ACGME? Who would collect it? Who would analyze it and inform programs on what to do with it? Would more data be useful data? Because programs would be responsible for obtaining real time data on all their residents on Common Program Requirements while also participating in pilot programs from AIRE to There, it would be powerful to have this breadth of data informing the success of innovations. This could ensure that common program requirements can meet the needs of all residents and programs throughout the country, enhancing ACGME's ability to grant accreditations. They would have more data points from programs and could possibly intervene earlier if early warning signs indicate that programs having difficulty. Like paradigm #2, we cannot predict the impact on enrollees to such pilot programs. If pilot programs through continuous data analysis are deemed ineffective, that may call negate residents' training in such programs. This livestream approach could then negatively impact residents' learning environment. It would be difficult for learners to learn in a constantly changing environment and conversely adapt to new requirements. There would be no predictability for them, the program leaders, or the faculty. We worry that the program director would become responsible for managing this level of data and become overwhelmed by the volume of it, leaving less time for other essential elements of the job. Also, what would be the threshold to trigger change? Should programs only change based on major and significant differences, or should they change based on minor differences as well? Due to these concerns, programs and program directors may not honestly report their findings due to consequences from accrediting agencies.

Finally, in reflecting on this 30,000-foot view, the future seems bleak. We seem to be preparing for a time when AI and advanced practice providers (APPs) will spend more face time with patients, and the internist will be more specialized and function as consultant. Would algorithmic care through APPs and AI lead to better care? Secondly, the future seems to put more onus on individual patients and their role in maintaining health, but social barriers like poverty and access to care are not expected to change. As advocates for our patients, we

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the next....if you solve enough problems, you get to come home". General internists thrive in taking a rigorous approach to solving complex problems. We are well suited to be at the forefront of addressing the complex clinical, social, political, educational, and research aspects of the COVID-19 pandemic. That said, I'd hate for us to get so caught up in solving the immediate problems that we lose sight of the priorities that we have identified as a field, as an organization, and as individuals. We must simultaneously solve the immediate problems in front of us and look to the future while staying true to our fundamental values.

In the midst of the day-to-day seemingly overwhelming tasks and issues, I find myself wondering how we will function differently when we are past the peak of this

pandemic. What lessons will we learn from this experience that will fundamentally change the way we work, care for patients, and interact? There is much innovation occurring. I encourage all of us to capture this innovation and apply it to addressing the following fundamental priorities as a field and organization:

1. rapidly expanding the delivery of care through virtual health means.
2. learning how to stay connected with each other through new means.
3. challenging ourselves with interacting with learners in new ways.

What can we learn from these experiences that will facilitate

the delivery of high-value, evidence-based person-centered and community-oriented health care?

In these times of change and uncertainty, SGIM, too, is learning new means of connecting with and providing value to you, the members. SGIM staff, Council, Committees, and Commissions are identifying effective approaches to moving forward our shared priorities. We will solve the problems together and SGIM will remain our professional home. Even though we weren't able to meet in person this May, let's be purposeful about connecting with each other and with our personal and professional missions.

Share your experiences, continue to build and enhance our community, and we will achieve our mutual goals.

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COMMITTEE UPDATE (continued from page 12)

do not believe that patients experiencing social barriers to care be held responsible for healthcare disparities. An IM-advocacy pathway would need to exist so that we could promote change within systems that make and keep people sick. Furthermore, in being tasked to see the most complicated and challenging patients, physicians might suffer higher levels of burnout. There would be fewer opportunities to celebrate small wins with patients and relish in the individualized coaching that is so incredibly rewarding in primary care. Instead, algorithms and non-physicians would be doing that very rewarding work. Even though we might be preparing for this future, we have strong concerns about it and are motivated to change it. We have a responsibility to deliberately influence a future we believe to be just, in line with our values, and one in which we uphold the promise we make through the Hippocratic Oath.

Thank you again for this opportunity to reflect and comment on three potential paradigms in medical education. We accept the challenge to be dynamic, compassionate, and just as we move forward in the changes to training and the practice of medicine in the upcoming future.

Sincerely,

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Following this response, SGIM was invited to attend a day-long summit to facilitate open dialogue with stakeholder leaders in the internal medicine community including members of the IM2035 Writing Group, members of RC-IM and the ACGME Board of Directors, representatives from AAIM, ABIM, ACP, SGIM, the American College of Osteopathic Internists, the ABOIM, and four current residents. The purpose of the summit was to engage in a shared vision of what needs to be done to better prepare our residents for the future practice of medicine. Participants answered two vital questions:

1. What can we do now to offer residents individualized educational experiences after they complete two years of foundational training in their internal medicine residency programs?
2. How can we promote innovation and participation in pilot programs that will offer residents individualized educational experiences?

From the conversation, it became apparent and essential that our professional societies should collaborate to work on the components we believe to be vital for the physician of the future, so that we can start teaching it now. We are on the cusp of designing residency. Let us not wait for change, but be the forces that change it to what it should be.

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previously unavailable, they would leave the building in search of it.

Rather than a reactionary approach, a different paradigm, the Housing First model,⁴ can theoretically be applied to the issue of poor dietary habits in the homeless population. The initiative provides short- or long-term rental assistance via two programs, respectively, rapid re-housing or permanent supportive housing.⁴ This model proves that providing individuals with stable housing without pre-requisites, serves as a platform for autonomy, remaining housed, improving quality of life, participating in job training programs, attending school, discontinuing substance abuse, decreasing domestic violence, and spending fewer days hospitalized.⁴ However, there are some individuals whose physical or mental health circumstances may prevent them from successfully living independently, even when provided with long-term rental assistance. Therefore, I propose that long-term community housing should be considered as an alternative to chronic sheltered homelessness.

To foster a healthier and more socially engaged community in this unique population, future interventions should pursue housing models which are conducive to a wellness-focused community living structure, such as apartment communities with improved communal spaces, or tiny house communities. Some wellness features may include plants, sunlight, access to exercise, and cooking classes. In addition, focused dietary knowledge assessment and education should be considered, including regarding portion size, the role of meat consumption in the development of diabetes, and serious complications of diabetes. Lastly, interventions to improve access to primary care and psychiatry, utilizing telehealth modalities when appropriate, could improve the health of this complex population.

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may still occur in other parts of the world. Additionally, the unsustainable worldwide demand for meat opens the door to many unethical and unsanitary animal husbandry practices. The requirement of land for animal grazing has compromised the world's forests. Setting fires to clear this land has had devastating consequences, and the Brazilian government's support for cattle ranchers is to blame for the Amazon forest fires of 2019.⁵

I can't help but wonder, if humans are more thoughtful about our interactions with wild and domesticated animals, can we prevent zoonotic infections? Furthermore, human interference in nature has resulted in a loss of biodiversity and unbalanced ecosystems—I wonder what repercussions this will have on

the health of humanity? How can physicians educate themselves about ecological problems and advocate for safer environments?

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Calaf is a brave prince from an unknown land who falls in love with the princess and declares his suit. She presents her riddles and, in triumph, the unknown prince answers them correctly (see table). Turandot despairs and the prince takes pity—offering the princess a riddle of his own—“If before morning you can discover the name I bear, I shall forfeit my life.” But Calaf’s riddle risks more than his own life since the princess then decrees that none shall sleep, under penalty of death, until the name of the unknown prince is discovered. Calaf admonishes the princess for her cruelty and Turandot’s strength and desire for revenge leave her, and she weeps for the first time. Calaf then reveals his true identity thereby putting his life in Turandot’s hands. With the arrival of dawn and the assembly of the court, Turandot addresses the emperor and the people and states: “I have discovered the stranger’s name—it is Love!”

Nessun Dorma! Nobody shall sleep! I know many who have not slept much during this difficult time, meeting and working round the

The Three Questions of Turandot	Answer
What is born each night and dies each dawn?	Hope
What flares warm like a flame, yet it is no flame?	Blood
The ice that gives you fire, what can it be?	Turandot

clock—all the healthcare workers and their trainees on the front lines treating victims of the pandemic while caring for other patients stemming the exponential and relentless rise. To meet the needs of the front line care effort, leaders and managers organized teams of providers not accustomed to inpatient, ICU, and ED care with many primary care physicians performing duties not done since training. The situations were not ideal; make shift hospitals, ICUs, lack of testing capabilities, shortages of swabs, masks, and ventilators. The effort to “flatten the curve” required ingenuity and determination. Researchers racing to study the characteristics of the virus and its epidemiology with the intent to reduce its spread, and develop therapeutics, and ultimately a vaccine. All this in several weeks!! Nobody shall sleep!

These are times where our resolve is tested in order to improve the care for all. And these are the times we show everyone what we are made of. The SGIM listserv, GIM Connect, has been lively with ideas and suggestions for diagnosing, managing, and post discharge caring of patients infected and recovering from the COVID virus. It is this collective energy that makes our society and our alliances a gift.

Leadership roles taken on during difficult times are particularly challenging yet especially critical. It is during this crisis that our new president, Dr. Jean Kutner from the University of Colorado, makes her debut, not in Birmingham as anticipated. This issue of *Forum* features her inaugural President’s column.

I look forward to her leadership during this difficult time.

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SGIM *Forum*

Society of General Internal Medicine

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