

PERSPECTIVE: PART I

ENFORCING UNJUST LAWS VIOLATES MEDICAL ETHICS: PHYSICIANS WHO DO SO MUST BE HELD ACCOUNTABLE

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Medical historians will note that physicians violating the law in the name of patient care is not a new phenomenon in the medical profession. When there is a need, some physicians are willing to risk it all. For instance, the lineage of case law that led to the formation of “decisional privacy” as a constitutional right, which set the foundation for the *Roe v. Wade* decision, started with an act of civil disobedience by Dr. Buxton in the *Griswold v. Connecticut* case. Despite a Connecticut law prohibiting contraceptives, Dr. Buxton, in collaboration with Planned Parenthood, opened a contraceptive clinic to challenge the law. While their efforts initially resulted in a criminal conviction for Dr. Buxton, they ultimately overturned contraception bans on constitutional grounds, at least for married women.^{1,2}

Since the decision in *Dobbs v. Jackson Women’s Health Organization*,³ overturning *Roe v. Wade* and fully relegating abortion regulations to the states, physicians in abortion-restrictive states have had to decide between providing ethical care and care that is legal within their jurisdiction. This can substantially differ from ethical care. The American Medical Association’s (AMA) Code of Medical Ethics mandates that “[in] exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.”⁴ Despite this ethical mandate, providing care that violates the law carries the potential for significant personal and professional liability, even if it is consistent with ethical standards. Alternatively, failing to prioritize ethical responsibilities over legal mandates risks violating the profession’s ethical standards, creating a difficult conundrum. The *Dobbs* decision will

lead to the rise of more Dr. Buxtons in the years to come, especially in abortion-restrictive states. The medical profession must applaud their courage and, more importantly, protect them.

One area of legal jeopardy with real-life consequences is potential adverse action by the state medical boards. What differentiates state medical boards from other forums is that the trier of the law and the fact are medical board members, many of whom are physicians. Here, we argue that based on the AMA’s Code of Medical Ethics prioritizing ethical obligations over unjust legal mandates, these physician members of medical boards who enforce unjust laws against other physicians are violating the profession’s ethical standards. Organized medicine must hold these physician members of state medical boards accountable when they uphold unjust state laws and discipline a physician for conduct that is in accordance with ethical standards.

Physician members of state medical boards often obtain their positions based on being licensed physicians in their respective jurisdictions. Stated differently, if not for being a physician, they would be ineligible to serve in their role. Consequently, they must act within the constraints of the profession’s ethical guidelines. When they fail to do so, including when they vote to sanction physicians who have not deviated from their ethical obligation, they should themselves be sanctioned for unethical behavior.

We acknowledge that physicians are only bound by the ethical codes of the societies they join, and

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FROM THE EDITOR

SCHOLARLY PUBLICATIONS: OVERCOMING WRITER'S BLOCK AND SHARING UNIQUE EXPERIENCES

Michael Landry, MD, MSc, FACP,

Editor in Chief, *SGIM Forum*

Writing. The joy of some, the bane of many.

I never considered myself a writer. Several mentors could easily confirm that comment. Their pushing and prodding would lead to the occasional article in which I would serve as a co-author and contribute to others' works. I convinced myself I disliked writing—it was too hard, I did not have the time, and I did not have the skills. Sound familiar to any of you?

Applying for and being selected as Editor in Chief of *SGIM Forum* made me face a harsh reality: I knew I would be “forced” to write 36 articles over the course of 3 years. “Forced” is a strong word since this was a voluntary decision, and I was under no obligation to apply, although I received encouragement to consider the position. I decided to apply and face off against a professional challenge that had long confronted me.

“You can write about anything which has been vivid enough to cause you to comment upon it. If a situation has caught your attention to that extent, it has meaning for you, and if you can find what that meaning is, you have the basis for a story.”¹ As I prepared to start my journey as Editor in Chief, this quote became one of my guiding principles. I learned to look for and listen to conversations, articles, and experiences in a different light. If an experience or discussion caught my attention, it made me question: Would this be a topic that would interest SGIM members?

This thought of constant awareness regarding interesting topics is like an early concept in LEAN training, which is to identify *muda*. “Muda is a core concept of waste in the Toyota Production System (TPS), the building block of Lean management. It is the non-value-adding activities that do not cause a value-increasing effect on the product or the customer.”² Once you understand the concept of muda, it is easy to see muda all around

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BUILDING AND STRENGTHENING RELATIONSHIPS

Martha S. Gerrity, MD, MPH, PhD, FACP, President, SGIM

*"Relationships with patients, colleagues, team members, healthcare organizations, and communities are at the heart of who we are as generalist physicians. Developing relationships is essential for our well-being, personal growth, career advancement, and the overall richness of life."*¹



“ Relationships matter at the most basic level. As human beings, we exist as members of collectives, and we survive only if we are accepted and recognized by others, starting at birth. We are thus interdependent, both emotionally and physically, at the most basic level of survival.”¹

Relationships with patients, colleagues, team members, healthcare organizations, and communities are at the heart of who we are as generalist physicians. Developing relationships is essential for our well-being, personal growth, career advancement, and the overall richness of life. Strong, positive connections with others contribute to a sense of belonging, purpose, and fulfillment; and healthy relationships mitigate burnout.²

SGIM offers the support and ability to develop relationships with colleagues outside of our own institutions and those who may have a different focus for their work.

These relationships help us in performing our work, whether it is clinical, education, research, health policy, or administration. I would not be where I am or have a rich career without the relationships formed through SGIM. This experience was the genesis for the #SGIM24 annual meeting theme, “Strengthening Relationships and Valuing Our Diversity.”

How do we develop and strengthen our relationships? In my January 2024 president’s column, I described a few rapport development skills from the Three Function Model of the Medical Interview.³ As a first step, these skills (e.g., reflection, support, partnership, and respect) are helpful in building relationships with your clinical, educational, or research team members and with organizational leaders. They let people know that we hear them and want to engage.

The second step is recognizing our inter-dependence with others in all of aspects of our work and life. Martin

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Q & A WITH SGIM'S CEO AND SGIM REPRESENTATIVES TO THE WOMEN'S PREVENTIVE SERVICES INITIATIVE (WPSI): A HIGH-IMPACT PREVENTIVE HEALTH COALITION TO IMPROVE THE HEALTH OF WOMEN

Brigid M. Dolan, MD, Med; Amy Weil, MD; Eric B. Bass, MD, MPH

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S GIM seeks to strengthen its voice in advocating for a just system of care by supporting initiatives led by other professional societies on topics of importance to our members. For several years, SGIM has supported efforts of the American College of Obstetricians and Gynecologists (ACOG) to enhance preventive care of women by selecting members to serve as representatives to WPSI. Recently, Dr. Bass talked with Drs. Dolan and Weil about their experience representing SGIM on ACOG's WPSI committees.

EB: What was your first impression of WPSI?

AW: When I arrived at the WPSI meeting in September, I was struck by the imposing exterior fencing, semicircular pillars, and curved walkway entrance as I approached the front door and wondered "How do I get in?" I was asked to show identification and after security confirmed my name on the meeting list, I was buzzed into the building. Although as doctors we are at pains to differentiate health advocacy from political advocacy and to wonder about what security measures we need to practice safely, I realized at that locked door, things are different here. Somehow the stakes seemed higher, and the lines more finely drawn. The feeling was fleeting as I was warmly welcomed by the rest of the WPSI committee. We began the stimulating business of vetting recommendations in progress with healthy and polite debate.

As Brigid and I reflected together just after this first meeting, we considered the level of security at the venue, a reminder that providing healthcare to women now includes unsettling moments. We shared gratitude that, as internal medicine clinician-educators focused on women's health, we had the opportunity to influence policy decisions impacting the care of patients.

EB: What exactly is WPSI?

BD: Before being named as SGIM's representatives to WPSI, we were unsure of its role in the care of patients. However, as general internists well-versed in United States Preventive Services Task Force (USPSTF) activities, SGIM members *should* be aware of WPSI and its role in guiding preventive health policy for patients who identify as women.

When the Patient Protection and Affordable Care Act (ACA) was drafted in 2010, lawmakers and stakeholders recognized gaps in preventive health for women within existing preventive care guidelines. They stipulated the creation of a commission to create recommendations to fill these gaps, thus improving the health of women in the United States. Shortly thereafter, the Institutes of Medicine (now known as National Academy of Medicine) developed an initial set of Women's Preventive Services Guidelines and a report recommending next steps to close gaps in existing preventive services for women. As a result, in 2016, the Health Resources and Services Administration (HRSA) commissioned the development of a coalition of stakeholders from across health care with a goal of creating and revising recommendations on preventive health for women. This coalition is now known as WPSI. The guidelines created by WPSI and adopted by HRSA were determined to carry the same weight with regards to legal coverage as the USPSTF guidelines rated as "A" or "B."

EB: What are your respective roles in WPSI?

AW: I serve on the Multidisciplinary Steering Committee, a group that chooses topics for evidence-based review and guideline creation. Brigid

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DIGITAL EVALUATION AND MANAGEMENT SERVICES: A ROUTE TO HARMONY WITH THE PORTAL

Stephen Fuest, MD; Erin Murphy, MD

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The patient portal can precipitate a spectrum of emotions for SGIM members. Asynchronous health care between visits has grown and the number of notifications to the physician can be staggering. One study (conducted before the COVID-19 pandemic) found that per 1.0 clinical FTE in an academic practice there were approximately 372 and 468 monthly messages sent to male and female primary care physicians, respectively.¹ Comparison of patient use of electronic means to communicate with clinicians before and after the pandemic found an adjusted OR 1.99 (95% CI 1.18-3.35).² Considering this sharp uptick in electronic communication, the portal offers an avenue for care delivery highlighted by increased patient ease to contact clinicians with additional clear benefits to patients and opportunities for clinicians. For patients, it is faster to send a message akin to a text, simpler than navigating a call center, and a message provides a written record for reference later, if medical advice is forgotten. For providers, no specific time needs to be blocked for an appointment, phone tag is eliminated, and the message itself can often serve as documentation, eliminating the need to perform services and then write a note. Patient access for short-term/acute follow up with their own PCP is often limited, and response time to a portal message may be faster than waiting for the next available appointment. These are reasons whereby patients and clinicians can benefit from the portal. As clinicians with different experiences initiating clinic systems to deliver efficient care through the portal, we describe our efforts to meet patient preference and capture clinical productivity in our health systems.

In 2020, the Centers for Medicare & Medicaid Services (CMS) introduced the online digital evaluation and management (E/M) services codes 99421, 99422, and 99423.³ Requirements include the following:

- The patient must be established with the clinic;
- The patient must initiate the portal message;
- Consent is obtained for insurance to be billed;
- The problem requires physician or advanced practice provider (APP) decision making;

- The specific problem cannot be addressed in the preceding or following seven days by another E/M service;
- Documentation is performed for the encounter; and
- Communication is through a HIPAA-compliant secure platform.

The code is selected based upon total time spent over the seven-day period, ranging from 5-10 minutes (code 99421), 11-20 minutes (code 99422), and 21 or more minutes (code 99423). Examples of eligible time include reviewing the chart and patient-supplied data, communicating with other members of the healthcare team, placing orders, creating a plan, and communicating with the patient. Eligible time is based upon physician or APP time addressing the patient request, but does not include support staff time. Time cannot be double counted with other reported services. Work relative value units (wRVU) for each code are: 99421 (0.25 wRVU), 99422 (0.5 wRVU), and 99423 (0.8 wRVU).⁴

We have found online digital E/M services to be helpful for many low complexity E/M conditions. Examples of beneficial clinical scenarios include upper respiratory infections, cystitis, titration of medications for chronic conditions, second opinions for results or plans of another clinician/specialty, or request for a referral that requires initial evaluation and triage. We have found inconsistent benefits for moderate or high complexity decisions where more value results from a synchronous face-to-face visit.

Notably, scenarios where 99421-3 are not used include when a patient sends a portal messaging requesting an appointment or a refill of an existing prescription, if the message is clarifying information from a visit in the past 7 days or leads to a visit in the next 7 days, or if total time spent on the message is less than 5 minutes.

Patient consent is fundamental to these services. There are a variety of methods for obtaining consent. One option includes opt-in systems where the message is triaged for complexity and then a message is sent to the patient requesting consent to bill their insurance. Alternatively, some healthcare systems have elected to ob-

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ELDER ABUSE: THE IMPORTANCE OF RECOGNITION AND REPORTING BY GENERAL INTERNISTS

Sarah Tietz, MD; Jennifer L. Michener, MD; Elizabeth M. Bloemen, MD, MPH

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About 10% of older adults experience elder abuse in the form of physical abuse, verbal abuse, sexual abuse, financial exploitation, or neglect each year.¹ Most states mandate that physicians report any suspected case of elder abuse.¹ Physicians may feel uncomfortable identifying and intervening in abuse cases due to the complicated nature of patient presentations and challenges encountered with systems for abuse reporting and investigation.¹ Given the morbidity and mortality associated with mistreatment, it is critical that internal medicine (IM) physicians recognize and intercede for older patients.¹

Experts at the University of Colorado created a clinical team dedicated to the care of elders experiencing mistreatment, which is one of the only elder abuse programs in the country. The Vulnerable Elder Services, Protection, and Advocacy (VESPA) team provides inpatient and emergency department consults for elder abuse and neglect, modeled after the success of child advocacy teams in pediatrics. VESPA strives to coordinate with the primary care provider (PCP) and help advocate for victim-centered care across the healthcare continuum. The following case highlights VESPA's collaboration with the IM PCP for a particularly challenging case and illustrates the role of the PCP in the medical response to mistreatment.

Case Presentation

Elements of this case were changed to protect the identity of the individuals involved, but the key components are consistent with the index case.

An 85-year-old man with advanced dementia was admitted to the hospital for hypoxemia. He was found to have aspiration pneumonia and was treated with appropriate intravenous antibiotics. At the time of admission, indolent weight loss was noted. His son was documented as the primary caregiver and medical power of attorney. No other family was involved.

Due to the patient's oxygen requirement and rehab needs, discharge to a skilled nursing facility (SNF) was recommended. The son preferred the patient be discharged home, citing concerns about poor conditions in local SNFs. The patient was discharged home with oxygen and home health services.

A few weeks later, the patient saw his PCP for a post-hospital visit. He was doing well and weaning off oxygen. The son was present for the visit and reported that home nursing and physical therapy were coming regularly. The PCP noted the son to be abrupt and condescending to her and the staff, but no additional concerns were documented.

One month later, the patient was taken to the local emergency department (ED) with increasing confusion after a fall. He was found to have recurrent aspiration pneumonia. In the ED, nursing staff witnessed the son using demeaning language toward his father, and the patient's physical exam demonstrated multiple bruises. Social work and the VESPA team were consulted. The patient was admitted to the Acute Care for the Elderly (ACE) inpatient service, a hospital service that specializes in the care of older patients. A report was made to Adult Protective Services (APS). APS started their investigation but could not substantiate abuse to a level that warranted removal of the son as power of attorney. The patient was discharged home under the care of his son. The VESPA team alerted the patient's PCP of the abuse concerns and worked to set up additional home resources.

Two weeks later, the patient and his son came to a PCP follow-up visit. The patient had new bruises, including on his face, which were not documented on the recent admission. He was also acutely confused. The patient's PCP sent the patient back to the ED for urgent head imaging and made a second report to APS. The patient was discharged from the ED when the head CT did not

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THE POWER OF CONVERSATION: HOW PODCASTING HELPED ME ADDRESS IMPOSTER SYNDROME

Elizabeth C. Esselman, MD

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Bejan, Julia, and I were on our ICU rotation together. It was a busy month with high acuity and many tragic cases. Amid the chaos, Julia and I frequently reflected on our own medical education by discussing podcasts, details of the learning environment, and how to make morning rounds more engaging. One afternoon, Bejan blurted out “You two should start your own podcast.” We laughed at him, but the idea stuck. After that, our podcast, *Review of Systems*, evolved slowly during small moments of connection in our hectic lives as medical residents. Our ideas weaved together through long overnight admission shifts, challenging days on the wards, and shared time outside the hospital.

As internal medicine residents, we find ourselves immersed in medical education, experiencing both its highs and lows. To process and share these experiences, we created a platform to explore the intricacies of the systems surrounding us. We aimed to illuminate not only how the medical education system encouraged us to grow as physicians but also how it sometimes drained and disheartened us. What started as a passing idea during a busy shift gradually matured into a regularly scheduled podcast with episodes now premiering every two weeks.

Initially, we identified a handful of topics essential to discuss. Some were lighter, such as reflections on bedside rounds and the unknown influence of artificial intelligence on the future of medical education. Others were much heavier and touched on the hardships of being a physician: burnout, imposter syndrome, and the tragic topic of physician suicide.

A poignant episode for me is “Beating Burnout” in which we interviewed two internal medicine physicians, Drs. Adrienne Mann and Tyra Fainstad, about their coaching program called *Better Together*.¹ The program includes thought-based coaching for physicians, with the goal of decreasing burnout and increasing well-being. We discussed imposter syndrome, which Dr. Mann defined as “a belief that you are not good enough despite evidence to the contrary,” and how this leads to burnout.²

My cohost, Julia, our guests, and I had a meaningful conversation about our individual experiences with imposter syndrome as internal medical trainees. I remember leaving the interview excited to share this discussion with our colleagues and hopeful that it would aid in normalizing these feelings.

Three months later, listening to the podcast on release day, I had a realization. While applying for my first job as a future hospitalist, I was showing classic signs of imposter syndrome: feeling unworthy, experiencing persistent feelings of self-doubt, and overworking to compensate for my feelings of inadequacy.³ When the episode launched, I was on vacation with my family in Oregon, going on daily hikes, reading books outside, and watching the sunset over the mountains every night. Instead of relaxing, I found myself obsessing over my job search, repeatedly editing my curriculum vitae and working on the fifth draft of a cover letter. This was all to calm the relentless voice of my imposter syndrome. I felt like I was going to be exposed as a fraud.

I listened to Julia candidly discuss her concerns about becoming a senior resident on our podcast and I realized this was exactly what I needed to hear. In a moment of vulnerability, Julia listed numerous reasons why she did not feel ready to lead a team. I worked with Julia regularly on the inpatient wards, so it was easy for me to challenge her thoughts. I see her as a brilliant and conscientious physician. When I heard her express similar insecurities to those I was feeling, it helped me understand and adjust my own faulty perceptions. Through this reflection, I experienced what I hoped these podcast episodes would do for others.

My experience is not unique. Imposter phenomenon is common among physicians and is associated with burnout, lack of professional fulfillment, and even suicidal ideation.³ It is important for SGIM members to recognize the signs of imposter phenomenon, especially given that internal medicine residents and practicing physicians are known to routinely experience imposter

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KAIZEN: FUNDAMENTAL FOR EXCELLENCE

Farzana Hoque, MD, MRCP (UK), FACP, FRCP

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"Continuous improvement is better than delayed perfection."—Mark Twain

When I began my internship, I was apprehensive about an upcoming journal club presentation due to my fear of public speaking. However, I decided to dedicate a few minutes each day to watching instructional videos on enhancing my public speaking abilities. I challenged myself to deliver more presentations and became a member of Toastmasters. My daily commitment to honing my public speaking skills yielded remarkable results, as I have now received invitations to speak at 60 regional, national, and international conferences.² As healthcare professionals, SGIM members must consistently work on improving their skills.² There are moments when frustration sets in, especially when substantial progress is not immediately evident, and we may contemplate giving up.

Kaizen is a Japanese philosophy meaning *change for the better* or *continuous improvement*. This powerful approach promotes a mindset where small incremental changes create an impact over time. The effects of continuous improvement grow increasingly substantial with consistent repetition, much like money through compounding interest. In fact, the numbers speak for themselves: after 365 days of continuous 1% improvement, we can become 37 times better than when we started.

Often, when we set big goals and make drastic changes to our daily routines, our initial excitement and motivation may wane over time. Our brain naturally resists these sudden and drastic changes. However, with Kaizen, SGIM members can focus on small, manageable goals each day that gradually move us closer to our desired outcomes to achieve sustained success in personal and professional endeavors.

The following factors are fundamental for pursuing excellence through Kaizen:

Consistency

Consistency is a crucial element of the Kaizen method, emphasizing a regular and reliable practice of continuously improving. As the saying goes, "Slow and steady wins the race." Consistency has the power to surpass intensity. For instance, going to the gym for just one or two days may not yield noticeable results. However, by consistently engaging in regular exercise over an extended period, one will witness gradual improve-

ments in physical and mental well-being. The activity is ingrained in your routine and a habit develops when you consistently practice a behavior or follow a process. Completing each smaller step consistently brings you closer to your goal and boosts your motivation for the remaining tasks.

Know Your Key Drivers, Both Internal and External

Self-awareness, a foundation of emotional intelligence, is the art of knowing and accepting ourselves, even the parts that are hard to see or understand.³ It is a crucial way of developing friendly relationships with our authentic selves. A self-aware leader is mindful of emotional triggers, biases, and strengths.³ After defining your goal, create a comprehensive process plan that outlines key steps and necessary timeframes for achieving it. Identify key stakeholders who can offer guidance and support in reaching your objectives. Keep them regularly informed about your progress and actively seek their feedback. Utilize their suggestions to continuously improve your work and enhance the overall quality of your output. To sustain momentum, consistently adapt, evolve, and expand areas of improvement. Celebrate achievements, no matter how small, to foster an encouraging atmosphere around continuous improvement efforts.

Brief Pause to Flourish

In a world full of constant distractions, it can be challenging to establish a genuine connection with our inner selves. However, recent research suggests that incorporating periods of silence into our lives has the power to stimulate the generation of new cells in the hippocampus, increase our energy levels, and foster a more adaptable mindset. By consciously creating these pauses in our day, we create a mental oasis where we can genuinely reflect and identify the things that ignite our passion and capture our attention. It is essential not to leave this to chance but rather prioritize it as we would any other commitment in our lives. For example, taking a brief walk amidst our busy schedule can provide an opportunity to reflect on how we approach problem-solving in a practical manner. These short pauses can be astonishing as you witness the organic emergence of your best ideas.

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THE PSYCHOSOCIAL IMPACT OF SURVIVING PEDIATRIC CANCER: RECOMMENDATIONS FOR INTERNISTS FROM THE PEDIATRIC CANCER SURVIVORSHIP LITERATURE

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With the advent of innovative and improved treatments, more children with cancer are surviving into adulthood. The current estimated 5-year overall survival rate for all childhood, adolescent, and young adult malignancies exceeds 80%.¹ The most recent data approximates that there are 495,739 survivors of childhood and adolescent cancer (diagnosed at ages 0-19) as of January 2020.² This growing population will be seeking ongoing primary care; therefore, it is imperative that internists are informed of best practices for holistic care, including assessment and treatment of psychosocial impacts of childhood cancer. However, guidelines regarding the best practices for adult survivors of childhood cancer are often published in the pediatric literature and may be less visible to those in internal medicine who are accepting young adult patients. We share this important information with SGIM members by summarizing recent findings on the psychosocial impact of a cancer diagnosis among adult survivors of pediatric cancer and recommendations to address these psychosocial impacts in order to improve the care delivered by SGIM's members to this population.

Previous studies determined that some adult survivors find value from the resilience they developed from surviving life-threatening illness and may even experience posttraumatic growth.³ However, further research has determined that a subset of adult survivors of childhood cancer face increased morbidity from psychosocial dysfunction and disease. Lee et al demonstrate the increased risk children and young adults with cancer have of developing psychological disease as well as the factors that put certain populations within this group at risk.³ Their analysis revealed significantly increased incidence and severity of depression, anxiety, and psychosis, including schizophrenia. These rates were highest in children and young adults with cancer (CYAC) diagnosed in adolescent years (ages 15-19), those with family dysfunction,

those with lower family income and less social support, and those patients with primary CNS tumors.

Given the unique risk factors and needs of specific populations within adult survivors of childhood cancer, it will be important for their care teams to identify these at-risk patients via effective screening techniques and to provide timely and appropriate treatment. This study determined that “timely identification, preventive efforts, and psycho-oncological intervention in vulnerable groups especially at risk are recommended.”³ Although pediatric providers must be aware of existing guidelines while transitioning these patients to adult care, it is imperative for internists receiving these patients into their practices to be well-versed in the management of health screenings and psychosocial health for this at-risk population.

Likewise, the American Academy of Pediatrics (AAP) recommendations cite additional studies demonstrating that adult survivors (or those from like households) with lower income and educational levels are more vulnerable to worse outcomes related to general health, mental health, functional impairment, activity limitations, pain as a result of cancer treatment, and anxiety or fears related to cancer and/or treatment.¹ In addition, the AAP cites studies demonstrating that adult survivors experiencing psychological distress are more likely to participate in health-risking behaviors (e.g., tobacco, alcohol, and substance use).¹

Based on these findings, the AAP highlights that as, “emotional health and family functioning may be affected by the cancer experience, proactive assessment of and referral to mental health services are important to optimize the quality of survivorship. Finally, personalized risk assessment would not be complete without consideration of socioeconomic and community factors that may affect access to survivorship resources and health care.”¹ Family functioning is a predictor of

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demonstrate any signs of intracranial hemorrhage. A report of suspected abuse was not made by the ED physician and the VESPA team was not consulted during that visit because the ED physician did not suspect abuse was at play. The PCP discussed the case with the VESPA team, who continued to provide available resources and coordination with APS. The PCP and the primary care clinic social worker remained in contact with the VESPA team, but they were limited in their ability to intervene, given the results of the initial APS investigation. The VESPA team and social work continued to focus on providing resources and support to the patient's son to minimize the potential for abuse.

One month later, the patient came back to see his PCP. The son reported that the patient fell the day prior. The patient had a large hematoma on his forehead. The son declined to take his father to the ED but agreed to a CT of the head, which did not show any intracranial hemorrhage. The PCP expressed concern that the son could not care for his father at home safely. The PCP recommended nursing home placement, which the son agreed to consider. The PCP discussed this visit with the clinic social worker, who notified VESPA and APS.

Later that week, the PCP called to check on the patient. The son reported that his father fell again and was more confused than usual. The PCP advised urgent ED evaluation, and the son agreed. In the ED, the patient was noted to have a subdural hemorrhage and recurrent aspiration pneumonia. The son affirmed the patient's DNR/DNI status on admission. The patient's oxygen requirement increased on day three of the hospitalization, and progressive pneumonia was seen on chest x-ray. The patient's clinical status continued to worsen, and a family meeting was called with the

PCP, hospital medicine physician, and VESPA team. The son decided to pursue comfort care. The patient passed away that evening, with his son at the bedside.

Case Discussion

This case highlights the all-too-common way elder abuse cases present and progress. It also captures the challenges with detection, reporting, and management, especially when the suspected abuser is the patient's caregiver and decision maker. Additionally, the outcome in this case occurred despite a wealth of resources, not available at many institutions. Here we discuss lessons learned from this case that are important for all SGIM clinicians to consider.

The medical literature is beginning to describe injury patterns and medical comorbidities in cases of elder abuse, many of which were present in this case.^{2,3} Adult victims of abuse are more likely to have maxillofacial injuries that are present without concurrent injuries on the upper or lower extremities.² Adult victims of abuse and neglect often present with weight loss and malnutrition, easily mistaken for another etiology.³ For patients with dementia, diagnosing abuse can be particularly challenging, requiring the SGIM clinician to maintain a high index of suspicion for maltreatment. Despite these challenges, it is important for SGIM clinicians to identify and report any suspicion of elder abuse so the appropriate authorities can investigate. Vulnerable adult victims of abuse experience adverse outcomes beyond the initial injuries including increased rates of anxiety, depression, nursing home placement, hospitalization, and death.¹ Early intervention to prevent ongoing abuse is critical.

This case also demonstrates the incredible challenges coordinating care for elderly patients across the

healthcare continuum. It emphasizes the importance of a multidisciplinary team to support patients while APS investigations are conducted. It also shows consequences that can result from underreporting of suspected abuse and a lack of clear documentation about abuse concerns.

Conclusion

Through this case, we highlight the importance of SGIM physicians in recognizing elder abuse and knowing the appropriate mechanisms for local reporting. Though specialized, multidisciplinary teams may not be available in every community, the components of a successful multidisciplinary team are present in many hospitals.¹ Engaging ways to create these teams in the local community are important for improving elder abuse outcomes. SGIM clinicians are integral parts of the elder abuse prevention and management team. Engaging with social work and geriatric colleagues to optimize care coordination for elderly victims of abuse and neglect is a key role for IM physicians.

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Luther King, Jr. described this when he wrote the following:

“All men are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly affects all indirectly. I can never be what I ought to be until you are what you ought to be, and you can never be what you ought to be until I am what I ought to be...This is the inter-related structure of reality.”⁴

In our work, we experience this interdependence every day as we care for our patients, teach our trainees, conduct research, and lead in health care. We work in teams and depend on the work of team members. What my patient care (or education, research, administrative) team does affects my work and vice versa. Our teams and healthcare organizations may not always be effective in supporting the work we do together. After recognizing this interdependence, how do we start to improve team function and, in turn, enhance well-being?

The theory of relational coordination (RC) and tools, including the RC survey, may give us ideas for where and how to start.⁵ This concept reflects the work of Tony Suchman, MD, MA, who taught me about patient-physician communication at SGIM meetings. He is the founder and senior consultant for Relationship Centered Health Care, an organization that consults with health system leaders and organi-

zations with the goal of fostering relationship-centered administration within these organizations. Dr. Suchman introduced me to Jody Hoffer Gittel, PhD, Professor at Brandeis University's Heller School for Social Policy and Management, with a focus on organizational theory and behavior. Dr. Hoffer Gittel developed the theory of relational coordination based on her research to identify characteristics of highly functioning organizations, including many healthcare organizations. The RC survey is based on her studies of many organizations across multiple fields and quantifies communication and relationship dynamics within and between “teams” in an organization. Because relational coordination has potential implications for the work we do as academic general internists, I called on Drs. Suchman and Gittel for advice about our annual meeting in Boston, Massachusetts, #SGIM24. The more we talked the more excited I became about introducing the RC theory and tools to SGIM members to help us improve team and organizational functioning in our healthcare settings.

#SGIM24 aims to deepen our skills in relationship building and bring together people with diverse perspectives and strengths to take on the interconnected challenges we face in health care and in our communities. Through special symposia and workshops, we hope to provide you with ideas, strategies, and tools. We also hope to highlight the diversity of SGIM—ambulatory and inpatient

physicians, researchers and educators, and junior and senior faculty—demonstrating that diversity is a strength and that we are stronger together. Please join us at #SGIM24 as we learn more about building and strengthening relationships.

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LEADERSHIP AND HEALTHCARE ADMINISTRATION (continued from page 8)

Kaizen is not a one-time project but an ongoing philosophy. The Kaizen approach teaches us that small, regular steps truly do pay off, reducing the risk of burnout. By embracing Kaizen, SGIM members can unlock their full potential and seize every opportunity to foster a journey of transformative growth.

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serves on the Dissemination and Implementation Steering Committee, which is tasked with ensuring that WPSI recommendations are disseminated and implemented throughout the United States. The committees have representation from stakeholders with diverse lenses on the promotion of women's health. Representatives come from physician subspecialty organizations, nursing organizations, advanced practice clinician groups, women's health advocacy organizations, legal organizations devoted to women's health, and payor groups.

EB: What does WPSI do that USPSTF does not do?

BD: When WPSI was created, the USPSTF did not address many topics in women's health. While the 2023 USPSTF guidelines include screening for anxiety and intimate partner violence, both were included in WPSI recommendations prior to inclusion in the USPSTF guidelines.¹ The WPSI recommendations also include topics that are critical in the comprehensive care of women and are not included in existing USPSTF recommendations. Guidance pertaining to contraception, diabetes during and after pregnancy, obesity prevention in midlife women,² and urinary incontinence³ are preventive care topics unique to the WPSI recommendations at the time of writing. All are crafted with rigorous systematic review methodology and guideline development processes carried out by expert physician-scientists.¹

WPSI further clarifies their charge as predominantly offering guidance for cis-gendered women, noting that their recommendations are also "relevant and applicable to individuals who are transgender, non-binary, or otherwise gender-expansive. Founded on the principles of promoting equitable sex-and-gender-based care, WPSI recommends access to and the provision of respectful, gender-affirming,

high-quality, and safe health care."¹ They amplify a commitment to addressing health disparities related to poverty, racism, and other social contributors, stating that "WPSI is acutely aware that black women, women of other ethnic minority groups, and women living in poverty face disproportionate barriers to basic health care."¹

For SGIM clinician-educators, the WPSI website includes tools to support learner education. The Well-Woman Chart⁴ combines recommendations from all major organizations whose guidelines are part of ACA-covered care, including the USPSTF, Bright Futures for Children, the Advisory Committee on Immunization Practices, and WPSI. The charts are available in PDF and web-optimized versions, with notations indicating populations who qualify for selective screening. Recognizing that some clinicians are less comfortable in the primary care of women during and after pregnancy, the WPSI Well-Woman Chart also includes resources highlighting key topics to address during these critical time periods in the health of women.

Beyond writing guidelines and educating clinicians, WPSI also aims to educate the population at large regarding critical preventive health recommendations by creating patient-facing print- and web-based resources in English and Spanish (with more languages under development). The resources support clinicians in informing patients about evidence-based preventive health and its coverage by insurance plans.

EB: How can SGIM members get involved in WPSI?

AW: There are several opportunities for general internists to engage with WPSI:

- submit a new topic for consideration;⁵
- when available, submit a public comment regarding recommendations in progress;

- access WPSI's resources on clinical practice, patient education, and publications; or
- ask one of us questions about WPSI committees.

As we have learned more about WPSI and its role in patient care, we appreciate having the opportunity to serve as the SGIM representatives to WPSI. In this role, we can provide the perspectives of academic general internists to inform health care policy. We hope to continue engaging with others in SGIM to share the important work of the initiative and to continue efforts to collaborate as a community to advance the health of women.

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medical societies lack jurisdiction over non-member physicians. Furthermore, membership in medical societies is optional for physicians. We also acknowledge that not all medical societies follow the AMA's Code of Medical Ethics. Consequently, some physician members of state medical boards may not fall under the jurisdiction of the AMA or any other medical society. Nonetheless, some estimates indicate that more than 75% of physicians are members of a national specialty organization⁵ and, therefore, subject to their ethical codes. Hence, it is likely that a large swath of physician members of state medical boards fall under organized medicine's jurisdiction. The potential of being sanctioned by ethics boards serves as a critical disincentive to deter physician members of state medical boards from prosecuting their colleagues who provide the standard of care and comply with the profession's ethical standards despite unjust laws. Although we have only discussed sanctions for physician members of

state medical boards here, the same argument can be advanced for any physician in a place of authority, especially for those in positions requiring a medical license.

Physicians who violate unjust laws in the name of patient care and in accordance with the profession's ethical standards take significant personal and professional risks. When they do so to uphold ethical standards and provide appropriate care to their patients, the least the profession can do is support them in any way possible. Holding physician members of state medical boards accountable on ethical grounds is just one of those ways.

**(Note: The opinions in this article do not purport to reflect the opinions, views, or positions of SGIM or any other entity.)*

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psychosocial outcomes for adult survivors of childhood cancer,³ and the AAP recommends assessing these dynamics along with socioeconomic factors to determine which patients will benefit from further evaluation and referral for mental health support.¹

The Children's Oncology Group (COG) guidelines also encourage screening for psychological and mental health of childhood cancer survivors of all ages, including adult survivors of childhood cancer. The guidelines recommend annual screening for depression, anxiety, post-traumatic stress disorder (PTSD), and suicidal ideation, as well as regular assessments of educational/vocational progress.⁵ The premise for screening all survivors, from the COG's perspective is that "of survivors experiencing clinically relevant

anxiety, depression, or PTSD only 12% are receiving psychological care and 13.6% are reporting use of psychotropic medications."⁵

Evolving research into the late psychosocial effects of childhood cancer, often found in pediatric journals, finds that adult cancer survivors are often resilient but that a subset of patients does require vigilant screening and treatment. As generalists providing preventive health for a wide range of patient populations, it will be important that we recognize and integrate these guidelines for the care of adult survivors of childhood cancer into our practice. By screening all our patients who are adult survivors of childhood cancers for their social and economic situations as well as mental and emotional health, internists can mitigate the poor outcomes this

at-risk group faces without adequate support. Incorporating the findings summarized here, including existing screening recommendations from the AAP and COG, into clinical practice in adult primary care can help improve quality of life, improve and prevent poor mental health, decrease risk taking behaviors, and promote fulfilling lives and careers through education and training. This summary will help internists provide better, evidence-based, and comprehensive care to this resilient and growing population.

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tain opt-out consent by notifying patients during the process of sending a portal message. Opt-out systems typically notify patients that most portal messages are free, but those requiring medical decision making and more than 5 minutes time may be billed to insurance, and the patient agrees to have their insurance billed by sending the message.

There are questions about whether patients or insurance should be billed for portal messaging. The quantity of this work has increased, as this is meaningful care, and it warrants recognition as such. If the goal were to simply generate maximal revenue, then patients could be directed to schedule a face-to-face appointment or do a physician telephone service (codes 99441-3), either of which reimburse more consistently in higher quantity, but often with a delay for available scheduling. Instead, utilizing online digital E/M services benefits patients and clinicians alike. As technology changes we need to modify our practice with it.

Concerns regarding patient cost sharing are important. Insurance coverage is variable, yet value needs to be recognized for provider time, training, and expertise. Multiple institutions have posted expected cost sharing on their websites for their patient's reference. Clinicians providing beneficial care outside of visits should have productivity incorporated in their work measure. However, many institutions and providers have found that most patient messages require only a quick response from a clinician and do not require time or medical decision making that would lead to patient cost.

Based upon our experiences, we recommend the following steps for SGIM members to incorporate this into their practices:

- Become familiar with requirements for online digital E/M;
- Meet with a billing specialist to determine documentation expectations;
- Create workflow to obtain consent*;

- Prepare background information, FAQs, and common scenarios to educate clinicians, staff, and patients;
- Do it!; and
- Perform periodic process review for optimization.

*Consent can be a more intimidating step for those newly adopting this practice. We recommend utilizing standardized phrasing to make consent more efficient and consistent. For example:

"I should be able to address this issue through the portal if you consent for me to bill your insurance for the service. Please reply yes or no. If yes, please also answer the following clarifying questions ..."

We also recommend considering an opt-out consent system during the process of patients sending the message to increase efficiency. For example:

"If your provider's response to your portal message requires medical decision making and more than 5 minutes' time, your insurance may be billed for this service. By sending this message you consent to that possibility."

If the healthcare system has not yet adopted a standardized "disclaimer opt-out" consent approach, then it is beneficial to work with the Nursing or Medical Assistant Team to recognize scenarios that may meet criteria for this service and obtain consent prior to forwarding messages to the provider. Obtaining consent does not require the clinician to use codes 99421-3. Consent can be obtained initially but later it might be recognized that the question required less than 5 minutes time or resulted in a visit within 7 days, therefore ending in no use of 99421-3.

The number of portal messages received by clinicians is objectively high and this has been a topic of discussion at SGIM meetings for many years. General internal medicine

is poised to lead innovation in this arena given its position in patient care. The codes for online digital E/M services represent an opportunity to deliver care to patients in a different venue should they seek it. Incorporating 99421-3 could contribute further to helpful practice redesign, perhaps resulting in a future state where SGIM members do not have scheduled visits continuously throughout their clinic. Instead, they would have periods protected specifically for asynchronous portal care: patients would benefit, clinicians would have time appropriate for their efforts, and practices could avoid negative financial impacts.

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you in the systems that we engage in daily. When you begin to develop a writer's mindset, you start to see and hear things differently. For me, this has been taking a next step after the conversation or experience with a focus on "would SGIM members be interested in this?"

Identifying a topic though might be the easier part. Each of you probably has an experience you could easily write about. Don't hesitate to start. As physicians, we learn to focus on the final state of medical care and how to get there. We learn how to treat patients with optimal medications and optimal interventions, but only later find that each patient is different, and treatments must be tailored to the individual, their needs, and their preferences. To many struggling authors, this optimal state can be the greatest stumbling block. We expect to see the final state of our article in that first draft without recognizing that great writers and authors go through many iterations, yet the reader only sees the final version. As William Faulkner states, "Get it down. Take chances. It may be bad, but it's the only way you can do anything really good."³

Great topic: check. Understanding that iterations will follow and perfection cannot be the enemy of good: check. Sitting at the desk with an empty word document and trying to get the first words typed: stuck in neutral. To get started, Dorothea Brande says, "All that is necessary to break the spell of inertia and frustration is this: Act as if it were impossible to fail. That is the talisman, the formula, the command of right-about-face which turns us from failure towards success."¹ Start typing using stream of consciousness with no editing and only later go back to revisit those initial thoughts. Work with others as the conversations about the article often lead to the sentences of the article when put to paper.

Why is this topic the focus of my February column? Over my 20+

years as an SGIM member, I heard amazing presentations, workshops, plenary sessions, updates, and informal hallway conversations which would make great *Forum* articles that SGIM members would cherish and learn from. In the September 2023 issue of the *Forum*,⁴ I wrote that my vision for the *Forum* was a publication by SGIM members for SGIM members in a conversational manner. I want to encourage more members to write articles that SGIM members will want to read. As Google CEO Sundar Pichai states "A diverse mix of voices leads to better discussions, decisions and outcomes for everyone."⁵

Why publish in the *Forum*? It has a very high acceptance rate for articles germane to our members. With an appropriate topic, it is likely you will see your final product published if you put in the work and coordinate with the editorial team. This gives SGIM members ranging from mid-career and established members to junior faculty a chance to publish their personal experiences. We love to include the works of students, residents, and fellows (SRF) as they will be tomorrow's leaders. Opportunities exist for SGIM committee and commission members to publicize their work and recruit new members in the process. Committee and commission members should coordinate topics through their group and leadership to ensure that the topic reflects the goals and visions of the group and is not concurrently being worked on by other members. SGIM regions have a chance to recognize key presentations from their regional meetings and broaden the reach of those sessions that non-regional SGIM members would not get to see at the regional meeting. The *Forum* can also publish research that may not meet the rigors and scrutiny of peer reviewed journals, such as *JGIM*, but which can still add value to the medical community.

At the 2024 Annual Meeting in Boston, Massachusetts, the editors

of the *Forum* and *JGIM* will jointly present a workshop on understanding the options for publishing within the SGIM organization. We will highlight the differences and similarities and work within small groups to assist authors in getting those first steps completed on the path to publication.

As physicians, educators, researchers, and administrators, we work within the medical and scientific community. Although we all search for knowledge, each of us has unique stories and strengths to share. "There is just one contribution which every one of us can make: we can give into the common pool of experience some comprehension of the world as it looks to each of us."¹

Will you share your unique perspectives with fellow SGIM members through your submission to the *Forum*?

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syndrome.^{3,4} Although limited research exists to evaluate treatments for imposter syndrome, key focus points are conversation, reflection, and awareness.⁵ This type of reflection can be achieved with clinical coaching, as demonstrated by our podcast guests, but may also be accomplished through other organic and facilitated discussions. Our podcast, and other similar outlets, can provide additional avenues for internal medicine trainees and faculty to process feelings of inadequacy. Given the negative sequelae that result from imposter syndrome, creating ways for physicians to engage in reflective conversations about self-doubt should be considered during medical training and throughout physicians' careers.

Review of Systems started as a podcast about the history, structure, and legacy of the medical education field. However, it also serves as a platform to normalize the struggles physicians face and to highlight the wonderful clinicians working toward

change. What began as a casual conversation evolved into a powerful way to tell stories and connect with others. These conversations, though difficult at times, are critical to helping physicians understand the complexities of medical education, and, in doing so, help physicians process the feelings so many of us learned to internalize.

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