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BREADTH

DEALING WITH DEATH: PERSPECTIVES FROM THE DARK SIDE OF MEDICINE

Amanda Clark, MD; Adrian Sims, MD; John Caleb Grenn, MD; Elizabeth Fryoux, MD

Four physicians, each at different points in their careers, share personal experiences on dealing with patient deaths with the hope to convey the importance of reflection on guilt, resilience, and growth.

The Initial List

Dr. Amanda Clark (avclark@umc.edu; @amandavclark) is an assistant professor of medicine at the University of Mississippi Medical Center.

Before I started medical school, people gave me advice about many things—for example, which study materials are best, how to do well in Gross Anatomy, when to start studying for board exams. There were books, e-mails, and conversations filled with advice about various classes, professors, and studying strategies.

No one ever told me what to do when a patient died. No one told me about the twinge of pain I would feel when we told the family this would be his or her last day. Worst of all, no one prepared me for the pain and guilt of an unexpected death.

Like many things in medicine, I "learned by doing." My first patient that died was unexpected and while I was calm during the conversations, the OR, and the code, I cried in my car, at home, and in the shower for weeks. Seeing someone's mortality makes you question everything.

The second was no easier. He was younger than me. I couldn't stop thinking about his lifeless body after the code ended. I began to keep a list of initials: E.A., J.W., R.Y.

And then there was the one on the first night of call my intern year. Also unexpected and this time, as the physician, I was sure it was my fault. He was set to be released from prison the next week. He was kind.

As time lapsed, the deaths kept coming. The lady in the ICU waiting on a new liver. The unexpected massive stroke. The man who was happy to be discharged home. The young mother. The man who didn't feel well in clinic. The young girl with cystic fibrosis. The avid football fan. The lady with the worried eyes. The many high-grade cancers.

It's now been more than 10 years since that first death and there have been many more. I don't keep a list of initials anymore. Written down or not, they stay with me and they still hurt.

We are all human and we make mistakes, but I now understand that some patients are very ill and sometimes they die—maybe unexpectedly and despite our best efforts. We are not God. We took an oath to heal and do no harm and, while we do our best, sometimes our best is not enough—not because we aren't strong or smart enough, but because life can unexpectedly end. There is no crystal ball. I have stopped asking myself "Was this my fault?" and now ask "Were we doing all we could?" Because now I understand. Our best is all we can do.

Why didn't anyone teach me how to deal with death? Probably because it's complicated, there's no one way to cope, and well, it's tough to be vulnerable. Talking about the things we want to put behind us is hard, but these conversations must happen. We must debrief. We must grieve. We must find a way to move forward. And most importantly, we must allow space for our trainees to do the same. Otherwise, the initials will add up, the grief and guilt may become insurmountable, the burden too heavy to bear.

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FROM THE EDITOR

YOU CAN'T GO HOME AGAIN

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

"When things are at their worst is when you will see the good, the bad, and the ugly. Where people are under pressure you see like the true essence will come out and some people will break your heart, people who you expected to react differently will just break your heart and disappoint you but then other people who you expected nothing from will show you a strength and a resilience that just is an inspiration."

—*Andrew Cuomo, Governor of the State of New York,* Daily COVID Briefing, Easter Sunday, April 12, 2020

It's hard to write my penultimate editorial without mentioning the COVID pandemic. I tried. I just couldn't get past the first paragraph. It's all different now. It will not be the same again. Not in three months, not in one year, never. Relationships are different. Roles are different. I am different.

Front line staff have changed. This story has been and always will be about the patients, the healthcare team, and the front line staff—in the EDs, the inpatient wards, ICU, and primary and urgent care. Patients placed their trust in us to support, treat, and, in too many cases, ease their suffering. It's not like we've never felt helpless when we confronted a disease we couldn't treat or pivoted to the role of palliative care provider. But the heavy toll came when it happened multiple times per day, seven days a week, and in the span of 6-8 weeks. The wave came hard and stayed. We stood our ground. The strength and resilience that the governor referred to on Easter Sunday was in full view these past few months. No one broke my heart. All were an inspiration.

We know more about the virus today than we did when this all started, more than we did last month, more last week, more yesterday but not nearly as much about it as tomorrow. New information came at us like drinking from the proverbial fire hose:

- **Hydroxychloroquine is a game changer!—No, it's not!**
- **Place them prone! Give them zinc! Vitamin C!**
- **They clot!! Anti-coagulate them!**
- **You want to give them what!!??**

How we do research has changed. At Northwell, we stood up clinical trials from concept to recruitment in a matter weeks. We organized the data such that we can perform rapid queries to answer clinically impactful questions for frontline staff to use. We literally ran to the

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NAVIGATING AN ENVIRONMENT OF UNKNOWN UNKNOWNS

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

In looking back, it is apparent that what we thought was a complex environment has only become more so. There are certainly more unknown unknowns now than ever. VUCA feels like an understatement some days. Many of us have felt that we have spent all of our waking (and at times sleeping) hours solving unsolvable problems.

In 2018, I gave a presentation at the ACLGIM Hess Institute entitled "Leadership in Complexity: Succeeding in the Setting of Unknown Unknowns." I talked about the current environment as being consistent with VUCA.[1,2]

- *Volatility*: The speed of change; the more volatile the world is, the more and faster things change
- *Uncertainty*: The extent to which we can confidently predict the future; the more uncertain the world is, the harder the future is to predict
- *Complexity*: The number of factors that we need to take into account, their variety and the relationships between them; under high complexity, it is impossible to fully analyze the environment and come to rational conclusions
- *Ambiguity*: Lack of clarity about how to interpret something; when information is incomplete, contradicting, or too inaccurate to draw clear conclusions

I emphasized the complexity of the academic environment, describing complexity as the domain of the unknown unknowns. In this domain, considered the domain of emergence, cause and effect cannot be known in advance. Experimentation and monitoring and diversity of perspective are often necessary to solve problems. I shared Dooley's tips for being successful in the setting of complexity:

1. Create a shared purpose (explain the "why")
2. Cultivate inquiry, learning, experimentation, and divergent thinking (build many relational connections and networks)

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HOW TO TEACH PROCEDURES? MEDICAL PROCEDURE SERVICES INTEGRATED INTO RESIDENCY ELECTIVES MAY BE THE SOLUTION

Emily Grossniklaus, MD; Robin Stiller, MD; Tyler Albert, MD; Amanda Shepherd, MD; Rosemary Adamson, MB BS

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Procedural competency expectations for general internists are in flux, and current procedural training for resident physicians varies across internal medicine programs. Traditionally, general internists performed a variety of bedside procedures both in inpatient and outpatient settings. However, the number and variety of procedures performed by generalists have been steadily declining.[1] The degree of bedside procedural competency an individual provider will need depends on a number of factors, including: patient population and practice setting, availability of proceduralists and subspecialists, and the provider's own interest in performing procedures.

Recognizing this heterogeneity, the ABIM requires that all residents have the opportunity to become competent in procedures essential to their intended field of independent practice or subspecialty fellowship training. Common to all procedures, and thereby specific to the ABIM requirements, is demonstrating the ability to discuss and obtain informed consent, prepare and maintain standard and sterile fields, and apply local anesthetic.[2]

In this setting, it is understandable that procedural training practices in U.S. Internal Medicine (IM) Residency programs are quite variable. The majority of graduating residents report inadequate exposure to procedural skills during residency training,[3] which raises concern regarding whether they are able to competently perform what were formerly considered to be core procedures. This is problematic, as many graduating residents may need to be able to safely perform beside procedures depending upon their subsequent practice settings.

Currently, most residency programs are using two training approaches to teach procedural skills: dedicated simulation-based workshops and learning procedures from more senior residents or supervisors as opportunities arise while on clinical service. Both strategies have significant shortcomings. Although workshops often include trained procedural instructors, simulation can never fully replicate performing procedures in the clinical setting. Unfortunately, learning procedures "ad hoc" while balancing other clinical service obligations provides inconsistent opportunities to learn and practice procedures. Additionally, supervising physicians may be under-qualified in teaching and performing procedures. Medical procedure services (MPS) provide an alternative approach to achieving procedural competency.

MPSs are an optimal training strategy for residents who desire to become competent in bedside procedures.[3] In this model, residents are taught and supervised by procedure trained attending physicians to perform common bedside procedures in the clinical setting. MPS rotations have a dual purpose of providing timely procedures while off-loading other providers from procedural obligations. Participants are more likely to perform a greater volume and variety of procedures, education is maximized as the most effective instructors can be selected on the basis of competency and skill, and concomitant clinical responsibilities of the trainees are minimized.

To date, there have been seven such reports describing the development, implementation and evaluation of MPSs in the peer-reviewed literature, dating between 2004-18.[4-10] These rotations range in length from one to four weeks. All services included training on thoracenteses, paracenteses, and lumbar punctures; an additional three services included central venous catheter placement[4-6] and two services included central venous catheter placement and arthrocentesis.[7,8]

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Reviewing these reports reveals several important themes:

1. In five of the seven studies residents were given dedicated clinical time to participate in the services.
2. In all of the described rotations, residents had expert supervisors available to guide them as needed (including both hospitalists and sub-specialty providers).
3. All the electives provided supplemental didactics, with a variety of strategies ranging from video instruction,[5, 7, 8, 9] simulation training,[7, 8, 10] dedicated didactic sessions,[8, 10] discussion of key concepts,[7] Web-based curriculum[7] to dedicated ultrasound-specific training.[10]

Reported outcome measures were also variable, spanning from resident self-assessment (of satisfaction of training, comfort/confidence, subjective knowledge and skill)[5, 8, 10] to knowledge assessments via written tests[7] and assessment of procedural volume.[4, 9, 10] Notably, several of these studies investigated patient outcome measures, including successful procedure rates,[4, 6] use of best practice safety measures,[6] and complication rates,[5, 6, 10]

Overall, self-assessment measures generally improved with implementation of the MPS, including resident comfort/confidence[8, 10] and perceived improvement in knowledge.[8, 10] Objective improvement in medical knowledge and skills using observation with checklists was also reported.[7] Studies that examined rates of procedures performed by residents after implementation of an MPS showed increased numbers of procedures and ability to "credential" residents to perform invasive procedures.[4, 9] Although one group found improvement in complication rates as compared to the literature,[5] another showed similar rates of major complications.[6] However, studies that investigated rates of "successful" procedures found more successful procedures in MPS groups when compared to procedures performed by primary services.[6]

Challenges to the implementation of MPS include a lack of standardized published curriculum and limited hospital and residency program resources. Although there have been guides published for individual procedures (for example: lumbar puncture and paracentesis on MedEd Portal), there is no published literature or "handbook" on how to create an MPS. As such, each institution creates a unique service—which can be advantageous as it enables rotation directs to not only create services that are adaptable to their institutions but also the risk of inconsistency in degree of competency among graduating residents. Carving out dedicated resident time from already packed schedules and funding full-time supervisors present additional challenges.

Implementation of an MPS appears to be a promising approach for providing self-selected trainees with the procedural competency they need for their future careers. Outcome data regarding MPS electives, while limited, show an increase in resident-performed procedures,[4,9] improved objective procedural knowledge and observed skill level,[7] and improved patient safety outcome measures with either stable or improved complication rates.[5, 6] As such, an elective rotation for residents to hone their procedural skills is an effective mechanism to improve both resident competency and shows promise for improving patient safety outcome measures.

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LETTER TO THE EDITOR

Conny Morrison

Ms. Morrison (constance_morrison@med.unc.edu) is a fourth-year medical student at the University of North Carolina School of Medicine in Chapel Hill, North Carolina. She has been involved in advocating for vulnerable patient populations as a member of the American Medical Student Association, Physicians for Human Rights, and Healthcare for All NC. She will start as an Internal Medicine Resident at UNC in June 2020.

I was recently asked by my medical school to look up the policy positions of my future medical specialty society and choose a policy about which to contact my state legislators. I was disappointed to find that the Society of General Internal Medicine (SGIM) last published a policy position on American healthcare reform in 2009. The first principle of this position proposes "that all United States residents have access to affordable, comprehensive, equitable health care for medical, dental, mental, and substance use disorders, including prescription drugs and necessary devices, as well as preventive care."[1] Additionally, a 2015 SGIM *Forum* article identifies healthcare access as a key focus of the Clinical Practice subcommittee and declares that "this subcommittee is committed to universal health care access."[2] Yet, there appears no follow-up SGIM position paper advocating for a specific solution that would help achieve this important objective.

> **I cannot bring myself to join a physician society that does not actively speak out for the best interests of our patients, a significantly more vulnerable group that we have taken an oath to protect. SGIM should join the ACP in being a leader on healthcare reform now by endorsing single-payer, before policy decisions are made for us and our patients without the expertise and input of America's general internists.**

To a growing majority of physicians, this solution is a universal, single-payer health care system.[3] I support a single-payer system, also known as Medicare for All, because each of my future patients deserves high-quality care without fear of going bankrupt. As a fourth-year medical student at UNC School of Medicine, I have already cared for many patients whose deaths could have been prevented by simple, cost-effective screening and treatment available with health insurance. While the Affordable Care Act was an important step in the right direction, its limitations have further proven that a universal system that takes the profit out of healthcare is the only path forward to improving and expanding access to care for all Americans. The new reality we face in addressing the COVID-19 pandemic makes the case for Medicare for All even more clear and dire.

McCormick, et al., succinctly argued in their 2018 perspective piece for the moral and practical reasons SGIM should be in favor of a single-payer system.[3] Nonetheless, no further policy has been released. While I understand that the primary function of a specialty society such as SGIM is to advocate for policies that protect and support their members, I cannot bring myself to join a physician society that does not actively speak out for the best interests of our patients, a significantly more vulnerable group that we have taken an oath to protect. Other physician organizations have made moves in this direction in response to calls from within and outside of their membership. Since 2018, the American Medical Association backed out of the Partnership for America's Health Care Future, an alliance centered around opposition to Medicare for All, after its members voted narrowly against endorsing single-payer.[4] More recently, the American College of Physicians (ACP) has endorsed single-payer or public option reform as the best ways to achieve universal access.[5]

SGIM should join the ACP in being a leader on healthcare reform now before policy decisions are made for us and our patients without the expertise and input of America's general internists.

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A CLEAR PATH FORWARD: REFLECTIONS ON SOCIAL DETERMINANTS OF HEALTH THROUGH A RESIDENT-LED QI PROJECT

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The fields of Quality Improvement (QI) and Social Determinants of Health (SDH) sometimes seem to reside in their own realms, as if being bestowed with a memorable acronym relegates each entity to its own pathway and followers. Attending physicians, trainees, and students interested in improving patient outcomes are seemingly compelled to self-identify with one or the other—they must become "one of the QI people" or "one of the SDH people." Moreover, the QI realm tends to gravitate to the inpatient setting, where a canon of memorable topics has emerged. Medication errors, falls, CAUTIs, CLABSIs, and VAPs dominate the landscape, in large part because of the colorful posters in *comic sans* font that line the hallways and break rooms in any given med-surg unit. In reality the thoughtful practitioner must be cross-trained across these fundamental ways of understanding health and society, and be competent in the principles of implementing meaningful change. Application of QI science is necessary to meet the challenges of investigating, understanding, and eventually mitigating the inequities associated with SDH.

SGIM has issued a call to action by way of this year's annual meeting theme: we must better understand the impact of SDH on clinical outcomes. Efforts such as the SDH Fast Facts[1] are crucial to help clinicians build a toolkit rooted in evidence and focused on identifying and intervening upon health inequities. Developing ways to support this effort at the graduate medical education level can seem challenging at first glance. But when I reflect on the lessons learned through a SDH related QI project at my resident continuity clinic, I see a clear path forward.

During my residency at Emory in Atlanta, Georgia, my primary clinical training site was Grady Memorial Hospital. Grady is *the* public safety-net hospital and Level 1 trauma center for Metro Atlanta primarily serving an under- and uninsured, marginalized, and poor patient population. As such, Grady holds nothing back in orienting residents to the harsh realities of gun violence, homelessness, and inequities in access to care. The ups and downs of training at Grady leave such a permanent, memorable impression that a resident is said to be "Grady-made" at the end of training. To me, that meant coming away with not just a strong foundation of clinical training, but an equally strong foundation in understanding the SDH which are integral to every patient's experience.

Nearly 34% of patients seen at the Grady primary care center have a diagnosis of Type 2 diabetes. It is indisputable that patients with diabetes and low socioeconomic status have worse outcomes compared to those with higher status.[2] Not only is the risk of developing diabetes higher but also there are higher rates of associated retinopathy and nephropathy.[3] And as trainees, a harsh reality we had to reconcile with our ideals and aspirations as physicians was that low socioeconomic status portended patients receiving worse care for their diabetes.[4] As well-meaning internists-in-training being taught by other well-meaning internists, we wanted to understand more about why our diabetic patients weren't receiving optimal care and how we might improve their quality of care.

To address this issue, our Primary Care program cohort created a QI project aimed to improve diabetes outcomes among patients at Grady's primary care center. To foster durable change, we established a legacy project involving all three resident classes in the Primary Care program. Iterative Plan-Do-Study-Act (PDSA) cycles were aimed at identifying opportunities for process improvement in clinic, with the overarching goal to lower the A1c of our most poorly controlled patients with diabetes (defined as A1c greater than 10%).

We surveyed our patients to assess their knowledge about diabetes and management of diabetes, and very quickly recognized that the prevailing factors affecting their diabetes control extended far beyond our clinic walls. We assumed that cost and low health literacy were likely to be important issues, but the survey responses starkly demonstrated the true impact of these issues on the health of our patients. There was a palpable weight to our findings, which showed that—even with access to a sliding-scale pharmacy—difficulties affording medications prevailed, and this was associated with poor control. On the other hand, self-report of eating vegetables in the last 24 hours correlated with an A1c less than 10%.

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INVESTING IN THE FUTURE OF GIM

Mark D. Schwartz (Mark.Schwartz@nyulangone.org) and Hollis Day (hollis.day@bmc.org), Treasurer and Treasurer-Elect, on behalf of the SGIM Finance Committee.

SGIM, our professional home, is fueled by financial support from various sources.[1] Most of our operational revenue comes from member dues and registration fees for our annual meeting, which we were not able to hold in Birmingham this year. As we navigate this challenging year together, we recognize that special initiatives require additional funding to be successful. Therefore, SGIM now needs your support for a new, special initiative—the Future Leaders of GIM Fund.

New Future Leaders of GIM Campaign (2019-21)

SGIM's mission is to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone. To succeed in this mission, it is critical that we build SGIM's community to ensure a robust pipeline of future general internists. SGIM has a small fund to support trainees to attend our annual meeting or become yearlong members, but it is time that we deepen our commitment to nurturing our associate members.

Therefore, we have initiated a new campaign to raise money for the Future Leaders of GIM Fund. This will expand our successful Young Scholars in GIM Scholarship[2] (for medical students and residents), and our Investing in GIM Scholarship[3] (for GIM fellows) programs that provide scholarships for SGIM membership and annual meeting registration for associate members. These scholarships build our membership pipeline by engaging people entering, or considering entering, the field of academic general internal medicine. Over the last five years, these scholarship programs have funded more than 200 medical students, residents and fellows.

We appreciate the strong initial response to the Future Leaders of GIM Fund. As this goes to press, the campaign has raised over $35,000, with 100% participation by SGIM's Council members. This has already enabled us to extend our scholarships for 2020 to increase the number of recipients and build this program going forward. Our goal is to raise at least $100,000 over the next two years, which would allow us to double the number of scholarships for trainees for at least the next four years.

No Margin, No Mission!

Only a sustained financial commitment to the organization by our members will let us thrive into the future in these uncertain times. SGIM is enacting new strategies for financial growth including innovative membership recruitment and retention efforts, philanthropy, grants, and meeting exhibits and sponsorship, all of which will meet the high ethical standards of our external funding policy. However, to be successful, we must each challenge ourselves as members to create a broader culture of giving at SGIM. If most members commit to giving annually, no matter the amount, SGIM will be a stronger, more sustainable organization with a powerful voice. Will you join us in creating this culture?

Donate at: https://www.sgim.org/donate

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The Investing in GIM Scholarship has introduced me to a new specialty society that brings something to my professional life that other societies have yet to bring. It has also made it more affordable for a junior physician to attend the national SGIM meeting. Furthermore, this inspired me to submit multiple scholarly projects to the meeting and I can't wait to attend and present!

—Benjamin Vipler, MD

The Young Scholars program allowed me to attend SGIM and present my work to a national audience, and in so doing not only share the findings of my research, but it allowed me to connect with a national community of scholars and field experts that has helped shape future directions in our research. This opportunity allowed me to grow as a trainee, and to better understand the broader context of the community that I was joining and that my work could contribute to. It was an honor to participate in SGIM as one of the Young Scholars and through the program's support, I feel that I gained an additional opportunity to move my career forward and envision what the future may hold.

—Alexandra Rojek, MD

GAPS IN CARE DUE TO A SCATTERED ELECTRONIC MEDICAL RECORD

Sanah Ali, MD

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Inefficient utilization of care is a major challenge in Medicine in the United States—an underemphasized facet is poor communication between electronic medical record (EMR) systems. While EMR adoption has expanded significantly, the ability to interoperate is limited in this billion-dollar industry, and information blocking continues to occur. There have been gradual improvements, including the government's introduction of Meaningful Use Incentive Programs in 2009, renamed "Promoting Interoperability" in 2018. Born from this were Regional Health Information Organizations—local hubs to share and access patients' health information electronically. However, holes and inaccuracies remain in EMRs. For example, it is particularly dangerous when you cannot determine a patient's baseline health status, and cannot elicit what, when or where medical devices were placed. Inter-hospital record shares are formatted differently and accessed in a separate tab in most EMRs (including Epic's Care Everywhere and Cerner's Community View). A fax uploaded as a PDF cannot fully be integrated into the fabric of most EMRs, making that content unsearchable except manually. There is no mandate for this information to be in HTML format. While consensus on data formats and elements has improved, including via "Fast Health Interoperability Resource"—an application programming interface—there are still barriers to interoperability. The potential for innovation remains, including via Smart Health IT, a platform which allows innovators to create apps which can be used across health care systems. Furthermore, the Trusted Exchange Framework and Common Agreement (TEFCA) was released on April 19, 2019, and outlines "rules of the road" for nationwide electronic exchange across disparate networks. Additionally, the MyHealthEDataInitiative aims to break down barriers for patients' access to their records.

I wonder if we, as patients, are inextricably tied to one health system. When we stray, it is common for there to be no medical record in sight at the time of care, or for it to be inaccurate or incomplete. We are surprised, upset and frustrated when providers do not know our stories, and vice versa. Furthermore, there is no national patient identifier. This leaves room for countless medical errors (especially in medication reconciliation), unnecessary testing, and delays in care. A single EMR is the obvious ideal however it has barely been discussed in American literature as it is not feasible—a frustrating realization that I encountered during my research. The barriers to this appealing idea include weak physician political advocacy, concerns regarding funding, fear of bureaucratic burden, stifling of innovation (as with Veterans Affairs use of Vista CPRS), and data security. Security concerns of a single EMR are likely blown out of proportion given that most security breaches in the United States have been phishing or hacks of third-party companies,[1] and multi-factor authentication continues to be protective. Given these concerns, a single EMR will not see the light of day in the United States anytime soon.

Even if interoperability is realized, our EMRs still run on the paradigm of hand-written notes and dusty billing standards. Each note is a discrete entity with one author. Inaccurate statements or misspellings are propagated. According to a paper from 2016,[2] saving physicians' time and eliminating data duplication has been on the EMR to-do-list since 1992. This expectation has yet to be realized. Furthermore, the volume of data remains an issue. Computers are not smart enough to condense the health record to remove fluff that is no longer needed; however, strides are being made in natural language processing. Graphic User Interfaces (GUIs) are underutilized, and do not auto-populate to illustrate important graphic trends without extra clicking. Procedure lists and problem lists are not consistently updated by the proceduralist or diagnostician who should be held responsible. Searching and reviewing the EMR is increasingly time-consuming as one patient may have thousands of notes. It may be difficult to find information even within a single note (such as PT/OT discharge recommendation) and nursing task-based notes are tedious to read.

In 2018, CMS announced a "Patients Over Paperwork" initiative to reduce provider burden by simplifying documentation requirements (in 2019) and reforming the associated billing codes and physician fee

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The Final Text

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Discharge orders in, check. Follow up appointment scheduled, check. Medication reconciliation completed, check. "I'm finally getting the hang of this discharge process," I thought to myself sometime mid-intern year. "Let me go check on her one last time before I head to clinic", I told myself. The neurotic idea of checking a twelfth time somehow made me feel that nothing would be missed, and I would have accounted for every possible variable that could happen. What a silly notion.

"Is your mom on her way?" I asked. She was young, thirty years old. "I just texted her. She'll be here in about an hour," she said with a smile as she thanked me, an intern with no real medical prowess, for taking care of her. She was chronically ill having battled lymphoma for some time and had now suffered a small stroke. "I'm on my way to clinic but I look forward to seeing you in follow up next week" I said. The follow up would never come. As I was gathering my things to leave for clinic, the nurse knocked on our workroom door. "Your patient in 477 is having a seizure, I think," she said frantically. No way. How could this be? She didn't have a seizure disorder. I arrived to find her convulsing on the bed. "This doesn't make sense. She just spoke to me," I thought in bewilderment.

After emergent intubation, central venous access, and running through the Hs and Ts, she was quickly escorted to the CT scanner. Her aorta had ruptured from a pseudo-aneurysm. "Did you talk to vascular surgery like I asked?" my resident inquired. The blood pooled in my feet and I felt overwhelmingly faint. I suddenly felt very hot and needed to vomit. My resident had asked me to call surgery prior to her discharge about an incidental finding that was discovered on imaging. It was not intentional. It was not out of malice. Negligent perhaps, but not on purpose. She soon coded after that and was pronounced dead after valiant resuscitative efforts. Disclosing the details to her befuddled mother was, by far, the most difficult thing I've ever done. We sobbed. I considered quitting.

Emotionally, I spiraled into a very dark place for quite some time. Mentors, leadership, and friends assured me that making the consult would have not changed her outcome. After all, she was very sick. It provided no solace.

Over time, I did recover with a lot of help from people that knew a broken physician couldn't adequately care for patients and who truly care for me. I also realized that I was far from the only person who has experienced an unexpected death such as this. There are many good physicians who are good people that deal with bad, unexpected outcomes. The experience, for better or worse, has now equipped me to be able to help others that experience difficult events.

I kept in contact with that young lady's mother. I called her once and she told me something unexpected. "I know you did everything you could, sweetie. My baby was really sick. I don't blame you," she said. Her words pierced me, and I felt a globus sensation clutching my throat. I vowed that day to put my thoughts on paper, to share her story, and to help other clinicians that experience similar events. Our conversation ended with her words, "Besides, I'll always have her last text message she sent me. 'Love you mom and I'll see you soon.'"

The Eleventh

Dr. John Caleb Grenn (jgrenn@umc.edu, @jcgrenn) is a third-year medicine-pediatrics resident at the University of Mississippi Medical Center.

You didn't feel good this morning. Honestly, you hadn't felt good for at least two weeks, probably two months. But today, I saw something different, something urgent. How are you feeling? A weak shake of the head. Do you want me to call your family? I know they're coming to see you tomorrow, but do you think if they could, maybe today? A thumbs up. A nod. OK.

Your daughter was at work, but was going to try to get here. She knew, too, that this was coming. Though I wanted to express my new, odd, gut-felt urgency, I have been wrong about so many things so many times. I've seen too many linger, too many stew, but I knew that it would be today. I should have said that, but I didn't.

She wanted to be here, and so did your wife. I saw that in their eyes every day they sat there with you. Tears leaked from wrinkled corners. I wish I could have been there, too. I think you hoped one of them or at least someone would be there, but we weren't.

Somehow your death has me sadder than I thought I would be by now. I tend to cope with each patient's death a little differently, but I've never had to wear my sadness, to bear its heavy weight. This time I'm wearing it. I guess it's because you hoped someone would be there with you, because I think you knew today was the day like I did. Dying alone frightens me, too. It might just be because you met my expectation sooner than most of us thought you would, and it sneaked up on me when I wasn't ready to be surprised. Maybe I should have always felt this way, and it's normal. But in truth I think it's because you taught me that I've seen this enough now to know that you were going to die on the eleventh. Not the twelfth or the thirteenth or the next week. I knew that today was your last, and that it passed by stoically with the buzzing, the beeping, and the shallow, slowing breathing until it stopped, and the room went quiet.

Two years later, I realize that on the eleventh, your eleventh, I learned to speak up. I tend to trust

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BREADTH *(continued from page 10)*

my instincts a little more. Pressing premonitions get me on the phone with families faster. I make firmer recommendations; I tell people to come soon, that time is precious. The burden I had to start wearing that day weighs the same, but now feels lighter.

Learning from Death

Dr. Elizabeth Fryoux (efryoux@umc.edu, @Eamfryoux) is a chief resident in internal medicine at the University of Mississippi Medical Center.

As a resident, you try to learn as much as you can and as fast as you can. You realize how much there is to learn and how much you do not know. You feel so responsible for your patient's care. You realize, some sooner than others, that you will face losing a patient. Early in training, saving lives has been indoctrinated, so as physicians we equate death as a medical failure rather than a natural process.

As a new intern on our first call day, my resident asked me to go see a previously healthy 22-year-old man who presented with a two-week history of fevers and generalized myalgias that was associated with pleuritic chest pain, non-productive cough and a sore throat. He was admitted for fever of unknown origin and later diagnosed with Adult Onset Still Disease. He was on our service for the entire month and every morning I looked forward to seeing him and his family. Treatment was initiated immediately, but he continued to worsen each day and was ultimately further diagnosed with Macrophage Activation Syndrome and subsequently died from complications. This was the first patient that I took care of who had died, and I was devastated. I ached for the loss of such a young man and for his mother and girlfriend, who never left the hospital upon his entering. I constantly ruminated what I or we as a team could have done differently to have prevented his death. I felt hopeless and completely responsible that I let his family down. In time, I came to the realization that I could learn from his death. I made a vow in memory of him that I would view each patient as an individual rather than a disease. I would pay more attention to how I talked to my patients, how I managed them, how I touched them and the continual need to be a lifelong learner. The numerous sacrifices I would make as a resident would be for him rather than a means to an end. My work would be my calling rather than just a job. I reminded myself even though we could not save him and that his death was inevitable, this experience would allow me to help many others and do so as a better physician.

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TECHNOLOGY UPDATE *(continued from page 9)*

schedule (to take effect in 2021). Additionally, to reduce redundancy in the medical record for established patients, certain elements (such as chief complaint and history) documented by allied health professionals can be used for billing. Of the five E/M codes, level 2 thru 4 will be reimbursed at a single rate, and require supporting documentation currently associated with level 2 visits. Additionally, policies and payments for advancing virtual care are being finalized, and recently accelerated, as Telehealth gained a spotlight during the COVID-19 pandemic.

It is indisputable that discrepancies in patient data result in gaps in care. We can fill these harmful gaps with more user-friendly EMR features, including a multidisciplinary "team-based note" and "medical timeline". CMS admits that current documentation requirements may not account for the growing emphasis on team-based care. A team-based note should be considered as a method for optimizing team-based care. This note would allow multiple authors to edit a single note in real-time, with each contribution demarcated by provider name and timestamp. This would eliminate copy-forwarding, decrease time spent on chart review and documentation, allow consultants to focus on their areas of expertise, improve co-management of complex patients, and ease transitions of care. Additionally, a medical timeline would provide a bird's-eye view of health history. Improving EMR accuracy could strengthen the therapeutic alliance, reduce physician burnout, and indirectly improve data analytic capabilities (OHDSI [Observational Health Data Sciences and Informatics] is currently tackling this).

Another challenge is the utter lack of integrated HIPAA-secure inter-provider communication. Microsoft Teams, paging apps, and EMR-based mobile chatting make communication easier, but none are fully integrated into the EMR. While participation in nation-wide physician networks such as Doximity is currently voluntary, it has the potential for expansion into a more widespread communication platform. It is scary that the lag in healthcare technology exists despite the risks to patient safety. We owe our attention to the field of Clinical Informatics— our main interface with the communication technology industry. Furthermore, why not borrow inspiration from other professional fields, such as banks and financial sectors, who utilize iris and facial recognition? How can we phase out our archaic use of pagers, fax machines, and burdensome record request processes?

As an American health care provider, I am dismayed by our medical

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3. Enhance external and internal interconnections (sense-making)
4. Instill rapid feedback loops for self-reference and self-control (learning)
5. Cultivate diversity, specialization, differentiation, and integration (work through ambiguity and paradox)
6. Create shared values and principles of action (leverage values and behaviors as the "how")
7. Make explicit a few but essential structural and behavioral boundaries (simple rules to maximize emergence)[3, 4]

As general internists, we are well-prepared to lead change in complex organizations. The accompanying table provides examples of ways in which general internists are well suited to address common issues encountered in academic medical centers. Our role as leaders in this complex environment is helping others make sense of what is going on around them.

In looking back, it is apparent that what we thought was a complex environment has only become more so. There are certainly more unknown unknowns now than ever. VUCA feels like an understatement some days. Many of us have felt that we have spent all of our waking (and at times sleeping) hours solving unsolvable problems. Consciously or unconsciously, we have had to invoke approaches to leading, and navigating, in a complex environment.I have seen remarkable leadership at all levels—the students whose expected clinical training has been disrupted innovating ways to meet key organizational and patient needs; the trainees, staff, and providers identifying ways to provide compassionate care guided by the rapidly evolving evidence; the researchers applying their research skills to addressing key issues related to care delivery and the care experience, and the educators creating ways to assure that the need of students and trainees from all levels are being addressed.

Examples of Why General Internists Are Well-Prepared to Lead Change in Complex Organizations

Issue	Why General Internists Are Well Suited to Address
Capacity management and patient flow (inpatient)	Understand continuum of patient care across all care settings; Expertise in systems-thinking; hospitalists care for biggest percentage of inpatients
Sepsis mortality (inpatient)	Expertise in applying data science, quality improvement, health services and outcomes research, patient-centered outcomes approaches, and developing and testing predictive models
Integrating learners into hospital/health-system priorities	Link hospital/health system priorities to ACGME requirements; existing expertise in quality improvement
Population health/value-based contracting	Expertise in high-value health care and shared decision making
Clinical leadership development	Faculty development expertise
Enhancing access to primary and specialty ambulatory care	Expertise in designing, implementing and evaluating innovative models of care
System approach to opioid crisis	Expertise in substance use disorder and behavioral health and in integrating behavioral health into practice; policy expertise; links to community organizations

None of us have done this before. We are all learning together. We have become not a learning health system, but instead a learning health care community. We now find ourselves at the intersection of both continuing to address the emerging needs of caring for those who become ill with COVID-19 while considering the longer term implications. At our institution, as with many others, we are considering what we continue, what we never go back to, and how the care we deliver, the research we conduct and the education we provide will be changed going forward. So much has changed, and the future remains uncertain. It is truly a VUCA environment.

There are plenty of opportunities for general internists, and SGIM, to demonstrate leadership in this environment. If anything, the COVID-19 pandemic has further elevated the priority topics for SGIM and its members, such as social determinants of health, health disparities, improving healthcare delivery, provider well-being, leadership development, innovations in education, advocacy, and research. It certainly has highlighted the needs of older adults and the gaps in the social and medical support systems for this vulnerable population. This moment in time reminds me of when I was interviewing for my current role as Chief Medical Officer. A member of the search committee asked me, "How do we know that you won't just use this as a platform to advance your palliative care agenda?"Before I could answer, another search committee member responded, "That's exactly what she should do."Our communities, patients, families, healthcare organizations, and academic medical centers need us. We, as a general internal medicine community and professional organization, remain strong. We thrive in complexity. Now is the time to step up, in whatever capacity, and provide the voice, expertise and compassion to address the needs that have become only more urgent.

In this time of uncertainly some constancy is welcome. I am thus delighted to share with you that Eric B. Bass, MD, MPH, FACP, has

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agreed to a five-year renewal of his contract as SGIM Chief Executive Officer. To quote Immediate Past President Karen DeSalvo, MD, in her message to Eric when he returned his signed contract, "The Council is so thrilled to have you at the helm of SGIM in regular times. I can't tell you how appreciative we are in this time of crisis. Your steady hand, love of the organization and people, and thoughtful/innovative approaches to weathering this storm are recognized and appreciated by all."

Even as we are working on launching the virtual version of the 2020 Annual Meeting, we are looking ahead to planning for 2021. We recognize that annual meeting planning remains a uncertain venture at this point, especially as we have all been learning to function and interact in a more virtual environment and as we face the economic realities of the impact of the COVID-19 pandemic. SGIM is acutely aware of the importance of assuring that the Annual Meeting is of relevance and seen as value to its members in our rapidly changing world. I am thus pleased to announce that Rita Lee, MD, and Yael Schenker, MD, MAS, FAAHPM, will serve as the 2021 SGIM Annual Meeting Chair and Co-chair. Rita is an associate professor of general internal medicine at the University of Colorado School of Medicine. She has a passion for medical education, leadership development, and advocacy. Her advocacy work has been primarily around LGBT health equity. She serves as an at-large member of the SGIM Council and is core faculty for the ACLGIM LEAD program. During her free time, Rita is an avid gardener and enjoys hiking, skiing, kayaking, and rock climbing with her wife and two boys. Yael is associate professor of medicine in the Division of General Internal Medicine and director of the Palliative Research Center at the University of Pittsburgh. She is a palliative medicine physician with a primary care background and a proud member of SGIM since 2007. As a health services researcher, she is passionate about improving the quality of serious illness care and mentoring a diverse new generation of research scientists. In her free time, she enjoys backpacking, biking, and canvassing for progressive candidates in Western Pennsylvania. Rita, Yael, and I are committed to assuring that the 2021 SGIM Annual Meeting continues to serve its members by making connections and creating community. We look forward to sharing plans with you over the coming months.

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wards to share the latest info so that front line caregivers could change their management. It's been exhausting but exhilarating.

The banners, lining the halls to the employee health entrance and corridors of my hospital, still call out to the heroes in the ED, the ICUs, and on 9 Monti, 7 Tower, 5 Katz, etc. In the absence of baseball, it is reminiscent of a mid-summer game at Citi Field (we are, of course, in Queens). I wonder which healthcare hero is going to win rookie of the year, MVP, and the most saves? Many have known the heart break of losing. The song *Here Comes the Sun* by the Beatles is playing more often now when a patient is extubated.

Somewhere between the last month's and this month's issues we felt compelled to release an additional SGIM *Forum* simply referred to as "COVID-19". People needed to write and express themselves and we felt *Forum* was the perfect venue in which to do it. I hope you find it to be a source of inspiration, hope, and information.

This month's issue tries to get back to the work we do as academic internists. Drs. Clark, Sims, Grenn, and Fryoux fittingly provide us with four thoughtful pieces on dealing with death. Dr. Grossniklaus discusses how to teach procedures through medical procedure services integrated into residency electives. SGIM President Dr. Jean Kutner also provides a framework looking toward this uncertain and complex future in her monthly column.

All the best and be safe!

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We extended our work determining the most common zip codes among our patients, and this highlighted the extent to which access to a major grocery store was limited. As my time in residency neared its end, our focus shifted towards developing an affordable grocery shopping list, based on informal price analyses and discussion with clinical nutritionists to develop easy, practical, diabetes-friendly recipes.

I learned many lessons through this three-year journey. But as I reflect on this experience as now an attending myself, the following three key points are most important to share with my colleagues and trainees:

1. When given the time, support, and opportunity, residents will always dig deeper to serve their patients, far beyond the problem lists generated by the electronic medical record. Our supporting faculty ensured protected time for all three residency classes of the Primary Care program to meet in-person, brainstorm, and pursue actionable steps to move this project forward.
2. Quality improvement is as much at home in the wards as it is in clinic. A strong foundation in QI principles provided us with continued momentum to generate new ideas of improving our delivery of care in the outpatient setting, and unexpectedly served as a vehicle to more intentionally explore our patients' SDH.
3. Understanding and integrating SDH is a critical component of any QI project. Without a deliberate effort to understand what was truly impacting the health of our patients, we never would have created interventions that were most likely to have an impact.

Now more than ever, we realize the magnitude of effect that SDH have on clinical outcomes. Cost, access to food and medications, and cultural biases are among the plethora of factors that demand our attention. Breaking down any perceived academic silos between "QI" and "SDH" is critical for success. Applying QI science in the primary care setting—especially as an educational tool among residents—is a simple way to understand the SDH unique to our patient populations.

I would like to express my thanks to Drs. Stacy Higgins and Shelly-Ann Fluker for creating the space to make this work possible, my colleagues Alejandra Bustillo, John Ricketts, and Gretchen Snoeyenbos for their work on the project, and the patients of Grady Memorial Hospital for participating in our survey.

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record-keeping. In a perfect world, we would wear a concise medical summary on our wrists, and it would be easily and securely accessed by providers. In some countries, citizens already have medical smart cards.[3] The European Union is on the brink of rolling out a multi-country EMR exchange—the first of its kind—called *eHDSI (eHealth Digital Service Infrastructure)*,[4] as recommended by the European Commission in February 2019.[5] This large undertaking inspires hope that we can improve the U.S. EMR within the constraints of our system, and perhaps aspire to a unified EMR someday.

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