VOL. 43 ▪ COVID-19 ▪ 2020

SGIM Forum

Society of General Internal Medicine

PERSPECTIVE: PART I

TSUNAMI COMING

Diana Mancini, MD

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I am standing at a shoreline, watching and waiting tensely as a massive wave approaches from afar. My colleagues are quietly filling in at my side—as we stand in front of the many sick and vulnerable, we realize a larger number is on the way. With friends and families behind us, we are hoping that, at the end of the day, we protect ourselves enough to not place them in danger when we return home. We are readying side by side to lock hands and brace for the tsunami to hit.

I have more than 60 hospital medicine clinicians standing with me, collectively facing an opponent we cannot see but, more importantly, cannot exactly predict. An opponent that threatens our safety and challenges us to sharpen our skills to keep our communities, our families, and ourselves safe. As chief of my division, I feel the trepidation of my team, building as a deep and low vibration among us. We are being called to follow the oath we all took many years ago—to stand and protect those around us knowing that it could be our end. Yet every member of my team is preparing to step forward and serve.

COVID has caused hospital staff to redesign floors and processes to accommodate patient increases. Dr. Mancini, CHM, provides a unique perspective as she and her team prepare for a wave that threatens their hospital, their lives, and those they hold most dear.

I am seeing courage—deep courage—the kind you can see in one's eyes as he/she steps into a storm. My friends and colleagues are watching patients and clinicians dying around the world; terrified and exhausted, they fight an illness without the needed knowledge and tools. Yet, here I am asking my team to do the same—a horrible request when you realize that following their oath could risk their families, even their lives. These clinicians, my colleagues, are throwing themselves like sandbags in front of the water, gathering every shred of information they can collect to equip themselves for a battle I cannot guarantee they will even know if they have won. All I can promise is that if they win today, they can fight tomorrow, maybe against overwhelming odds.

In the face of a wall of water, I am learning that communication is a crucial weapon as a leader and physician. Providing daily communications of goals and imminent obstacles has empowered my team to leave the assumed safety of their homes and fight. I am encouraging every member of my team to use new knowledge and skills to steady us in this battle. Whether it is training to become intensive care proficient or developing clinical or research algorithms for future care, we are grounding ourselves in our most natural skills of learning and adapting. Like so many of my colleagues, I have had to overcome fears to remain effective in my work. I worried about the donning and duffing of protective gear, making multiple mistakes the first few times I practiced. I worried how any subtle errors might put my children at risk. I struggled to reconcile these fears, some I have never known prior to this crisis, but it has become second nature, with practice and support. Now I don a superhero head cover, hand sewn by a colleague's sister, to remind me I have a well of courage deeper than I realize.

I am feeling solidarity. I am experiencing for the first-time clinicians across disciplines urgently gathering,

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A CHANGE IS GONNA COME

Francine Jetton, MA

Ms. Jetton (jettonf@sgim.org) is the director of communication & publications at the Society of General Internal Medicine.

"We're not going to be able to hold the 2020 annual meeting…"

Those words hung in the air over the video call. It's not like I wasn't expecting it; I knew it was coming, having been part of SGIM's COVID-19 response team that had met daily for the past two weeks. The night before, the CDC had banned group meetings of more than 50 people. Birmingham, Alabama, wasn't allowing groups of more than 100 to meet. It had become impossible for SGIM20 to continue as planned. But still, I wasn't expecting it when it had finally come down.

You might not know how much SGIM staff looks forward to the annual meeting every year. This would have been my 13th meeting (I made it to Toronto in 2007 even though I was hugely pregnant and stuck on a scooter, but I missed Minneapolis after the birth of our second son). Over the 14 years I've been director of communications at SGIM, I have come to know many of our members quite well. I think of some of you like extended family. Seeing you every year renews my joy in working at SGIM and reminds me why I have chosen a career in association work. Like you, I believe in the mission of our professional home. Like you, I am invigorated by the networking and personal connections that happen at an annual meeting; I come home from the meeting simultaneously exhausted and excited to start on new projects. And now, like some of you, I wonder, "How does SGIM continue in this new atmosphere? How does our organization stay relevant amid so much fear and worry—for your patients, for my children, for all of the people we love? What happens to us now?"

This extra issue of *Forum*, the brainchild of our wonderful outgoing Editor-in-Chief Joseph Conigliaro, focuses on some of the answers to these questions. Over the 43 years of *Forum*, it is the first time we are running a special issue—which should indicate the importance of this publication. We wanted to give members the opportunity to talk about concerns and issues around COVID however they see fit—through reflections, poetry, photos, Twitter chats, and scientific study. We wished to provide an atmosphere where people could listen to each other and make connections through the written word. And we

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Q & A WITH SGIM'S CEO AND PRESIDENT: RESPONDING TO THE CRISIS

Eric B. Bass, MD, MPH, and Jean S. Kutner, MD, MSPH

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April 12, 2020

1. What is SGIM doing to support members who are on the front lines during the novel coronavirus disease (COVID-19) crisis?

Every day we are inspired by the courage and commitment of SGIM members who are on the front lines of the COVID-19 pandemic. Knowing that our members are deeply engaged in directly providing clinical care and leading clinical programs under extraordinary stress, we made it a priority to offer as much support as we can.

First, we are collecting resources to assist members in various aspects of the COVID-19 response and posting them to SGIM's Web site.[1] The link includes resources on patient care, telehealth, hospital and clinical ethics, health equity, and caring for yourself. The site also provides links to resources created by other organizations (including the American College of Physicians, Society of Hospital Medicine, and Society of Critical Care Medicine), information about relevant Webinars and podcasts, and a special section featuring some of our own "Frontliners." We've used our weekly eNews to disseminate information about these resources. These efforts have been coordinated by SGIM staff members Francine Jetton and Julie Machulsky.

Second, we helped to launch a repository of selected clinical guidance materials for the COVID-19 response from academic medical centers. After the idea for the repository was proposed by SGIM members, including Katrina Armstrong, Eileen Reynolds, and Jennifer Haas, we explored how to collaborate with other professional societies in creating and maintaining an easily accessible repository. We were pleased when the Association of American Medical Colleges (AAMC) agreed to host the repository—it went live April 2nd and is accessible online.[2] The repository contains up to date COVID-19 treatment and management guidance to help clinicians optimize patient care. The goal is to identify and highlight areas of alignment in clinical guidance, and to make

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REFLECTING ON THE PANDEMIC AS A NEW YORK CITY HOSPITALIST

Chari Belmonte, MD

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Almost two years ago, I moved to New York City to experience the greatest city in the world, and it did not disappoint. I never expected that during my second year here, our lives would change dramatically. On the week when we had our first COVID-19 case, our hospital began to prepare for the surge by issuing travel restrictions. I remember being so upset that I had to cancel my trips—this feels like a lifetime ago.

Now, on the way to work, I walk on empty streets. Loud, honking cars are replaced by ambulance sirens, and the quiet neighborhoods are eerie. It's somber to walk from the train station to our hospital. One recent day, this walk allowed me to think about a patient with Down Syndrome who lost his father from COVID-19. The father was my patient's sole caregiver, and the patient now had no other family or friends. I wonder about what his future holds. I also think about families with loved ones sick in the hospital but unable to see them in person due to the nature of this cruel virus. As we continue to witness death and unfortunate complications due to COVID, the hospital atmosphere has been extremely sad. Trucks outside are parked as a temporary morgue. My fellow healthcare workers on the frontline are working as hard as they can while they also creatively come up with ways to protect themselves as we deal with the low supply of PPE.

I am thankful for the messages I get from people, including funny memes and packages from friends and family. Who would have thought I'd be excited to receive masks, goggles, and face shields in the mail? It is also heartwarming to hear strangers applaud for healthcare workers every night at 7:00 PM throughout New York City. This pandemic made me realize that what matters most is to show up, whether ready or not, to help others surrounded by people with the same goal to help lessen the suffering. This is our duty. At the end of the day, missing trips and cancelling plans do not compare to how important it is to be able to serve others.

I am optimistic that the city that never sleeps will be back on its feet again. When this happens, you will find me enjoying the city skyline view from a rooftop bar with a cocktail and thinking about this time that made me feel proud to be a physician in New York City.

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Photo credit by Chari Belmonte.

COVID-19 REFLECTIONS

Laura C. Hart, MD, MPH

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I hit a wall today.

I felt like I was doing really well with the changes that COVID-19 had brought on. Sure, we were making all sorts of clinic adjustments, but it was going to be fine because my job is all outpatient, not in the hospital. I was brainstorming with my husband about how he could handle his cabin fever from being at home, but I didn't need any help because I had the mental relief of going to work like I always do. I was good.

Photo credit by Thomas McGinn.

And then, I just … hit a wall.

Earlier in the day, I could feel myself struggling. With so many protocols and policies changing daily or even a couple of times in a day, you can't keep them straight and so instead of everyone feeling comfortable and confident in their roles, every question leads to scouring desks for the handout that covers that topic or scrolling through emails to find the message that was sent about it. You don't feel confident about anything. It's draining when issues that are normally simple are suddenly so very hard.

And then something that we do every day in my office, a teenager's physical in the med-peds clinic, hit a string of snags, and I was done. It's one thing when the stuff we are still figuring out is hard. But when the stuff we do without a problem any other day was suddenly beyond us, I lost it. I cried, right there in the office. And while those who know me know that I am crier, this just felt different. I was out of words. I couldn't even tell you how I felt. All I had for my emotions in that moment were the tears.

The tears didn't last long at the time, because they couldn't. There were two patients left to be seen and no other doctors in the office (social distancing—work edition). It was on me to pull myself together and get it done. I took a lap around the physician work room, blew my nose, washed my hands (yes, I used soap and water), and went to the next patient.

I got home a couple of hours later, hoping to relax, and mostly just felt guilty.

How could I dare to be frustrated at work when my husband and I are both still working and so many families have no income right now?

How could I dare to be frustrated at work when being able to leave your house is such a privilege at the moment?

How could I dare to be frustrated at work when I have colleagues all across the country facing such huge personal risk in hospitals without the necessary safety equipment?

How could I dare to be frustrated at work when my family is well and so many have loved ones suffering with this virus alone in ICUs around the world?

I keep trying to remind myself that everyone is struggling in ways large and small now, and it's ok to be struggling and acknowledge my feelings, whatever they may be. I don't know that I quite believe that yet.

Maybe tomorrow.

SPECIFIC SITUATIONS I NEVER IMAGINED THAT I WOULD BE IN

Erica Grabscheid, MD, FACP, FHM

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You have spent your entire career going to the guidelines, following algorithms, pulling up evidence-based articles, hunting down recommendations from experienced seniors, etc. Now, for the first time, there are no clear sets of instructions or even any experts. So how do we as physicians respond to these challenging situations?

Here are a few scenarios that I, as a New York City Hospitalist, have recently faced:

1. A rule-out COVID-19 patient has a psychiatric disorder and keeps leaving his isolation room and running in the hallways without a mask. How do I simply get him back into his room and have him stay there?
2. A CHF patient has been in the hospital for a few days. On the day of discharge, he suddenly looks terrible with generalized malaise and a cough. Is it COVID-19? Do I now put the patient in isolation and test for that? If the patient turns out to be positive, will I and the whole staff panic over the many days of exposure?
3. The world news is depressing. Here comes a patient after a suicide attempt. By the way, he has a cough. How do I put this patient in an observational setting?
4. Patients come in with "normal" things, like a pericardial effusion or dysphagia. But, all of a sudden, subspecialists can't come any more to do the consults. I learn that they are reserving their hours in case there are massive staffing issues. I understand the logic. But now what?
5. I need to make beds for the expected patient surge. One of the current inpatients has a finding of a renal mass, suspicious for carcinoma. I thank the patient for understanding his hasty discharge and tell him he must follow up with his outpatient provider. Turns out, the outpatient provider is not available until further notice.
6. An undomiciled patient leaves against medical advice (AMA) while their COVID-19 test is pending. How will I contact them with the test result? And how can this patient self-quarantine?
7. I have to round on 16 COVID positive patients all with acute hypoxic respiratory failure. How do I remember who is who, as my rounding list is under my PPE and untouchable?
8. Ventilators are a limited resource. I am putting patients on non-rebreather masks and high flow nasal cannulas at the same time, hoping it will do the trick (even though I don't remember this being a real combination last time I went to a pulmonary conference).
9. An 89-year-old COVID-19 patient has a significant cardiac history. Do I tell him that his wife has just died and that their son is sick from the virus? Is this a heart attack waiting to happen?
10. The hospital asks me to staff the new COVID-19 ambulatory testing site. Incidentally, a former doctor colleague I know recently has been doing that in the community. And wait, I just heard he was on a vent at a different hospital. How do I feel about being "volunteered" to staff the testing center?
11. A truck pulls up to the hospital. It is a Portable Morgue Unit designed for a mass fatality incident. What does that do to my mental health?
12. I am the primary caretaker for my family, and they are scared for my safety. I need to be around for them. But, by now, I have been exposed to the virus repeatedly and am just waiting to become symptomatic. Do I quit? Don't I need the health insurance that comes with the job now more than ever?

What have I learned from this so far?

- You will compare notes with colleagues to see if they have experienced the same. These notes will be your makeshift guidelines.
- You will learn to make (and stand by) decisions even if you aren't sure your decision is the right one. They will abide with the philosophy of doing no harm.
- You will be totally flexible and accept that every day is a learning curve; the way you practice today will be very different from how you practice tomorrow.
- You will learn that you can do all of this while being quietly terrified. And that is OK.
- And, you will proudly do the best you can during every shift.

In time, you will be the expert.

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COVID-19, TEMPLE, AND ME: A TIMELINE AND SOME THOUGHTS

Anuradha Paranjape, MD, MPH

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January 2020

News of a mystery virus linked to a live animal market emerges. At first, one heard about it on BBC; it took a while to penetrate US news media. I was in between two international trips—I had just come back from India and had a scheduled bike vacation to Vietnam for mid-February. So, it was more for personal interest I started following the spread of the virus, which acquired a name SARS-COV2. Soon there were reports of "the novel corona virus" on the news. Even though Temple started thinking about the response at an administrative level, I do not think any of us seeing patients in clinic envisioned that our lives would be disrupted within the matter of a few months. Since Vietnam still looked safe enough, off I went on another bike adventure. Interestingly, cases in Vietnam were few and far between yet everyone wore a mask. Same in Cambodia.

Fast Forward to February 22, 2020

I had just landed home after my trip. South Korea's cases had just skyrocketed and the grip of the virus on the world's people and economy started to tighten. Looking back now to early March, I remember being mildly peeved that I would not be able to travel in the short term. The thought that I would not see my ACLGIM and SGIM colleagues and friends seemed unthinkable and improbable. Now that peevishness seems selfish and a first-world problem.

By the first week of March, the virus seemed to be more than just a problem at a nursing home in the state of Washington. The first few cases had appeared in New York and the *New York Times* reported that approximately 2,000 people were quarantined. That alarmed me. Enough to cancel my weekend in New York City with friends and actually stock up on—yes—toilet paper but also most non-perishables. And no, I did not have an insider tip from anyone. I had been following the Hopkins GIS data map that had been highlighting the alarming spread of the virus across Europe. It was only a matter of time that the first case in metro Philadelphia would be reported, and it was reported a mere week later. Life as we knew it was about to change.

Photo by Anuradha Paranjape.

It Is Now April

I am really proud of our health system's response to the pandemic. By the middle of March, our COVID screening clinic was up and running, all elective procedures were cancelled, office visits were converted phone or video visits, and outpatient traffic was markedly reduced. Visitors were not allowed outside of rare exceptions for birth and death. One building converted to COVID floors with added ICU capacity. Interestingly, and sometimes to my frustration, some people took a little longer to convince than others that we were planning for a potential disaster. But by the time the "all hands deck" call went out, people were expecting it. Physicians from all fields are now staffing the COVID floors, sometimes outside of their comfort zone, side by side with hospitalist colleagues. To quote a sub-specialty colleague: "Put me wherever you need me, just tell me what I need to know to staff it."

I am equally proud of the Philadelphian and Pennsylvanian response. A stay at home order was issued for Metro Philadelphia shortly after the first cases were reported. The new normal now includes queues with social distancing to enter Trader Joe's; community groups rapidly collecting masks for health care workers; people making masks, more people out for walks even when it is not sunny and warm. Random gestures of kindness by strangers and neighbors—my faith in humanity has been restored.

All that I have written so far is not new to anyone reading the *Forum*. I do have to say that the speed and agility that both leaders in medicine and

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HEALING AT HOME AND ABROAD: A SYRIAN INTERNIST USES SOCIAL MEDIA TO HELP OTHER REFUGEES

Mohannad Altabban, MD, MSc, SBIM; Tiffany I. Leung, MD, MPH, FACP, FAMIA

Dr. Altabban (dr.m.tabban@gmail.com) is an internal medicine specialist and a global health professional, living in the Netherlands after leaving his home country of Syria in 2013. Dr. Leung (t.leung@maastrichtuniversity.nl) is an assistant professor at the Faculty of Health, Medicine and Life Sciences and a PhD candidate at the Care and Public Health Research Institute at Maastricht University in The Netherlands.

The current COVID-19 pandemic highlights physician and healthcare workforce shortages due to surges in patient care needs. Migrant-physicians are finding innovative ways to apply medical knowledge and skills as a doctor because of barriers and delays they encounter in achieving professional recognition. The following is an interview with Dr. Mohannad Altabban, an internal medicine physician who lives in the Netherlands after leaving Syria in 2013. The interview has been revised for clarity and readability.

Tiffany: Mohannad, thank you for this opportunity to talk with you about your experiences. Can you describe your background as a physician and why you moved to the Netherlands?

Mohannad: I finished my specialty training in Internal Medicine in 2011 in my home country of Syria. I practiced medicine in Syria, Jordan, and Yemen between 2007 to 2015. Because of the way the specialty track is structured in Syria, most of our time during Internal Medicine training is spent in the emergency room, intensive care and coronary care units. After finishing training, I worked in governmental public hospital, private hospital, and non-governmental organization hospital settings until 2013. In the beginning of 2013, I received threats and I was forced to leave Syria, so I moved to Jordan where I stayed for six months. While in Jordan, I worked as an internist-intensivist in a war trauma unit for Syrian refugees. However, the unit was forced to close because the government refused to grant licenses for continuing legal medical practice to us, meaning that only Jordanian-licensed physicians were permitted to continue working in the unit. At the end of 2013, I moved to Yemen and worked there for almost two years as an intensivist and manager of an intensive care unit. Syrian physicians were recognized and licensed by the Yemeni government with no need for a long bureaucratic process or examinations. However, in 2015, the Gulf-Alliance in the Arabian Peninsula started bombing the country and most Syrian physicians were forced to leave, again. I left Yemen to Saudi Arabia, where, again, we Syrian physicians faced the same recognition and licensing bureaucratic problems. I then moved to the Netherlands to do a Master of Global Health and start rebuilding myself and my future, along with the future of my family of four.

Tiffany: This is an incredible and dangerous journey you have been forced to take from your home country to the Netherlands. How do your experiences and knowledge on global health influence how you view the global response to the COVID-19 pandemic?

Mohannad: Global Health taught me a lot. On March 11, 2020, I advised the local elementary school to allow their children to go home and engage in tele-education. I was concerned for their health and safety first before the WHO announced COVID-19 as a global pandemic. This concern was because the vast majority of the school students belong to vulnerable populations. The next day, the World Health Organization announced COVID-19 as a global pandemic. The Dutch government responded later in implementing regulations for social distancing without a total "lockdown", which in my opinion, was too late. Globalization has changed how quickly infectious diseases travel across the world, and we, as a society, have not yet learned our lessons from Ebola, H1N1, and other previous outbreaks.

In my view, this pandemic highlights serious flaws in our preparedness: (1) contemporary health systems can still be fatally underprepared or designed to respond to such circumstances; (2) the national as well as international healthcare workforce should be engaged in new contexts, especially during a pandemic when all hands are needed; and (3) clear mismatches in prioritization of population health and the global economy have surfaced. Furthermore, when you drive a car, you do not arrive at a crossroad and then break, you must slow down while approaching the crossroad to anticipate dangers. Similarly, anticipating dangers and proactively enacting healthcare policies are essential global health promotion mechanisms, but the governments globally still cannot do that. While digital and technological advancements allow more connectedness than ever, we clearly remain vulnerable as human beings.

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Tiffany: With your background also as an internist, how are you currently applying your medical expertise to help patients and colleagues in this challenging time?

Mohannad: I see three main ways to help during this pandemic even though I am not practicing clinical medicine in the Netherlands. Social media offers quick access and communication between physicians like me who want to help others, using medical knowledge and skills, but cannot legally work as a physician where I live now.

First, reassurance. Posts on social media help provide knowledge on how to deal with sickness, hygiene, updates and news, and spread awareness that while COVID-19 is a major public health threat, it can be tackled with simple preventive measures. I also use social media to post limericks, jokes, funny videos, and pictures that bring a smile on the face of a scared population, but also teach something at the same time. Second, I'm a member of a Facebook group, the Syrian Coalition of Medical Consults. We remotely help people living in Syria or in refugee camps in one of the neighboring countries of Syria with their medical conditions, diagnosis and treatment. This can be done using regular posts, anonymous posts, or directly via private messages. Finally, there is a Dawini group (Dawidi in English means treat me) for Syrian healthcare workers. The group includes physicians and other clinicians who share experiences, knowledge, cases, articles, etc. Members use this platform to stay connected, and to help each other by sharing medical information and advice on solving or managing a complex case.

We cannot provide medical advice in the Netherlands. In the Netherlands alone, in 2014 there were 12 Syrian physician-refugees, which has continued to grow yearly to 62 as of 2017.[1] I expect there are many more now, and also in other countries. We can help with social and scientific action, but not with clinical practice because foreign doctors (literally translated from Dutch *buitenlandse artsen*) are not allowed to provide direct patient care due to extensive professional regulations—a common barrier in many western countries. Such strict regulation alienates and excludes valuable, experienced physicians and healthcare workers, who have specialized skills and genuinely want to help. It's also a matter of making a living as a refugee as well. However, the professional recognition pathway costs an enormous amount of time and money.[2]

Recently, the Royal Dutch Medical Association advised that the medical labour market may hire non-registered physicians if they have work experience in the last ten years and in an emergency situation, like the current pandemic.[3] However, I suspect that the medical labour market will not make use of this new regulation. The problem has always been that the medical labour market would prefer registered and licensed practitioners, most often for liability and insurance issues but perhaps for other reasons.

Tiffany: Thanks, Mohannad, for sharing your perspectives. I agree with you on several points. Social media has made information sharing in the global medical community easier than ever and is needed when the evidence base is actively developing to guide direct patient care treatment and evidence-based public health policies. One pandemic-related Facebook group I joined recently is Behavioral Health and Suicide / Violence Prevention in COVID-19, as there is also increasing concern about the mental health consequences of the pandemic for healthcare workers and the general public. Additionally, I agree there is a tremendous amount of untapped talent in migrant clinicians, just as you have done, and that finding ways to expedite the applications of such talent in a competency-based manner is one possibility to help address local clinical care needs.

Mohannad: Thank you for this opportunity. My thanks are also to my teachers, superiors, professors, and seniors and people from whom I learned so much. I thank them for everything they have taught me. They opened my eyes to so much, beyond my ability to explain. I hope they all stay sane, healthy, and socially active, even if physically remote, during these difficult times. We are together in this, let this be a lesson to all humans who still have the mindset of us versus them. We need to stand together to overcome the current public health crisis and the ones yet to come.

Tiffany: As pandemic-related measures continue around the globe, physicians, their patients, and healthcare leaders need to continue innovating and advocating for more accessible and equitable care. As we've discussed today, a key part of this is considering physician-migrants' skills and the diversity that they bring to the workforce when professional recognition procedures strive for their inclusion. As a global medical community, we are, indeed, #BetterTogether.

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SGIM

JUST STAY HOME

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(The author credits Aarati Jagdeo for her edits, with deep gratitude for her family and friends.)

Just Stay HOME

So many dying
So much goodness gone
Convoluted messaging
Keep it simple
Just Stay HOME

Introspection
Families bonding
D-Nice dancing
Community singing
So much possibility
When you Stay HOME

Genetic sequencing
Vaccines developing
Gates spending
Officials stammering
TV blaring
When you Stay HOME

COVID unmasks
Domestic violence
Child abuse
Booze overuse
Discrimination
Inequity
No money, No formula, No home
So much exposed
When some stay home.

To those who heal and care for us
You are more than "essential"
You are mortal
You die too
You can't see COVID
Yet so close to you

You can't see families
And They STAY HOME
And You Die Less
When We STAY HOME.

A Haiku: Solutions

Everyone stay home.
Now most jobs make PPE-
Masks, Vents, Vaccines too.

RAPID CHANGES IN SUBSTANCE USE DISORDER TREATMENT IN THE FACE OF COVID-19

Soteri Polydorou, MD; Molly McCann Pineo, MS, PhD

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We are in unprecedented times facing a public health crisis with increasing death tolls, limited healthcare supplies, and strained healthcare systems. Clinicians are maintaining care during a state of emergency while simultaneously minimizing unnecessary exposure. This scenario has added complexity for those who treat patients with Substance Use Disorders (SUD), specifically Opioid Use Disorders (OUD), where treatment options are significantly impacted by government regulations and commonly require frequent provider-to-patient contact. The field of addiction treatment is rapidly evolving during this crisis, and it is, therefore, our objective to inform and articulate pertinent regulatory and clinical service delivery changes based on our experience as an early epicenter impacted by COVID-19 within the United States.

The US Department of Health and Human Services (HHS) declared a public health state of emergency on January 31, 2020, thus setting forth a series of temporary regulatory changes effective during this declaration to the prescribing of controlled substances impacting the use of buprenorphine and methadone for the treatment of OUD.[1-5] The Drug Enforcement Agency (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), effective since March 31, 2020, have provided added flexibility to DATA waived clinicians treating OUD by authorizing the initial use of buprenorphine for new patients using telemedicine without first conducting an in-person evaluation; and later authorizing the use of a telephone assessment without requiring an initial examination in-person or via telemedicine.[6] DATA 2000 waivered providers have also been authorized by the DEA to prescribe outside of the state in which they hold DEA registrations.[7] Opioid Treatment Programs (OTP) which offer methadone in addition to other medication-assisted treatment options for OUD have also obtained federal regulatory flexibility authorizing telemedicine (virtual or by telephone) for the continuation of treatment; blanket exceptions to enable existing patients to be dispensed take home doses—14 days of methadone for less clinically stable patients and up to 28 days for those deemed stable; exemption of a physical examination for new buprenorphine patients only—methadone patients are still required a complete in-person physical evaluation prior to initiation of medication.[1-5] In addition, HIPAA and 42 CFR part 2, which specifically protects information related to substance use disorder treatment, have been temporarily modified during this crisis.[8-9] From our experience, partnership among both federal and regional agencies, such as the New York State Office of Addiction Services and Supports (OASAS) and New York City Department of Health, was another critical component which promptly supported and facilitated rapid implementation by clinical service providers.

These regulatory changes are prompted by inundated health systems, and the hope that SUD treatment can be obtained and maintained safely outside normative contexts. Inpatient addiction focused admissions have become disrupted as limited resources and space are needed to provide acute care for COVID-19 patients. Ambulatory addiction specialty services within our health system have expeditiously transitioned to providing comprehensive treatment including prescriber visits, individual counseling, and group therapy utilizing a telehealth platform. Telehealth offers an avenue to continue to provide clinical services to those already in care as well as engage those new to treatment as the most viable option to ameliorate part of the problem. However, its deployment has its own considerations, especially among marginalized and underserved populations.[4] And lastly, the limited use of toxicology testing as well as ongoing potential for reductions to in-person visits, in particular OTP attendance, remain areas of clinical focus which could benefit from further enhancements to telehealth systems.

The implementation of these clinical modifications, in combination with coordinated regulatory flexibility, provides a path forward to ongoing comprehensive SUD

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TELEVISITS DURING A PANDEMIC

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"Chief complaint: My mother is confused and can't walk by herself."

I reviewed my video visit schedule recently and was surprised to see this one. Not long before that, I had just encountered, "*Chief complaint: Possible DVT.*" In traditional circumstances, patients and family members would never consider seeing a doctor via a video visit for these complaints and doctors would refer these patients to an in-person care setting. In pandemic circumstances, these are becoming the norm as they try seeking medical advice and treatment in ways that maintain physical distancing and lower risk of personal exposure to COVID-19.

In a recent SGIM *Forum* issue, Tepper and Weissman deftly described and then busted myths and misconceptions about video visit integration into routine general medical care.[1] To clarify, video visits are a specific subtype of telemedicine: synchronous telemedicine, or real-time, patient-facing video conferencing. Generally, telemedicine also includes e-consults between healthcare professionals (synchronous or asynchronous), remote patient monitoring, and mobile health. Here, I'll refer to synchronous patient-physician video and telephone visits as *televisits*.

Since Tepper and Weissman's perspective, public health measures to limit spread of COVID-19 has turbocharged the widespread patient demand and physician adoption of such visits. Additional contributors include widespread deregulation of physician licensing requirements in the form of emergency licensure reciprocity between states, broader insurance coverage for video and telephone visits, and even waiving penalties for HIPAA violations in relation to using everyday one-on-one communication platforms.[2] I have one primary, paid medical license in good standing; since mid-March, as a contractor for one telemedicine platform, I have ten additional state licenses due to emergency licensure orders as of this writing. In traditional circumstances, achieving licensing in all U.S. states costs a physician more than $90,000,[3] clearly both a bureaucratic and costly undertaking. But these are not traditional circumstances.

In pandemic circumstances, there is no question in the medical community that televisits are a necessity to support patients who are afraid to seek in-person care and to relieve strained and overflowing acute care clinical settings. Some have non-COVID-19 acute complaints and others need continuing chronic disease management and are having difficulty accessing their usual continuity care. Pre-pandemic, education and counseling were already cornerstones of televisits; these, along with triage, have taken on even more prominent roles as medical decision-making and weighing benefits and risks of diagnostic and treatment pathways must now also account for patients' personal risk for severe illness from COVID-19 if they are exposed and subsequently infected.

In a previous role, I always felt that video visits implemented as an integrated part of a "bricks-and-clicks" model offered the ideal value-added option for primary care practice, where I already knew patients well.[4] An in-person clinic setting still offers immediate collection of more data, like an electrocardiogram, pelvic exam, a urine dipstick, or an x-ray, which allows for alternative diagnostic options to be ruled out and more definitive recommendations to be offered. On the drawbacks of telemedicine in general, other have stated better that it can "interfere with the development of physician compassion and patient trust."[5]

However, as this pandemic unfolds, I increasingly believe that narrative and dialogue with patients through televisits can provide a sufficiently compelling and vital part of the overall health system's emergency response. I still do worry about increasing care fragmentation as a result of standalone televisits, as well as potential information asymmetry or misinformation that enables hoarding of prescription medications and other essential resources. Nevertheless, televisits have a clear role to play now and probably will continue to have a persistent and prominent role in the future, whether they are the current "bricks-*or*-clicks" stopgap measure or integrated into a "bricks-and-clicks" model. In the meantime, I'm grateful to be able to still help my front-line colleagues by whatever means I have at hand.

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THINGS I LEARNED IN THE FIRST 2 WEEKS

Gaetan Sgro, MD

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That the proper pronunciation of fomites is fow-maites.

That, in the same way you're never been able to un-see your parents having sex, you can't un-see fomites.

That essentially anything can be a mask. A shard of coconut. A knee pad. A used coffee filter? It's worth a try.

That people have widely divergent views on the meaning of "shelter in place."

That I can give up handshakes, no problem. I kind of like this elbow thing. But now you're telling me I'm not supposed to have strangers rub dark tanning oil on my hard to reach places? How am I supposed to bronze evenly?

That my commute is really not that bad. It's the other commuters who are bad. While I wish them well, I hope they never come back.

Zoom.

That there are very clear, sensible criteria to guide testing based on the latest epidemiologic data, the ethics of resource allocation, and our nation's comprehensive strategy.

Wait, are you serious? I'm sorry. I just heard about Rand Paul. I have no idea what we're doing.

That my children will not eat the homemade mac 'n cheese I spent an hour preparing when I could have just dusted them with aerosolized cheddar and called it a day.

That my four-year-old has absolutely no concept of time, mortality, or even basic safety, and yet seems to take handwashing more seriously than any adult I've ever seen.

That non-profit health systems are not interested in profits. Never have been. But knee replacements? Can we talk about that offline?

That, actually, it's cool. We can reuse our masks. And we have floating hospitals now, so space is not an issue. We also have space. Outer space. Maybe we can build a space hospital.

That Trader Joe's is a germ-ridden hellscape. Still, the man at the door who greeted me with a spritz of hand sanitizer was extremely friendly. He made my day.

That, when I finally got a chance to go running last weekend and was passing over a particularly shabby stretch of sidewalk and my phone started buzzing with a volley of text messages, it was not one of the residents asking for post-exposure instructions, nor was it my boss calling me in for jeopardy. It was not even my father asking for clarification on whether or not he is allowed to stop by Carmine's so long as he just "grabs a pastry." No, it was—once again—my dear friend Dan, sharing another important pangolin meme.

That, as I nosedived into the concrete, my iPhone in one hand and my wedding band on the other helped absorb the impact. I think you'd be surprised by which of these items now needs to be replaced.

That, when the going gets tough, the tough buy meat. Seriously, what are you people doing with all that meat?

That, as of this writing, my children no longer eat chicken. Apparently, they've lost the taste for it. Wait, did you say they've lost their taste?

That the idea that love is blind seems to have been definitively disproven by the pioneering Netflix original series, *Love Is Blind*.

That the Netflix original series, *Love Is Blind*, can render the viewer temporarily incapable of thinking about anything other than Mark's stunning lack of emotional intelligence, and for that we are very grateful.

That, if you wouldn't (or couldn't) do it during an in-person meeting, you probably shouldn't do it during a Zoom meeting. I'm sorry, Kathy. I had to say something.

That *Ninja Kids* is a program on YouTube that causes my 7-year-old, periodically, to run screaming into the kitchen and jump kick me, *hard*, in the upper leg.

That home school is a cute idea. Really f*&%ing cute.

That my neighbors have all sorts of used and vintage masks, which I'm welcome to use if I wish to be killed and/or unemployed.

That, while my wife and I were in medical school, every friend and living relative was apparently acquiring the skills to knit surgical masks.

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PRIMARY CARE CHAT IN THE TIME OF COVID-19: FOSTERING CONNECTION, COMMUNITY, AND SOCIAL SUPPORT

Megan R. Gerber, MD, MPH, FACP; Colleen Christmas, MD, FACP; Gabrielle Mayer, MD; Indu S. Partha, MD, FACP; Mandi Sehgal, MD; Stephanie M. Sison, MD, MBA

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Our modern era has witnessed the explosion of electronic health record (EHR) use, hospital mergers resulting in large sprawling, multi-campus health systems, and mounting productivity pressures. As a result, primary care practitioners (PCP) commonly report feeling like cogs in a large, impersonal machine and express a sense of disconnection with colleagues. Increasing reliance on business models without fully engaging front line staff, and the push to maintain access are among the contributors to widespread reports of burnout; a growing shortage of PCP compounds the problem.[1,2] Southwick and Southwick recently opined in *JAMA Psychiatry* that while social support is strongly associated with both enhanced mental and physical health, clinicians are now experiencing a reduced sense of belonging and loss of social connection that has both created unprecedented isolation and fueled widespread burnout.[3] They attributed this to excessive time devoted to EHR use at both work and home along with growth in online learning and increased social media use.[3] In response, they called for building community and "development of longitudinal relationships through peer support and provision of space and time for staff and students to congregate and share their experiences."[3] We applaud this call for enhanced social support in primary care settings, but dispute that increased online learning and social media engagement promote isolation; we believe that the opposite is true. Since publication of this piece, the COVID-19 pandemic has hit the United States in full force bringing with it unprecedented levels of healthcare social distancing, rapid conversion to virtual education, and widespread use of telemedicine.[4] While these are designed to enhance both survival and healthcare capability, they may exacerbate clinician isolation.

We believe that carefully cultivated online learning and social media use that intentionally encourages engagement can actually increase social support and the feeling of belonging among PCP, which, in turn, can bolster morale and lessen burnout. Primary Care Chat takes place two Thursday nights per month (9:30 ET/6:30 pm PT). https://twitter.com/primarycarechat

In August 2019, our group of practicing and aspiring general internists and geriatricians launched a novel Twitter-based Primary Care Chat (PCC) (https://twitter.com/primarycarechat) with the goal of cultivating a supportive learning community for those practicing in primary care. During PCC, we bring together PCP to share the challenges and joys of primary care and engage in discussion and learning around common topics. Twitter chats are scheduled online gatherings in which pre-formulated questions and discussion points are posed to the virtual audience who sign on to the platform at a specified time and respond to each posted topic in threads. The chat format allows those participating to read and respond

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SILVER LININGS FROM THE TRENCHES OF THE COVID PANDEMIC

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I am a general internal medicine doctor, a primary care physician, and a service line director for Adult Health & Wellness in the MetroHealth System in Cleveland, Ohio. While I have always loved general internal medicine, I admit that in recent years I (like many colleagues) have struggled with an identity crisis. What does it mean to be a General Internal Medicine specialist?

I remember clearly why I chose internal medicine. I loved being the detective, the coach, the mechanic, the therapist, the problem-solver—all in a day's work. I loved hearing people's stories and understanding who they were as a whole and as a part of a larger system that would sometimes help and sometimes hinder them. I loved knowing at least a little bit about everything and being able to piece together this information to help people solve problems, educate them, and help them achieve their health goals. Early in my career, I would see patients in the clinic and follow them to the hospital when they got sick, and then transition them back to home and to see me in the clinic again. Over time, my work in the hospital setting decreased to a few weeks a year, and there became a growing distinction between a hospitalist and a primary care general internal medicine doctor. Primary care general internists are paid less than their hospitalist colleagues, and if payment is a sign of value and respect, primary care specialists have been on the bottom of the totem-pole for years now.

To make matters worse, the term *primary care doctor* gained traction, particularly after a 1978 Institute of Medicine report, *A Manpower Policy for Primary Health Care: Report of a Study*.[1] The second chapter defined the essence of primary care as: "accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services." While an accurate description of care provided by general internists practicing in the ambulatory setting, the document "lumped" general internists with other primary care specialists (family medicine, ob/gyn, pediatrics). Today general internists often practice side-by-side with family medicine specialists, seeing the same complexity of patients. In some healthcare systems, we are hired inter-changeably and the distinction between specialties has become blurred, causing many internists to again wonder—what does it mean to be a general internist? Furthermore, with fewer medical graduates choosing to become primary care specialists, we rely more and more on our advanced practice nurses to meet the growing demand for primary care services. Again, we lose our identity. Are we the same and interchangeable with a family medicine doctor? Are we the same and interchangeable with a nurse practitioner? What does it mean to be a general internist? It is no wonder why junior physicians in training are not choosing primary care general internal medicine.

As stressful as the COVID-19 pandemic has been for all of us, one silver lining from this experience has been that it has brought general internal medicine into the spotlight and provided us with a renewed sense of value. While being a generalist may not have been perceived as valuable pre-COVID, in a COVID environment, being a generalist has meant that we can be flexible and can serve in many ways. When our hospital needed to set up a Dr. COVID advice hotline, who was called on to set this up and staff it? When our hospital needed to set up a telephone-based outreach for primary care access, who was called on to develop and staff it? When our hospital needed to prepare for the surge of COVID cases and deploy doctors to staff the inpatient teaching services and supplement emergency services, who was called on the staff the surge? When our hospital needed doctors to train other doctors to be diagnosticians and generalists, who was called on provide the training? The answer to all these needs was General Internal Medicine doctors.

Our training in Internal Medicine made us ideal candidates to flex from offering advice on the variety of symptoms patients with COVID might present with to caring for our sickest, hospitalized patients. Our versatility and our breadth of knowledge is our strength. This has been the silver lining in the COVID pandemic. COVID has helped to solidify the importance of general internists as leaders in healthcare. GIM docs—this is our time! May we be flexible, versatile, and adaptable in this time of incredible stress, and may we be strong, together, as General Internal Medicine.

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the guidance broadly available to medical centers.

Third, we have used GIM Connect and the ACLGIM network to support conversations about the pandemic. Through such conversations, members have shared resources and experiences while offering valuable support to each other. During this crisis, we want all members to know that they have the full support of the SGIM community that we value so much.

Fourth, we asked the Health Policy Committee (HPC) and our professional lobbyists, CRD Associates, to do as much as possible to advocate for better governmental support for the response to the pandemic. They accepted the charge with fervor. Thanks to their efforts, SGIM has issued letters arguing for better support for critical needs, including personal protective equipment and ventilators, changing regulations to facilitate greater use of telehealth, changing policies that could limit the available healthcare workforce, and protecting health care workers from being punished if they voice concerns about a shortage of personal protective equipment available to them. We also have advocated for increasing federal support for the public health infrastructure and for research on the health care system's response to the pandemic and new telehealth investments.

Finally, we joined the call to include non-profit organizations in the financial aid bill that became the CARES Act.

In these advocacy efforts, we remain committed to our vision for a just system of care in which all people can achieve optimal health. Our advocacy work has benefited greatly from having an experienced and dedicated HPC with strong leadership, and well-developed relationships with other professional societies. Thanks to Erika Miller at CRD Associates, the HPC team has received detailed daily updates on issues being considered and actions taken by the legislative and executive branches of the federal government, including numerous actions taken by the Centers for Medicare & Medicaid Services. Although we wish the government had done more sooner, the collective advocacy seemed to help generate more action.

2. What are the financial implications of not having the 2020 Annual Meeting?

SGIM's national meeting has a central role in the life of the organization, and is our largest source of revenue, accounting for $1.78M in 2019. Thus, it is a huge loss both for SGIM members and for SGIM as an organization to be unable to hold the meeting that was scheduled for May 6-9, 2020. After we determined it was impossible to hold the meeting, we created a simple process for refunding fees to those who had already registered for the meeting. We gave registrants the option to apply their payment as a credit for a future meeting or make it a donation. The vast majority preferred a full refund, which we understand and respect.

Before the Annual Meeting was threatened by the emerging pandemic, we were running ahead of schedule on membership renewals, thanks to new strategies deployed by our Membership Committee, which has been supported by SGIM staff Muna Futur and Marley Dubrow. Not surprisingly, once it became evident that we would be unable to hold the Annual Meeting, membership renewals dropped off. Understanding that many members are fully immersed in the COVID-19 response, we decided to temporarily extend membership benefits for those whose membership lapsed. We want all members to have access to SGIM's community, communications, and resources during this extraordinarily stressful period. We are encouraging more members to renew their membership by the end of June.

To mitigate the financial loss from being unable to hold the Annual Meeting, we obtained legal advice on how to handle contracts related to the meeting. We applied for a loan from the Paycheck Protection Program established by the CARES Act that can be converted to a grant if we keep our staff working as intended. We decided to proceed with engaging a consulting firm to strengthen SGIM's capacity for conducting a long-term development strategy. The consulting firm started working in March with a six-month timetable for completing its work in conjunction with the Advancement Planning Task Force we have formed. This work was made possible by a grant from the Hess Foundation. In addition, the Hess Foundation generously offered another $100,000 to help support SGIM during this crisis.

3. What is SGIM doing with the content that was scheduled for presentation at the 2020 Annual Meeting?

SGIM staff, led by Corrine Melissari, Dawn Haglund, and Kay Ovington, is working hard with the Program Committee to implement a plan for offering virtual presentations of selected Annual Meeting content to be made available for asynchronous access. We focused on plenary presentations, special symposia, clinical and other special updates, and abstracts by trainees and junior faculty that were finalists for the Lipkin, Hamolsky, and clinical vignette awards. We sent invitations to the selected presenters, asking whether they will be able to submit a recorded presentation by the end of June. We plan to include a judging process so that we can make the Lipkin, Hamolsky, and clinical vignette awards. We also plan to offer continuing medical education (CME) and maintenance of certification (MOC) credit for the virtual presentations. We anticipate being able to offer 20-30 credits, which is more than what meeting attendees usually apply for. Although there will be a fee to apply for CME and MOC

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credit, the fee will be discounted for members. We plan to give members free access if they only want to view the presentations.

4. How will SGIM's annual planning process be different this year?

We have extended the timeline for committees and commissions to submit their plans for this coming year. The SGIM Council recognizes that committees and commissions may want to address new issues raised by the COVID-19 pandemic, but it will be important to balance those interests with non-COVID work that should continue. Therefore, we believe it will be very important to encourage and facilitate good communication between the committee/commission chairs and SGIM's Council and staff liaisons as the committees and commissions discuss their priorities and plans.

(Please note that in the next issue of the *Forum*, we will answer questions about planning for the future of SGIM after the pandemic.)

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healthcare workers on the front line demonstrated in adopting to the new normal has been amazing. What would have taken weeks or months even has been done in days—including setting up and modifying protocols for outpatient and inpatient care, getting billing codes, and accompanying documentation recommendation out to the physicians and staff, operationalizing telehealth visits, and more. Philadelphia city leaders called on our university to use the Liacouras Center, normally the venue for NCAA games, to be a field hospital for the city. Temple said "yes" without hesitation. Or asking for rent.

Personally, as a bicultural person whose family is not in this time zone, the hardest part is the unknown—when can I see my parents in India again? When can I travel to San Diego to see the family? But, on the other hand, there has been an unexpected upside. I'm even more connected to with friends and family than before—we check in on each other by phone, Whatsapp, and texting and I've reconnected with classmates from medical school. Imagine what a shelter in place order might have been 20 years ago? Although social media has been blamed a lot, it is social media and our devices that provide connection during times of social distancing.

Finally, I would like to share my three wishes for our post-pandemic future:

1. Let us not work sick again. Chiefs and chairs need to build a reserve for faculty so that physicians do not come in sick—most of us have worked sick because we did not want to burden our colleagues. Self-care is important, and social distancing when sick is actually a benefit to the health care system.
2. Let telehealth visits for vulnerable patients become a part of visit types. Just like Medicare was introduced as a concept in 1960 and now is a permanent part of our health care and social fabric, telehealth needs to remain an option for care.
3. May work-at-home policies become standard across healthcare systems as they are in the tech industry. Work-at-home policies allow families and individuals to flex their work hours to meet personal needs and actually when used thoughtfully, result in a more productive workplace.

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That I could make it 61.5 hours without once touching my face—my own face—only to have my perfectly sterile field shattered by three swipes of a McKesson Exergen digital temporal thermometer, at the entrance to my hospital, at 6:30 on a Monday morning.

That my house is precisely 2,466 square feet, not counting the attic, which is really just an unfinished crawl space.

That, sometimes, I've found, after a long day of work and/or home schooling, it's nice to unfold the ladder, climb up into the attic, and lie face down on the floor, just for a little while.

That, if we had enough yarn and enough knitters (which it seems like we do) maybe we could knit a containment shield around Myrtle Beach? Like, just for a few weeks?

That the only thing we have to fear is fear itself but dying has been gaining ground.

That my thigh is sore.

I wonder if Trader Joe's has any ice cream.

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treatment services during the current COVID-19 public health emergency as well as future crises. The coordination and continuing care for our patients is paramount, and it is essential that as we move forward, we continue to identify and inform on how best to navigate the current crisis to ensure proper treatment for SUDs.

Acknowledgements: With much appreciation to Dr. Joseph Conigliaro, Dr. Blaine S. Greenwald, Bruce Goldman, and the dedicated, innovative, and adaptable multi-facility addiction services teams at Northwell Health, as well as OASAS and COMPA.

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learning, and sharing. Together, we are exchanging experiences and questions through masks, preparing for a battle we can't quite comprehend. We are learning very quickly that to survive this tsunami, we must break down our traditional practice domains and stand together. We created daily rounds where our intensivists, infectious disease doctors, hospitalists, surgeons, palliative clinicians, and anesthesiologists can discuss the wins and losses from the day before and strategize over the patients who are decompensating. We have learned that to improve efficiency and preserve PPE, we need surgical expertise in the medical ICU and anesthesia support in the ED. Domains that were historically not crossed, now forging together to prepare us for the swells ahead. We have community physicians and sub-specialists racing to the hospital to cover general medicine teams so that hospitalists and cardiologists can help cover the ever-expanding intensive care units. An elaborate structure of coverage created in days without staff hesitation. I am confident that these relationships will stand the test of time long after this crisis has passed—an unexpected gift emerging out of a traumatic storm.

I still worry that this powerful solidarity may not be enough. As the numbers far exceed our capacity and our resources become more depleted, I worry that we will be left sorting through a wreckage that none of us are prepared to comprehend. I worry how to lead my team, my colleagues, and support my family and myself as we heal from this unfathomable trauma. The damage left behind in this disaster will require healing with the entire community.

I have never known anything like this. I studied to learn the fundamental patterns of medicine. I trained to learn how to identify the red herrings when they present. I practiced with my hands-on at the bedside to appreciate the subtleties of human responses during distress. I honed all of these skills and more to ascend as a leader in my field; yet, I feel a sense of despair in the face of such a giant.

We stand in an eerie calm, as the streets empty and the hospital volumes temporarily drop—like the ocean water recedes just prior to the tsunami arriving. Our community, with nowhere to evacuate frightfully shelters in their homes, waiting for the impending natural disaster that is moving toward us. As the surge of water builds on the horizon, we feel the earth tremble under our feet and anticipate the wave, a battered shoreline, and path of wreckage in its wake. I stand hands locked with my colleagues waiting for the devastation to strike, readying our forces to rescue the sick and bring them to safety.

I am honored and humbled to be here. SGIM

hoped to help members understand that SGIM is still about community, even when we aren't physically connected.

I've seen this community on every video call I've been on since mid-March. When I meet with SGIM committees, project teams, or our thrice-weekly staff meetings we all start the same way, "How are you? How are you coping? Tell me something good that's happening, something you're looking forward to, or something that you need to get of your chest." I've seen volunteers and staff go out of their way to provide connection, comfort, and solidarity to each other. I've cried listening to stories from you and worried about you having to go into the hospital or clinic without enough PPE. And I have never been prouder of you and of my colleagues on staff at the national office. SGIM is our home.

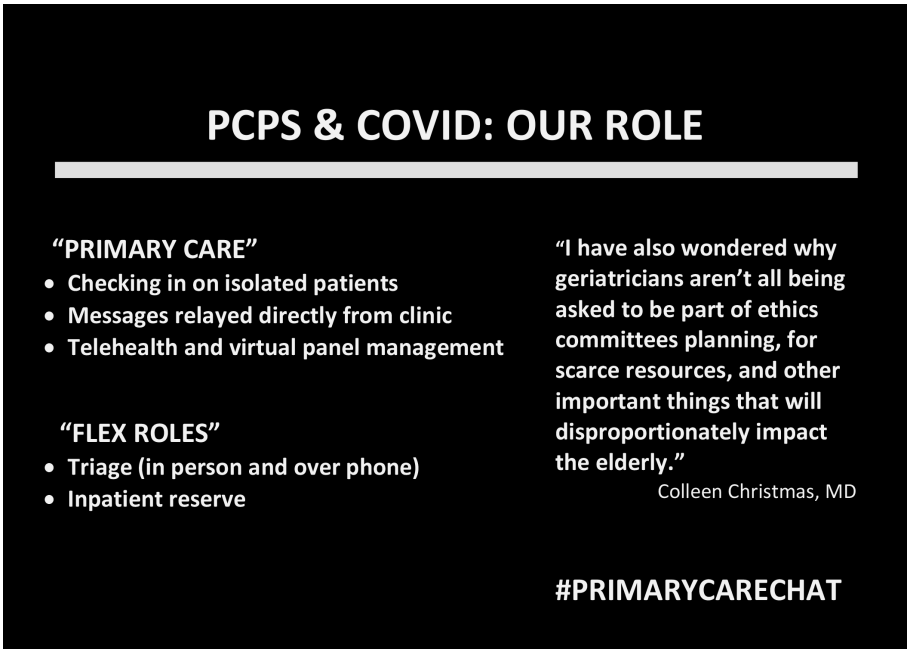
SGIM and its members are resilient and will come out of this crisis stronger than ever. We'll continue to help you foster connections with one another as COVID continues and beyond. We'll be bringing you some virtual content from the 2020 annual meeting soon and our committees and commissions are already planning their work and projects for the coming year. The work of SGIM continues unabated. We *are* family, and we will always stand together.

I'm looking forward to seeing you in Boston, Massachusetts, at SGIM2021! SGIM

to one another's answers. Those not available during the scheduled chat time may also read the conversations and respond at their convenience. Using the twitter handle @PrimaryCareChat and mission statement, "*deep dives into the art and joy of great adult primary care, as well as the evidence behind it,*" we have hosted bimonthly twitter chats on a variety of topics.

During our chats, we have held discussions around medical education and challenges in primary care (how to enhance interest in primary care careers, how we manage our time, humanism in primary care), presented knowledge-based topics (managing sleep disorders, rheumatologic conditions, dermatology, LGBTQ+ care in primary care) and covered special focus topics like trauma-informed primary care. Each one-hour chat is followed by a summary of teaching "pearls" and interesting ideas (see figure). We use Twitter Analytics to measure impressions and engagement and tweet a post-chat poll to measure benefit. Both impressions (averaging over 35,000 per chat) and the quantitative poll data we have collected demonstrate high utility and value of PCC.

Understandably, much focus during the pandemic has been on hospital capacity, ICU capability, and emergency department management; less attention has been directed toward primary care experiences. PCP have found our patients frightened, unwell, alone and in search of guidance through the uncertainty; we have had to provide reassurance and care while rapidly adopting virtual care modalities. As the teams responsible for ensuring continuity, we have significant concerns about our patients'—especially our older adults'—wellbeing. Additionally, mounting concerns about the potential need to ration care and supplies to maximize societal benefits weigh heavily on PCP who have cultivated deep and meaningful relationships with patients over the years. In response to these mounting concerns,



the PCC team posted a poll in mid-March 2020 asking our followers whether they would prefer a week off from our Twitter chats or a chat focused on the COVID-19 response in primary care. The response was resoundingly affirmative: PCPs wanted to gather online and discuss primary care during COVID-19 with a community of colleagues.

Our March 19, 2020 chat included the following questions:

1. "What role are PCPs playing at your institution on the COVID frontlines?"
2. "What is your approach to your outpatient patient panel? (example: Telehealth)
3. "How will (and should) the role of the PCP/primary care team evolve during this crisis and beyond?"
4. "What are you doing to stay sane/take care of yourself?"

Responses generated during the chat support our assertion that online learning and engagement need not increase isolation, but in fact can be structured to create a collaborative learning community and foster collegial social support which is especially critical during this unprecedented time.

To illustrate this, here is a sampling of tweets from the community during the COVID-19 Primary Care chat:

General Comments:

"I am feeling tremendous gratitude for this community tonight more than ever." (general internist)

"The #primarycarechat community is fantastic and so supportive. I'm so thankful for you all." (internal medicine resident)

"Hi my friends! Was so looking forward to this after a very long and stressful week." (geriatrician)

What roles are PCPs playing at your institution on the COVID frontlines?

"triage triage triage. Navigating day to day changes for patients while taking symptom, exposure and risk history. Daily check ins for all on home isolation log. Helping 2keep pts out of urgent cares and ERs.... Overseeing concerned residents." (general internist)

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"We are the frontline...We are trying to help people stay home, meet their medical needs and keep them out of the ED."
(general internist)

"I'm starting now with goals conversations to make sure I know [what patients want done] and document wishes. But I haven't yet touched the 'what if they can't/won't do what you are hoping for at the hospital.'" (geriatrician)

What is your approach to your outpatient patient panel?

"The whole thing is bizarre, moving target/info every 12 hours. Heuristics/thought process constantly in flux." (general internist)

"The whole team needs to work at their top skill, flexible. Avoid... underutilizing the skill of other professions, clinical pharmacist and integrated behavioral health." (general internist)

(Re lack of testing) *"the asymptomatic person who will have minimal clinical manifestations but will be COVID + will lose their minds. But could also provide some serious peace for others." (medical student)*

"I've been thinking a lot about this...phone and video visits can play a much bigger role, not just in a pandemic. Once people come out of isolation, I wonder what other disease processes we'll see. Depression & others?" (family medicine physician)

"I had not thought about this enough (before COVID-19)—virtual care such potential to address social isolation." (general internist)

What are you doing to stay sane/take care of yourself?

"I'm cooking, staying in touch with friends/ family, and burning some anxious energy in the name of acquiring PPE and other needed initiatives to help my [resident] friends. Also trying to sleep as much as I can, which has been tough. Oh, and exercise. EVERY. DAY." (medical student)

"Off next week...guilty a bit" (general internist)

"Take that vacation/week off without guilt. Your patients, learners & family all need you to take care of yourself. Plus, you'll charge back in refreshed just when someone else needs a break. This is going to last a while. In other words, what would you tell your learners to do?" (general internist)

"I have been seriously feeling it. Like how I felt after 9/11. I'm trying to find ways to be productive, because that always feels soothing. Exercising every day is unbelievably helpful to me. And honestly, I could not wait to connect with you all tonight." (geriatrician)

"Writing and reflecting a lot, watching lots of comedy, enjoying more home cooked meals!" (general internist)

"This chat has truly been valuable to me. This community...means alot for my #wellness." (general internist)

In summary, the COVID-19 pandemic is imposing the urgent need for social distancing and decentralization of care which is superimposed on pre-existing widespread feelings of isolation, disaffection and burnout among clinicians. We believe that carefully cultivated online learning and social media use that intentionally encourages engagement can increase social support and the feeling of belonging among PCP, which in turn, can bolster morale and lessen burnout.

Primary Care Chat takes place two Thursday nights per month (9:30 ET/6:30 pm PT), all are welcome https://twitter.com/primarycarechat

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The ISSN for SGIM *Forum* is: Print-ISSN 1940-2899 and eISSN 1940-2902.