

## PERSPECTIVE

## LEAVING AMERICAN HEALTH CARE: WHAT TO KNOW TO BECOME A PHYSICIAN EXPATRIATE

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I left American health care, a single fish swimming upstream against the usual flow of international medical graduates into the United States. International medical graduates (IMGs, formerly called foreign medical graduates) make up more than 25% of the practicing American physician workforce and about one of every seven resident physicians.<sup>1</sup>

Now, I am a sort of IMG, but in the Netherlands. Here, I'm a *buitenlands gediplomeerde arts* in Dutch: I am American-born and medically trained, and now seek a European medical license. I have yet to encounter another North American who completed the Dutch medical licensing procedure; only three have succeeded between 2005 and 2015.<sup>2</sup>

Barely two years ago, I never would have thought I would be where I am. My husband, a non-clinician researcher and a true global citizen, once dreamily suggested that moving anywhere in the world is possible—and that I would always have a career. The deceptively simple reasoning followed: Everyone needs health care.

Intrinsically, I already possessed a dormant seed of curiosity about working in another healthcare system. Under the right conditions, including my own cyclic burn-out and a job offer for my husband, plus a pinch of nurturing, that seed began sprouting into reality. A long-time personal goal began blossoming: I would try something completely new—a new language and new healthcare system.

This is not your typical international locum tenens experience in New Zealand or Australia, or global health experience. The usual challenges of expatriate life apply; for example, tax considerations, salary and costs of living

differences, and cultural integration. However, as a health professional, licensing and regulation adds complexity (and bureaucracy) that one only appreciates by doing. These are certainly well-known and worn experiences of IMGs in the United States.

Are you a fully licensed specialist in the United States and thinking about getting licensed in another developed country? If so, here are some tips, based on my early experiences integrating into the Dutch system:

### Speak the Language.

The Dutch Ministry of Health, Wellbeing and Sport, responsible for professional recognition procedures for all health professionals, takes a tough love approach: if you are not proficient enough to understand the application and procedures (available in Dutch only), then learn the language first. Language proficiency is essential.

In almost all member states of the European Union (EU), fluency to an advanced level of the official language is the first major step towards professional recognition. The reasoning follows: an effective doctor should be able to communicate clearly and empathically with patients, team members, and more.

Language immersion is ideal but tough to do in the Netherlands. This country boasts the highest English Proficiency Index of all countries globally that do not have English as an official language country-wide.

### Determine Your Scope of Practice.

As an American primary care physician, trained as a general internist, my job doesn't exist in the Netherlands.

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## FROM THE EDITOR

# CAN WE TALK?

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

*Forum*

*"The single biggest problem in communication is the illusion that it has taken place."*

—George Bernard Shaw

Lately, I've been thinking a lot about communication. In our field, and so many others, the ability to communicate at the right time and in the right context is critical. In many cases, good communication leads to a positive impression, and a better understanding among individuals. In our field, poor communication can mean the difference between life and death. Feedback and peer review are methods of communication that we regularly encounter in academic medicine. Communication is defined as "a two-way process of reaching mutual understanding, in which participants not only exchange information, news, ideas and feelings but also create and share meaning. In general, communication is a means of connecting people or places."<sup>1</sup> This month's *Forum* has several articles dealing with various avenues of communication.

Communication is not a passive process, but rather an interchange of information during which that information is often transformed in the process. Last year, Tom Gallagher wrote a series of "President Columns" about communication and openness in the Society with regard to how SGIM communicated to its members and how it operated. Tom's columns reflected the constant efforts by SGIM and the Council to continuously improve and be accountable to its members.

Feedback is a form of communication defined as "helpful information or criticism that is given to someone to say what can be done to improve a performance, product, etc."<sup>2</sup> This year, Giselle Corbie-Smith continues the emphasis on communication in her "President Column" by sharing several highlights from feedback received from membership surveys as well as the independent audit commissioned by the Council concerning SGIM's approach to communication and ultimately how we do business. The audit process was thorough and feedback received was comprehensive. Dr. Corbie-Smith shares the good and the bad, and offers her and the Council's thoughts and initial approach. There is much to be done.

In this month's Flashback40 feature, Avital O'Glasser opines on an article written by Adam Gordon in June 2008's *Forum* on the virtues of non-peer-reviewed articles. I consider peer review, defined as the "process by which a scholarly work (such as a paper or a research proposal) is checked by a group of experts in the same

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# LOOKING INWARD AND MOVING FORWARD: RESULTS OF SGIM'S COMMUNICATIONS AUDIT

Giselle Corbie-Smith, MD, MSC, President, SGIM; Francine Jetton, MA; Eric B. Bass MD, MPH, FACP

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*With these elements in place and the feedback we've received from the audit, we wholeheartedly agree with Pyramid's assertion that "SGIM has an important opportunity to become an organization that is the premier professional home of choice for the next generation of academic general internists".*



**A**s medical trainees and young professionals, we are taught the art of giving feedback. This delicate skill and instruction on how to offer feedback ranges from the “bologna sandwich” (positive—negative—positive) model of critique to one

where there's deep thought on how to help the learner seize opportunities for improvement. Last year, in the vein of seeking feedback on SGIM's internal and external strategic communications, membership messaging, and current slate of communication vehicles, Council convened an ad-hoc communications workgroup, led by Mark Schwartz and including Marshall Chin, Tom Gallagher, Karen Horowitz, Francine Jetton, Bill Moran, and Madeline Sterling. Knowing SGIM

needed outside help to facilitate this communications audit, Council engaged Pyramid Communications, a strategic communications firm with experience working with mission-driven organizations, to examine our current brand, messages, and communication vehicles. More importantly, Pyramid also looked into underlying areas that bolster strategic communications, including SGIM's structure, processes, and staff capacity. We further asked Pyramid to provide strategic recommendations for improving our Society.

Professionals from Pyramid Communications reviewed SGIM's print and digital materials, conducted personal interviews with members, staff, and council, and reviewed results of two surveys: a member survey on communications and a staff capacity survey. Just

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# WOULD YOU, COULD YOU...WRITE A NON-PEER-REVIEWED ARTICLE ANY DAY?

Avital Y. O'Glasser, MD, FACP, FHM

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Over the past year, in commemoration of SGIM's 40th anniversary, *SGIM Forum* has republished notable past articles along with fresh observations of the impact of that piece. It has been an opportunity to reflect on what has grown in excitedly surprising directions, what has stood the test of time, for what we were "off the mark," and when we were unexpectedly prescient. For this last #FBF, I selected Dr. Adam Gordon's piece, "I'll Write a Non-Peer-Reviewed Article Any Day", published exactly 10 years ago.<sup>1</sup>

In the piece, republished in this month's *Forum*, Dr. Gordon reflects on his own tenure as an associate editor for *Forum* and editor of the "This Month in *JGIM*" col-

umn (TMIJGIM) that also ran in *Forum*. The TMIJGIM column revisited research published in *JGIM*, ultimately and unexpectedly focusing more on "the interviewee... than my 'review' or interpretation of that work." The TMIJGIM column was one of the inspirations for how we selected our #FBF articles.

Reflecting on his non-peer-reviewed articles reflecting on peer-reviewed articles, Dr. Gordon muses about the overt imbalance in the importance and assigned value of peer-reviewed versus non-peer-reviewed articles, especially in academic institutions and in promotion and tenure tracts. However, he also makes a strong argument that non-peer-reviewed work can be personally invigo-

## I'll Write a Non-Peer-Reviewed Article Any Day

—Adam J. Gordon, MD, MPH, FACP, FASAM

As I close out my term as Associate Editor of the *SGIM Forum*, I am happy to reflect. My role as editor of the "This Month in *JGIM*" (TMIJGIM) column has been productive, invigorating, and rewarding. Too bad my academic institution is less excited about my work in this role: I should have been working on my research and publishing my own peer-reviewed work.

Through 18 TMIJGIM articles over three years, I have explored with corresponding authors who have published their work in the *Journal of General Internal Medicine (JGIM)* the origins of their research, their research career, and the trials and tribulations of original clinically related investigations. I found it easy to communicate with the corresponding authors. They seemed to be excited about having their work featured in another format outside of *JGIM*.

The TMIJGIM piece was much more about the interviewee and their work than my "review" or interpretation of

the work. Often the TMIJGIM articles had more expressions from the author-interviewee as quotes than my original thoughts.

Two surprises happened over the years: not one potential interviewee turned down being interviewed for a featured TMIJGIM piece, and not one potential interviewee asked to be "co-author" on the TMIJGIM *SGIM Forum* article. The latter surprise, co-authorship, involved a debate among the *SGIM Forum* editorial staff when TMIJGIM originated: Should we "offer" a co-authorship to every interviewee? In the end, we decided to offer this if the interviewee requested it. No interviewee did.

Perhaps interviewees recognized that the *SGIM Forum* was not a peer-reviewed publication and co-authorship would not be "valued" by their academic institutions—even though the publication was about their work and their experiences.

As an academic clinical investigator, like many of the interviewees for the TMIJGIM column, I recognize that peer-reviewed published literature is the "currency" of an academic career. In the tenure and non-tenure streams,

promotions are judged primarily with the number and quality of peer-reviewed publications and peer-reviewed grants. Reflecting on my recent promotion experience, I dutifully catalogued all my peer-reviewed articles regarding "quantity" (primarily the number) and the "quality" (the nebulous journals' impact factors). In the clinical-educator's world, peer-reviewed case reports and original research are also valued extremely highly by promotion committees. Many promotion committees are not similarly asking for quantification or quality factors of their faculty's non-peer-reviewed publications.

Why not?

Non-peer-reviewed publications include commentaries and opinions, letters to the editors, print or web-based reviews, book chapters, editorials, and even *SGIM Forum* articles. Many *SGIM* members are often invited to author non-peer-reviewed work on these products.

They must delicately balance the time to produce these products with peer-reviewed papers and grants. Other *SGIM* members contribute original thoughts or commentaries but

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rating and rewarding, valuable to the public and peers, a conduit for education and discourse, and a form of advocacy.

A recent *JAMA Internal Medicine* editorial questions how the “academic arms race” positively or negatively contributes to meaning and burnout in our work.<sup>2</sup> I found out about the article through a lively Twitter discussion, with multiple colleagues chiming in about the potential risk of the “publish or perish” attitude in academia.<sup>3</sup> Several contributors highlighted the value of pursuing work that was fulfilling for its own merit, such as non-peer-reviewed articles—ala, don’t do it because you have to pad your CV or “for show,” do it because you want to write it.

I realized during this conversation that some of my favorite and most fulfilling pieces to have gone through the process of writing have

been during my three years as an associate editor for *SGIM Forum*. I’ve published “art of medicine” humanistic editorials that were declined from peer-reviewed venues, I’ve had a forum (no pun intended) to muse about my great-great grandmother’s death certificate from 1938 documenting her fatal case of pemphigus vulgaris, and I’ve published for the first time a piece co-authored with my husband. Writing and editing for *Forum* has led to multiple new acquaintances and instant connections at conferences. I have stretched myself and indulged my creative side, and I’ve been fulfilled by mentoring students, residents, and junior faculty.

Dr. Gordon outlines how peer-reviewed publications are the “currency” of the academic world, judged by quantity, quality, and measures of impact. There are rumblings in the academic world that there is

potential for the non-peer reviewed publication realm to change with the rapid adoption of social media to disseminate, share, and converse about medical writing. In parallel to this, alternative and updated measures of impact, beyond a journal impact factor or number of citations, can now be tabulated, including for non-peer-reviewed articles. The times they are a-changin’.

There is a line from the Broadway musical *Hamilton*: “Pick up a pen, start writing. I wanna talk about what I have learned, the hard-won wisdom I have earned.”<sup>4</sup> I cite the line far too liberally, though with good reason, when it comes to discussing my enthusiasm for promoting scholarship. I hope that Dr. Gordon’s republished piece, with another 10 years of academic medicine experience, will compel you to write non-peer-reviewed articles. I simi-

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don’t seek to publish—peer-reviewed journals contribute little space for this type of thought. Interestingly, senior members of the faculty are often excited about writing an editorial or writing a book—they already have the necessary currency of peer-reviewed work and more protection within the institution (e.g., seniority, tenure), making pontificating in non-peer-reviewed work less risky.

Despite the relative non-importance of non-peer-reviewed work in an academic clinician’s dossier, non-peer-reviewed work is *valuable* to the public, to peers, and the academic faculty.

Non-peer-reviewed work by academic physicians is valued by the public. When an academic physician steps out from behind the ivory tower of academic medicine, the public receives expert knowledge. Letters to the editor or commentaries in metropolitan newspapers from academic clinicians are valued. Interestingly, more people read this work than a publication in a lower-tiered peer-reviewed journal. Physicians have been trained to be experts in medicine, and SGIM members are more than likely to be physician-leaders. Providing expert

opinion on the topics of the day (e.g., smoking bans in public places, tort reform, universal health insurance) are what leaders of academic medicine *should* do.

Peers value non-peer-reviewed articles. Take the TMIJGIM column. Over the years, I have received many positive and engaging comments regarding this column. One article prompted a national grant organization to contact me to assist in contacting the interviewee for a potential funding opportunity. In addition, over the years, I’ve published quite a few opinion pieces in the *Bulletin of the Allegheny County Medical Society* (Google it—you won’t find it in Medline!), which has influenced local opinion leaders and non-academic physicians. Now as president of that organization, I see that the *Bulletin* provides an excellent conduit to inform the members, non-members, and the public about what the Society is doing. Reporters, politicians, and other key stakeholders ask me more about my articles in this journal than my latest peer-reviewed article in *JGIM*.

Participating in non-peer-reviewed work is akin to community-based par-

ticipatory research. If we are to change society, we, as academic physicians, need to interact with society on its own terms. Non-peer-reviewed publications are a currency of this interaction. This type of currency can accomplish change.

Finally, non-peer-reviewed work is valuable to academic physicians. It is my opinion that faculty who enjoy working on non-peer-reviewed projects are more likely to become physician-advocates. They are advocates for their profession and their patients. They speak out. They are willing to express opinions that may be unpopular. Non-peer-reviewed work promotes debate and discourse.

Peer-reviewed work is (and should be) the currency of academic medicine. But non-peer-reviewed work is an important conduit for opinion and expressions of leadership. In monetary terms, if peer-reviewed work is valued as highly as a dollar, then non-peer-reviewed work should be considered at least a quarter. SGIM values the *SGIM Forum*, a non-peer-reviewed publication. However, the *SGIM Forum*’s value in academic medicine is less apparent. Why?

# PHENYTOIN-INDUCED DRUG REACTION WITH EOSINOPHILIA AND SYSTEMIC SYMPTOMS (DRESS) SYNDROME

Pinky Jha, MD; Chad Wenzel, MD; Stephen S. Erickson

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The comments in italics are those of the discussant, Michele Fang, MD. Dr. Fang (Michele.Fang@uphs.upenn.edu) is an associate editor of the *SGIM Forum* and an associate professor at the University of Pennsylvania, Perelman School of Medicine.

A 52-year-old African-American male with past medical history of ESRD on dialysis, diabetes, coronary artery disease, stroke, alcohol use, and recently diagnosed seizures presented with fever and a pruritic rash over his body and face for a week. The rash was a diffuse morbilliform rash over his trunk, arms, and face. The rash was not pruritic. He had fevers, but denied cough, dysuria, or diarrhea. He denied headache or mental status changes. Patient was started on phenytoin five weeks prior for new-onset generalized tonic-clonic seizure.

*The differential diagnosis for febrile patients with a rash is extensive. Diseases that present with fever and rash are usually classified according to the morphology of the primary lesion. Rashes can be categorized as maculopapular (centrally and peripherally distributed), petechial, diffusely erythematous with desquamation, vesiculobullous, pustular, and nodular. Potential causes include viruses, bacteria, spirochetes, rickettsiae, medications, and rheumatologic diseases. A thorough history and a careful physical examination are essential to making a correct diagnosis. Although laboratory studies can be useful in confirming the diagnosis, test results often are not available immediately. Because the severity of these illnesses can vary from minor (roseola) to life-threatening (meningococcemia), physicians must make prompt management decisions regarding empiric therapy. Hospitalization, isolation, and antimicrobial therapy often must be considered when a patient presents with fever and a rash. Maculopapular eruptions are most frequently seen in viral illnesses and immune-mediated syndromes. Viral etiologies of rashes include rubeola, rubella, erythema infectiosum, and roseola. Drug reactions can present as any dermatologic morphology and show no predilection for age, gender or race. Exanthematous eruptions most commonly occur in association with the administration of penicillins or cephalosporins. The rash usually appears within the first week after the offending drug is started and typically*

*resolves within days after the drug is discontinued. Drug-related reactions can be difficult to distinguish from viral exanthems, but they may be more intensely erythematous and pruritic.*

On initial presentation to the ED, patient was febrile (Tmax-103.1) and tachycardic. The patient had diffuse morbilliform rash over the trunk, arms, and face. His cardiac exam showed no murmurs but tachycardia; his lungs were clear. The patient's abdomen was non-tender but did show hepatomegaly and positive fluid wave. The patient's dialysis access was clean, dry, and intact without erythema or drainage. Laboratory results were significant for elevated AST 190 (baseline 20), elevated ALT 193 (baseline 20), elevated Alkaline phosphatase 870 (baseline 536), total bilirubin of 1.1 with 0.7 direct, albumin of 3.3, and INR 1.4. His BUN and Cr were 33 and 4.30, respectively; his last dialysis was one day prior to presentation. Complete blood count was consistent with anemia of chronic disease (unchanged from recent labs), white count of 6.1 and differential was significant for eosinophils of 16%.

*The clinical presentation is concerning for sepsis syndrome given fever and tachycardia and the patient's dialysis status. The patient's laboratory values also reflect increase in transaminases and biliary sepsis needs to be evaluated. However, the eosinophilia, rash, and initiation of a new drug, especially phenytoin is also concerning for DRESS.*

Ultrasound of the liver was performed which revealed hepatomegaly and ascites as well a thickened gallbladder wall with sludge. In the ED, patient was fluid resuscitated and started on empiric antibiotics for concern of sepsis. Initial UA and CXR were not suggestive of infection and, blood cultures were negative. A diagnostic paracentesis was performed at bedside. Fluid studies revealed a serum ascites albumin gap of 1.2, suggestive that this patient's ascites was potentially related to chronic portal HTN but no

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leukocytosis and negative gram stain.

Given the classic rash and eosinophilia with recent initiation of phenytoin, it became clear that the patient did not have sepsis, but had DRESS syndrome.

Patient was started on prednisone 80mg and topical steroid cream. Broad spectrum antibiotics were discontinued as infection was ruled out. His Dilantin was stopped and he was started on oxcarbazepine for seizure. The next day, the patient became afebrile and had significant improvement in rash along with improvement in liver function test. The patient's rash continued to improve clinically over the first few days of hospitalization.

*Drug reaction with eosinophilia and systemic symptoms (DRESS) is a hypersensitivity reaction to certain drugs characterized by fever, morbilliform rash, eosinophilia, and systemic involvement (hepatitis, nephritis). DRESS is potentially life threatening and therefore early recognition and intervention is critical. DRESS refers to an uncommon, potentially life-threatening hypersensitivity response to certain medications.*

*Antiepileptics in particular are classically associated with DRESS, along with allopurinol, sulfa drugs, and various antibiotics. As the name suggests, manifestations of DRESS may include high eosinophil counts (greater than 700 eosinophils/microliter) and damage to many different organ systems. The liver is the internal organ most commonly targeted, with a severe hepatitis being one of the main causes of death; however, DRESS can present with involvement of almost any organ, and symptoms may arise from visceral processes including interstitial nephritis, pericarditis, pancreatitis, and encephalitis. Morbilliform rash is a key external indication of DRESS, and if it is observed in a febrile patient within two to six weeks (longer than the typical time course of a Stevens-Johnson/toxic epidermal necrolysis reaction) of starting a typical inciting medication, DRESS should be given strong consideration in a differential*

*diagnosis. Facial swelling and painful lymphadenopathy are other clinical indicators of a potentially severe drug reaction. If a patient is believed to be experiencing DRESS, labs that should be obtained include a CBC (with a particular interest in the eosinophil count) along with creatinine, BUN, and liver enzymes to investigate possible visceral involvement. The most important initial step is to immediately discontinue recently started drugs that are thought to be the likely culprit of the reaction. The labs previously mentioned should continue to be monitored. Fortunately, the vast majority of patients fully recover after stopping the medication responsible for their reaction. It is imperative that physicians quickly recognize the signs of DRESS in patients recently started on new medications given the possibly fatal consequences of failing to do so.*

*Management includes oral steroid, topical steroid ointment, antihistamine and supportive care with iv hydration and antipyretics.*

Learning point:

**DRESS syndrome is a severe hypersensitivity reaction that has been implicated with numerous drugs. Early diagnosis and prompt treatment with corticosteroids is imperative.**

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SGIM

#### FLASHBACK 40 (cont. from p 5)

larly hope that our #FlashBackForty series this past anniversary year has shown how non-peer-reviewed articles can more than stand the test of time—and inspired you to write them yourselves (of course, with an SGIM Forum bias).

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SGIM

# CREATING A NATIONAL HEALTH POLICY AND ADVOCACY CURRICULUM

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If you have been to either of the past two Society of General Internal Medicine (SGIM) Annual Meetings, you have seen first-hand the burgeoning interest in health policy and advocacy. Workshops in these areas are more numerous and well attended than ever before, and the passion in the meeting rooms is palpable. It is heartening to see the passion to protect and even advance recent gains in U.S. health care, but this advocacy energy emerges out of a history of relative inactivity by physicians. In part, this historical lack of involvement is due to the dearth of health policy and advocacy education in medical training.

Physicians vote at rates approximately 30% lower than the general population.<sup>1</sup> Likewise, physicians have been uninvolved in advocacy efforts, for example, only 16% of pediatricians reported involvement in “child health advocacy” in 2010.<sup>2</sup> Physicians’ lack of engagement in policy and advocacy reflects our underappreciation of the impact we can have on the civic process and a lack of knowledge and skills to take steps toward action.<sup>3</sup>

There have been various calls for increased education in health policy and advocacy, going back as much as a quarter-century.<sup>4</sup> And while there exist numerous home-grown programs at academic institutions, our undergraduate and graduate medical education systems lack a standard set of health policy and advocacy competencies and a coordinated effort to ensure graduates of our training programs meet these standards.

In 2017, SGIM launched the Leaders in Health Policy Program (LEAHP), a one-year health policy career development program, with numerous participants that identify themselves as *clinician-educators* with roles in health policy and advocacy education at their home institutions. The goals of the LEAHP program are to develop SGIM members who will become effective and active health policy advocates and local health policy experts, leaders, and teachers, to develop an expanding national cadre of its Health Policy Committee members, and to broaden membership engagement in SGIM’s health policy efforts.

**We are entering an era of change in medicine. Physicians are coming to realize their potential as change-agents in our health system. By providing a comprehensive, accessible, and dynamic curriculum, SGIM can help medical educators prepare physicians to make this impact.**

To this end, a cohort of the inaugural group of the LEAHP program has begun to develop a health policy and advocacy curriculum that could be widely adapted across institutions. Since all LEAHP participants are required to produce “deliverables,” this made the LEAHP program the ideal place to incubate such a curriculum.

The following are five key goals that we identified in developing this curriculum:

- 1. Establish the core knowledge and skills for all learners of health policy and advocacy.** SGIM is an ideal organization to develop the core competencies and materials for health policy and advocacy, as many of our members are actively involved in health policy and advocacy research, implementation, and education. One of the authors (M.F.) began by conducting a Delphi survey of health policy experts; this iterative survey method allowed us to sort topics by level of import. It also allowed us to distribute topics for early (“101”), intermediate (“201”), and advanced (“301”) learners based on perceived importance and complexity. At this stage, we have developed the key learning goals and objectives and are now in the process of building out the learning materials.
- 2. The curriculum should be widely accessible, applicable, and disseminable.** We believe that all physicians should possess a minimum set of health policy and advocacy knowledge and skills; therefore, we intend to make the curriculum widely available

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in several ways. First, we will present it as a free resource from SGIM such that institutions and medical educators nationwide can access the materials.

In addition, since we recognize that not every institution has experts at the ready to deliver hour-long lectures on health policy and advocacy topics, the materials will also include teachers' guides and emphasize discussion-based sessions rather than lectures. Utilizing the "flipped classroom" model, an effective and increasingly common learning methodology, our curriculum will place less onus on the teachers to be "experts" in any given area, lowering barriers to adoption and broadening the reach of the curriculum.

Next, we intend to leverage our relationships with other like-minded organizations with large member bases to distribute the curriculum. In collaborating with these organizations, we keep with SGIM's goals to create linkages with other groups and further increase the opportunities of curricular adoption.

**3. Advocacy will be incorporated throughout.** While an understanding of the structure, function, and imperfections of the American healthcare system is necessary, we would fall short of our ultimate goal if we did not provide learners with the skills to initiate systemic change. Therefore, in addition to the "101," "201," and "301" learner categories, we have created a separate category of material devoted to advocacy skills. In addition, within each topic we will incorporate an advocacy-focused activity. For example, if a "101" topic covers Medicaid structure and function, then the advocacy activity would be to create a one-page leave-behind about a state's Medicaid program.

**4. We will continually evaluate the curriculum to ensure**

**effectiveness.** This upcoming year will serve as a "pilot" in which the curriculum authors will implement our first iteration of learning materials in their home institutions and collect data on its effectiveness. Meanwhile, we will develop methods to study the curriculum once it is implemented more broadly, providing us with valuable monitoring and evaluation and allowing us to publish the educational outcomes in a peer-reviewed journal.

**5. The curriculum must remain current and accurate.** Health policy is a constantly shifting landscape; while some areas remain relatively consistent, others can be changed in a moment's notice. In order to ensure reliable review, we are creating an interest group dedicated to health policy and advocacy education. On a regular basis, the interest group will, amongst other things, review curriculum materials to ensure accuracy and completeness.

We are entering an era of great change in the field of medicine. Physicians are finally coming to realize their potential as change-agents in our health system. But they are also realizing that, in order to reach this potential, they must better understand the health system and develop the advocacy skills. By providing a comprehensive, accessible, and dynamic curriculum, SGIM can help medical educators prepare physicians to make this impact.

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# TIME WELL SPENT WITH DR. CHRIS CALLAHAN: THE 2018 SGIM DISTINGUISHED PROFESSOR OF GERIATRICS

Jennifer L. Carnahan, MD, MPH, and Seki A. Balogun, MBBS, FACP

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Dr. Chris Callahan, longtime SGIM member and contributor, headlined the Distinguished Professor of Geriatrics programming at the 2018 annual meeting. The annual Geriatrics Posters Walk and Talk on Thursday morning kicked off the events. Poster topics ranged from decision aids for mammography screening to implementation and evaluation of a program of co-management of geriatric trauma patients. Dr. Callahan offered participants advice on their research design, potential next steps, and how to make the most of their time attending the SGIM meeting. He continued as the featured discussant at the afternoon geriatrics oral abstract session. Abstract topics included the relationship between mild cognitive impairment and appropriate treatment of acute myocardial infarction, the association between polypharmacy and quality of life, the impact of peer-to-peer support and health utilization among older adults, and a mixed method study of older, urban-dwelling veterans' use and non-use of VA care.

The following were the three highest-rated poster presentations in Geriatrics/Aging/End of Life at this year's meeting, listed with their presenting authors:

1. ***Emotional and Sexual Abuse Are Associated with Aging-related Genitourinary Dysfunction Among Older Community-dwelling Women*** by Carolyn Gibson;
2. ***A National Survey of Older Americans about Overuse of Health Care Services*** by Jeffrey Kullgren; and
3. ***Functional Impairment of Older Adults Presenting to a VA Medical Center Emergency Department: Findings from the GERI-VET Program*** by Jill Huded.

The following was the highest rated Geriatrics/Aging/End of Life oral abstract presentation:

***Associations between Polypharmacy, Symptom Burden, and Quality of Life in Patients with Advanced, Life-limiting Illness*** by Yael Schenker.

Dr. Callahan's keynote lecture was the highlight of the program and was attended by more than 150 people. His involvement with SGIM stretches back to 1989 and he shared his extensive historical knowledge. Early on, geriatrics specialists worked to increase their numbers but the sheer volume of aging patients living well into their 80s, coupled with a dearth of trainees interested in specializing in geriatrics made it clear that new strategies were needed. SGIM members and others developed the approach of infusing geriatrics principles into other specialties and general internal medicine training and practice.<sup>1,2</sup>

Dr. Callahan suggested that those who are driven by the goal of improving the care of older adults should seek out local and national leadership positions.<sup>3</sup> This leverage will allow for advocacy of this vulnerable population and continued infusion of geriatrics principles into the very fabric of medical care. He noted during the question and answer period that one inherent reason why we need to advocate for our older patients is that "when they become frail, they become hidden at the same time."

In his 2017 publication, Dr. Callahan advised coalition building in three ways in order to increase the chances of improving health care of older adults: 1. Grassroots coalitions with patients and families; 2. Stronger relationships with CMS to strengthen our voice in healthcare policy; and 3. Building effective coalitions with local healthcare systems.<sup>4</sup> Though these "marching orders" may seem daunting, they are key to establishing a sustainable, scalable, and valuable medical care culture that is able to identify and meet the needs of older adults. Dr. Callahan ended his talk with an inspiring quote from Albert Camus' *Myth of Sisyphus*: "The struggle itself towards the heights is enough to fill a man's heart. One must imagine Sisyphus happy."

These important issues are what drive SGIM members who participate in the Geriatrics Interest Group

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and the newly formed Geriatrics Commission. We continued discussion of the following topics with Dr. Callahan after his talk:

1. **What have been your favorite aspects of this year's meeting?** "I have probably attended more than 20 SGIM meetings. My favorite aspect of the meeting has always been reconnecting with colleagues from across the country. I think of the SGIM meeting as a place to recharge and reenergize. SGIM returns you to your home institution filled with new ideas for improving patient care."
2. **Can you expand on your thoughts on the existing generalist-geriatrician collaborations?** "Generalists and geriatricians share many of the same challenges and opportunities. Both also face the difficult balance of remaining true to their overarching and broad principles of care while navigating in a world that perhaps overvalues the currency of 'specialist.' At a local level, I believe the two groups should increase their interactions and collaborations on areas of common interest. These collaborations wax and wane over the years and they require considerable energy by program leadership to help sustain. That said, any two faculty with an interest can help build these bridges- maybe it starts with a conversation over coffee."
3. **In what ways do you think these collaborations can be strengthened?** "We strengthen collaborations by identifying and tackling common challenges that represent the important unmet needs of our patients. We need to work shoulder to shoulder on opportunities important to us and our stakeholders. Social interactions between these groups are great but they are strengthened by engaging

in important work at the local level where teams of generalists and geriatricians can see that their hard work is producing dividends for patients."

4. **You spoke in your talk about the importance of volunteering. Can you expand on the rewards of volunteering for SGIM?** "Volunteering at SGIM helps you look up from your grindstone and see how your work dovetails with the larger efforts of our larger community. Volunteering at SGIM expands your scope of responsibility and authority so that your efforts might reach a larger population of patients. Volunteering at SGIM provides you access to people who inspire you. Volunteering at SGIM helps you pay it forward for the many benefits you have received from the organization."
5. **What are some of the important areas in aging research that you think SGIM members can and should continue to pursue in the future, especially younger investigators looking for their niche?** "I view choosing and pursuing an area of research as a discussion rather than a personal decision. Young investigators might imagine a Venn diagram with four circles: your passion, your institution's priorities, your patient's priorities, and a funding stream. Through discussion with your mentors and colleagues and stakeholders, you will identify the intersection of these four circles: there you will find your niche!"
6. **Do you have any final words of wisdom for young generalists and geriatricians?** "You build a career one step at a time, one brick at a time, and through perseverance. Perseverance and persistence are more powerful than most any other talent. All of the more senior people with whom you may come into contact

followed this same journey—they all started somewhere. The best way to get started is to get started and keep moving forward."

**Note:** Christopher M. Callahan, MD, MACP is the Cornelius and Yvonne Pettinga Professor of Aging Research at Indiana University. He is a scientist in the Regenstrief Institute, Inc. and is the founding Director of the Indiana University Center for Aging Research, now in its 21<sup>st</sup> year of operation. He received the Midcareer Research Mentorship Award from the Society of General Internal Medicine in 2006 and the Edward Henderson Award from the American Geriatrics Society in 2016. In 2017, he accepted the role of chief research and development officer at Eskenazi Health, one of America's largest essential health care systems. He was selected as the Distinguished Professor in Geriatrics for the 2018 Society of General Internal Medicine meeting.

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# IMPROVING HOSPITALIST'S KNOWLEDGE, PREPAREDNESS, ATTITUDE, AND BEHAVIOR ON LGBTQ HEALTH

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Decades of activism, organizing, changing attitudes, and reforming public policies led organizations—such as the National Institutes of Health, Institute of Medicine, The Joint Commission, and the U.S. Department of Health and Human Services—to recognize the health inequities the lesbian, gay, bisexual, transgender, and queer (LGBTQ) population faces. One factor in these inequities is the lack of healthcare provider knowledge about the LGBTQ population leading to negative client-provider relationships, which could be related to poorer LGBTQ health outcomes.<sup>1</sup>

A four-hour LGBTQ health educational session was created for a Hospitalist group at a major academic medical center to improve knowledge, preparedness, attitudes, and behaviors in LGBTQ-affirming care. A total of five self-selected Hospitalists participated in a four-hour educational session on LGBTQ health. There was no baseline data collected on the level of education, experience, or personal bias the Hospitalists had regarding the LGBTQ population. A pre- and post-educational session knowledge survey was given to measure the Hospitalists' knowledge of LGBTQ definitions and concepts, and social and health inequalities experienced by the LGBTQ population. The questions in the knowledge survey were based on the curriculum of the National LGBT Health Education Center's "Achieving health equality for lesbian, gay, bisexual, and transgender (LGBT) people" and validated by an expert panel made of members from the academic medical center's LGBTQ Committee.<sup>4</sup> Hospitalists' attitudes toward and preparedness to treat the LGBTQ population were measured pre- and post-educational session using a modified Lesbian-, Gay-, Bisexual-, and Transgendered-Development of Clinical Skills Scale (LGBT-DOCSS).<sup>2</sup> Auditing 30 random patient charts of each participant to assess if sexual orientation and gender identification was recorded pre and post-educational intervention measured the participants' behavior.

The participants' in the four-hour educational session demonstrated statistically significant improvement in knowledge of LGBTQ-affirming care; however, they did not exhibit statistically significant improvement in preparedness or attitude. The participants' showed statically

significant improvement in behavior with recording sexual orientation however they did not in recording gender identity.

These results reinforce what is already known in literature—educational sessions can improve participant knowledge regarding LGBTQ concepts and health needs. Although some research has shown an improvement in participant preparedness and attitudes towards the LGBTQ population through an educational session this study did not validate those results.<sup>5</sup> Possible reasons attitudes, preparedness, and behavior with gender identity did not improve include that the small sample that participated in the educational session limited statistical analysis; LGBTQ health needs are expansive and cannot be completely addressed in a four-hour educational session, which may have left participants feeling unprepared to competently address LGBTQ health issues after the educational session, and thus assessing themselves even lower than before the session; educational sessions that improve LGBTQ knowledge alone do not improve preparedness, attitudes, or behavior but also require affecting each participant's awareness, skill, encounter, and desire to learn about the LGBTQ population.<sup>3</sup> In addition, the sample was self-selected and already engaged on the topic of LGBTQ health; therefore, the attitude and preparedness, scores were already high at baseline and incremental improvement post intervention were not statistically significant.

An important lesson learned during the process of this intervention is that research on how to improve knowledge, preparedness, attitude, and behavior of health providers in LGBTQ-affirming care is limited, and future studies should focus on what interventions can effectively improve this. Concepts to explore include whether increased LGBTQ encounters, either through simulation or personal encounters, improve preparedness, attitude, and behavior. Without a change in provider attitude and preparedness, LGBTQ patients will likely continue to face poor provider interactions, which will make them less likely to seek medical care and lead to the poor health outcomes and behaviors we see today.<sup>1</sup> Another important lesson learned is that institutional

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Continuity care in a primary care clinic setting is not typical of a Dutch general internist's scope of practice. Outpatient Internal Medicine clinic functions more like a specialty service. Inpatient service is no different than in the United States.

I had to decide: to become a Dutch primary care physician or huisarts, which is a closer scope of practice to my prior work experience, I would likely need to do three-year full-time residency training locally. For Internal Medicine, since I did residency in the United States, at least partial professional recognition would obviate repeating residency in full.

### Find Out What Documentation You Need.

The professional recognition procedure as a foreign physician in the Netherlands differs depending on where you received your medical diploma. That is, medical graduates from another EU country may more easily obtain professional recognition, although language proficiency is still required. Once you master the official language, you might need an extensive list of required documentation for the licensing application. In my case, I contacted my previous training institutions and employers for notarized letters; I tracked down hundreds of hours of CME certificates; I also submitted original diplomas with my application, along with copies of middle and high school diplomas.

### What Tests Will You Take? What Clinical Experience Will You Need?

First, I must pass a physician communication skills exam to prove my Dutch language proficiency. Then, medical knowledge exams follow, which almost precisely parallel the United States Medical Licensing Exams—but are administered almost completely in Dutch. A part is also in English, implicating English language mastery, a challenge for non-English and non-Dutch speaking

physicians. To compare, neighboring Belgium, for example, does not have a communication skills exam, but does require proof of advanced Dutch language coursework and administers medical knowledge exams in Dutch, one of Belgium's official languages.

The Netherlands' professional recognition procedure was newly implemented in 2005, emphasizing new examination components, and covering recognition up through medical school graduation. After M.D. recognition, the Dutch Federation of Medical Specialists, most closely equivalent to the American Medical Specialty Boards, evaluates the equivalency of foreign physicians' medical specialty training. Without equivalency, full-time Internal Medicine specialty training lasts six years, with a duty hour limit of 46 hours/week, including any years of subspecialty training.

Although redoing residency is not necessarily required in the Netherlands, as it is in the United States for IMGs, a *buitenlands gediplomeerde arts* must do at least three months of work under supervision, regardless of non-EU country of origin.<sup>2</sup>

### How Is the Physician Workforce Regulated?

Consider Australia and New Zealand, who popularly import American and Canadian physicians.<sup>3</sup> Both countries experienced rural physician shortages, so modified regulations for licensing foreign doctors decades ago. International locum tenens recruitment in the United States consequently became a specialized service aimed at American doctors seeking a relatively quick transition to another English-speaking healthcare system.

But this is not true for all countries. In the Netherlands, the Dutch government regulates the physician workforce. Some residents and young doctors are in fact troubled by difficulty finding long-term positions, especially those in certain subspecial-

ties, in desired locations. To me, this means that the Netherlands is not necessarily wanting for a larger physician workforce, which may mean less incentive to simplify procedures for foreign physicians to become licensed.

### Understand the Local Culture of Medicine. What Can You Bring from Your Experience?

Social integration is a foundation of expat life, but integrating into the local culture of medicine offers a unique immersive experience. Learning about a culture through how its healthcare system functions, how it approaches health and wellness in society, and how each party participates in patient-physician or physician colleague relationships differs in both visible and subtle ways. Consider one small example: in my residency, chief residents led weekday morning reports, presenting one interesting patient case report interactively with interns and residents as a learning activity. Dutch morning report combines working and learning, involving students, residents, and both general internist and specialty attendings. An overnight resident presents patients admitted, distributes them to specialty services, reports on notable overnight coverage events, and everyone is positively welcomed to share opinions on cases discussed. Such is the social and group nature of almost any group meeting I have attended. A teaching session then follows for the remainder of the hour.

Other issues are universal: Physician burnout and suicide are also concerns, although the incidences are lower than in the United States<sup>4</sup> and the system offers different and arguably more effective supporting infrastructure and policy to help physician trainees and practitioners. Electronic health records are also widely implemented, but with inconsistent interoperability and heavy administrative burdens for clinicians.

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## BEST PRACTICES (continued from page 12)

support at the senior executive level is incredibly important for sustainability. To sustain an LGBTQ educational session like this will require a commitment to LGBTQ health from the implementing institution.

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## PERSPECTIVE (continued from page 13)

### So, What Next?

It seems that what my husband once pondered is partially true. I will treat patients again and hopefully will not need to repeat training. But it will take a few years of investment (time, finances, and patience)—this is likely applicable if you plan to continue clinical practice in any EU country.

Aside from the final desired outcome—to see patients independently again—the good news is with full professional recognition as a physician in one EU country, it should become easier to be recognized by another member country. That

means that after I achieve Dutch licensing as a general internist, I can start working on learning French or German next!

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## FROM THE EDITOR (continued from page 2)

field to make sure it meets the necessary standards before it is published or accepted<sup>33</sup> as a form of communication or at least a representation of the communication process of articles that we consider valued in academic medicine. The discussion is particularly relevant in regard to how we solicit and review the quality of articles we publish in *Forum* and how they are viewed by our readers and by our peers who judge our work, especially for academic promotion.

This month we also have a feature that we don't see as often as I'd

like in *Forum*—a Leadership Profile. Jennifer Carnahan and Seki Balogun share a thoughtful Q&A and commentary with Chris Callahan, this year's Distinguished Professor of Geriatrics at the 2018 National Meeting. The opportunity to hear from a seasoned and innovative academic clinician on what it means to be a member of SGIM and the growth of geriatrics as a specialty is not to be missed. In addition, Tiffany Leung's piece reveals her own issues around language and communication when leaving American medicine and becoming a clinician in another

country. Finally, this month has another great Morning Report case, and descriptions of curricula around LGBTQ affirming care and National Health Policy and Advocacy.

Happy reading!!

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**SGIM**

before the annual meeting in April this year, we received their very comprehensive and thoughtful audit and recommendations. We shared these findings with Council, and during the annual meeting also shared a synthesis of results with committee chairs and past presidents. Additionally, Tom Gallagher highlighted summary points from the report for members' consideration during his presidential address. Now that we have had the opportunity to discuss the report with Council, we wanted to make sure that the main results were also available to SGIM members. The audit highlighted strengths of our organization as well as opportunities for growth. Some of the key findings are as follows:

- **SGIM provides an important community to academic generalists. SGIM is a place that members go for connection, support, mentorship, and career opportunities. Pyramid described these attributes as a key asset and recommended we strongly promote the community aspect of SGIM. They further recommended we use these attributes as building blocks in our programs.**
- **SGIM has dedicated staff who are eager to do their best work. SGIM staff are talented professionals who direct the work of the committees, commissions, regions, events and publications; they are anxious to use more of their skills and experience to continue making SGIM the premier home for academic general internists. Our staff is one of our most valuable resources, and we can do more to integrate them as trusted partners in our work while supporting their professional development.**
- **SGIM's current strategic priorities are not effectively providing direction, structure, and focus for the organization and its staff. We need a more effective strategic**

**plan to help members and staff concentrate their efforts on activities with measurable objectives that will have greatest value for advancing SGIM's mission.**

- **SGIM'S current organizational structure, coupled with a vast amount of work for both members and staff, promotes silos and makes communications inefficient and are not as effective as they could be. The way we are currently organized splits communications, marketing, and membership functions, and further organizes work along specific channels like social media. We could communicate more effectively with a more specific strategic plan for promoting content integration across functions and channels, and for facilitating collaboration between members and staff.**
- **SGIM's communications are well written; however, they can be improved with strategic direction. Our communications need more substantial content that members want to see and engage with more deeply. Communications could be improved by having a goal-oriented strategic plan along with a staff structure that promotes content integration focused on specific and measurable goals.**

Admittedly, feedback offered to help us improve can be difficult to hear, particularly when we're all working hard. Fortunately, Pyramid Communications offered specific areas in which to start:

- **Update and enhance SGIM's strategic plan with more specific business and programmatic goals and measurable objectives to drive organizational activities;**
- **Revise and refresh SGIM's mission, vision, and brand to communicate more effectively the organization's value to members and external audiences; and**
- **Realign the organizational struc-**

**ture to strengthen the ability of members and staff to collaborate and make best use of their respective talents.**

The communications audit recognized the incredibly strong foundation upon which SGIM can build to refine our priorities and sharpen our focus. We have many of the needed elements to put Pyramid's recommendations into action. Work has already begun in several areas: 1) We have a strategic planning process underway, that will culminate in the Council's June retreat. We will share the process and outcomes of that retreat in future *Forum* columns; 2) We are working on refining our mission and vision statement as part of this strategic planning process; 3) We are explicitly ensuring engagement of staff in this strategic planning process so that they can be more effective partners in advancing the Society's mission and goals; and 4) We have a work group developing a financial sustainability plan for the organization. As that group convenes and makes their recommendations, we will share these with SGIM members. With these elements in place and the feedback we've received from the communications audit, we wholeheartedly agree with Pyramid's assertion that "SGIM has an important opportunity to become an organization that is the premier professional home of choice for the next generation of academic general internists".

We want to extend a personal heart-felt thanks to all staff and SGIM members who completed surveys, participated in interviews, answered questions, and supported Pyramid Communications in gaining access to needed information. Your contributions will help our organization plan for the future and become better at serving the needs of our members and providing a positive workplace for our staff. THANK YOU, and let's move forward together!

**SGIM**



# **SGIM** *Forum*

**Society of General Internal Medicine**

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