

ANNUAL MEETING UPDATE: PART I

INSPIRATIONAL STORIES FROM 2021 SGIM EDUCATION AWARD RECIPIENTS

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The Awards Subcommittee of the Education Committee is pleased to highlight this past years' SGIM Education Award Winners! Each award recipient shares the inspirations, triumphs, and challenges that contributed to their impressive achievements.

Diane B. Wayne, MD: Career Achievement Award for Medical Education. What inspired you to pursue a career in medical education?

I have been fortunate to have several wonderful role models who inspired my love of medical education. The first was my father, Eugene Bronstein, who was a pioneer in the field of radiation oncology. His life was forever changed when he was able to enroll in medical school in 1944 while on active duty in the U.S. Navy during WWII. He taught me the power of education and how it changes lives and future generations for the better. The second inspiration occurred in residency. As a resident at the University of Chicago in the early 1990s, I treasured the academic atmosphere and supportive culture shaped by Drs. Arthur Rubenstein and Holly Humphrey. I learned about the balance between setting high expectations and providing encouragement and support for trainees, and vowed to emulate it in my future career.

What career accomplishments are you most proud of?

When I was the internal medicine residency program director at Northwestern, we came up with a catchphrase for our program that our residents were “nice, hard-working, and smart.” Historically there has been a lot of

emphasis in medicine on multiple choice examinations and memorizing facts. Yet, medicine today is a team sport that requires excellent communication skills and the ability to work collaboratively with others. Each year I am more and more convinced that rewarding kindness, compassion, helping out a colleague and simply being “nice” are critical to developing our trainees and creating optimal learning environments that allow everyone to thrive. While I am proud of career achievements and awards, I hope to be remembered for emphasizing “nice” as a cornerstone of individual behavior and the learning environment.

Can you describe one of your biggest professional challenges and how you approached it?

No matter how much experience you have, leading through change is always difficult. I have tried to approach this professional challenge with transparency, clarity, and consistency. I find that taking the time to discuss “why we are doing this” is critical to success. Team members may have differing views and adapting to the pace of change can be challenging. Leaders must understand this and take the time needed to thoughtfully consider additional viewpoints and perspectives.

Do you have any other wisdom to share?

I'm so grateful for the wonderful opportunities I have had as a medical educator, hospital administrator and academic collaborator. I was taught early that a diverse team is the strongest team—whether in research, clinical

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FROM THE EDITOR

FINDING FAMILY IN #MYFIRSTSGIM

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
Editor in Chief, *SGIM Forum*

One could say I was a late bloomer. When I think about #MyFirstSGIM, I am reminded of the period of my early career when I started to recognize the importance of finding a professional home. Before graduating residency, I had been gently encouraged to consider applying for a GIM fellowship, but at the time had not pursued it for personal reasons. I had been only one of two graduates from my program that year who began practicing primary care internal medicine immediately post-residency. At the time, I did not yet know what it meant to belong to a professional home: The extent of my engagement in professional societies as a student or resident involved poster presentations of research or clinical cases.

As soon as I started my first job as an academic general internist, I realized there were so many things I still needed to learn for independent practice and to find my “why” in academic and scholarly pursuits. (As a side note, this continues to be an evolving and dynamic process.) By the time I attended my first SGIM annual meeting, I had only eight months of practice as an early career primary care internist behind me—along with all the trials and triumphs that come during the first year of being a brand-new attending physician. Those months were a period of significant growth: I learned how to effectively and efficiently supervise resident continuity clinics, mentor rotating students during my own clinics, fully and independently drive care management plans for patients with complex conditions, take at-home calls for my partners, creatively and systematically problem solve to help patients address social determinants of health within that specific community, and so much more, all a part of becoming an independently practicing clinician-educator.

My first SGIM was the first professional society meeting I attended as a newly minted attending physician. I was a late bloomer as a SGIM member, attending the meeting simply because I had the educational funds and allotted continuing education time to do so. It was eye-opening. That year, the theme was “Promoting Generalist Values in Times of Change.” When I listened to the plenary speakers and attended various sessions about patient engagement, health systems change, team care, quality improvement, and so much more on how U.S. health systems and primary care can evolve to achieve an equitable, high-value, accessible, and compassionate system, I was sold. That was my lightbulb moment. I felt like I found the place where my philos-

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WHY SGIM IS MY (AND YOUR) PROFESSIONAL HOME—CAREER DEVELOPMENT

Monica L. Lypson, MD, MHPE, FACP, President, SGIM

I attended my first SGIM meeting as a resident in my hometown of Chicago in 1998 (#MyFirstSGIM). SGIM invests in the success of its members through career development workshops, special symposia, and longitudinal programs that all combine in-meeting and between-meeting educational activities. SGIM is finalizing the implementation of the learning management system, GIMLearn, to facilitate career development and the storage of many artifacts. This long-term investment will benefit us all in our future career development.



As the end of summer approaches, so does the end of the SGIM fiscal year. Although membership renewal is in January, I reflect on the value of my SGIM membership at this point in the year and how it has been an investment in my own career development as the annual plans are being put into place. Career development is described as the “interactive progression of internal career identity formation and the growth of external career significance.”¹ Hans Hoekstra noted that throughout our careers, we must take on different roles: director, guide, maker, inspirator, expert, and presenter. The *maker* focuses on outcomes and attaining goals. The *expert* functions as a “go-to” problem solver. The *presenter* uses interpersonal communication skills and the *guide* uses influence to support others and their learning. The

director and *inspirator* both embody their titles—the director harnesses the collective wisdom of the group to enact strategies and the inspirator focuses on values and principles to motivate change beyond the *status quo*.

SGIM has provided me and I hope all of you with a vehicle to develop professionally. I attended my first SGIM meeting as a resident in my hometown of Chicago in 1998 (#MyFirstSGIM). Being an active member since then, SGIM has provided numerous occasions to experience many of these roles. I assumed the expert and maker roles by serving as a former lead for the Minorities in Medicine Interest Group and the SGIM Disparities Education Symposium.² As a participant in our mentoring programs, a member of multiple annual program committees and as SGIM Secretary, I assumed the presenter and guide roles. Serving as SGIM President,

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SGIM Forum

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The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.

Q & A WITH SGIM'S CEO AND PRESIDENT ABOUT SETTING PRIORITIES FOR THE NEXT YEAR

Eric B. Bass, MD, MPH; Monica L. Lypson, MD, MHPE

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Lypson (mll2215@cumc.columbia.edu) is the President of SGIM.

How does the SGIM Council set priorities for the organization?

For many years, the SGIM Council has held a retreat every June to set priorities for the next 12 months. It is a time for the Council to review achievements of the past year and discuss current challenges. In June 2018, Dr. Giselle Corbie-Smith, the President of SGIM, led a seminal retreat in which Council sought to “clarify our vision, refocus our mission, better understand our organization’s capacity, and identify how we may capitalize on our collective strengths.”¹ SGIM emerged from that retreat with a clear statement of our mission—to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.² Since then, SGIM has focused on four organizational goals and strategic priorities: 1) foster the development of general internal medicine leaders in academic and other settings; 2) promote scholarship in person-centered and population-oriented approaches to improving health; 3) advocate for our vision of a just health system that brings optimal health for all people; and 4) ensure organizational health including a thriving SGIM staff.

In each subsequent June retreat, the Council has wrestled with how to maintain continuity in overall strategy while addressing new problems. As Dr. Karen DeSalvo put it at the end of her presidency year in 2020, “we are constantly working to find balance in maintaining a focus on core priorities that can be achieved within our resources against the issues and new opportunities that arise every day.”³

The 2020-21 year brought exceptional challenges with the COVID-19 pandemic. Despite those challenges, SGIM accomplished a lot under the leadership of Dr. Jean Kutner.⁴ As Dr. Kutner declared in her recent *Forum* column, “if not for the thoughtful planning that was achieved during Dr. Corbie-Smith’s presidency which was expanded upon and operationalized during Dr. DeSalvo’s presidency, I don’t think that SGIM would have weathered this turbulent year as well as it has.”⁴ Now we prepare for another year, keeping our eyes on the organiza-

tion’s priorities while tackling new problems and staying true to our core values.²

What input does the Council receive from SGIM’s committees and commissions?

SGIM is a member-driven society. For that reason, the Council relies heavily upon input from the members who serve on SGIM’s committees and commissions. To prepare for the Council’s June planning retreat, we asked all committees and commissions to submit a plan for the coming year. Each committee and commission had to describe its top 3 priorities for the 2021-22 year and explain how each initiative supports SGIM’s mission. They also had to explain how they plan to engage members in their work and how they could collaborate with other groups inside or outside SGIM. In addition, we asked each committee and commission to identify content suitable for inclusion in our new learning management system (GIMLearn) and consider how they could contribute to SGIM’s plans for strengthening our commitment to diversity, equity, and inclusion.⁵

What was most striking about the plans submitted by SGIM’s committees and commissions this year?

The most striking aspects of the plans were the mission-driven focus, energy, and creativity reflected in the 120 pages of plans we received from the committees and commissions. The plans build upon the foundation established by previous Councils while proposing new initiatives designed to address current problems in the post-COVID world. Together, SGIM can do anything we put our minds to; however, we are unable to do everything. We will ensure that our resources are put to good use by choosing from a tremendous collection of initiatives. Over the next few weeks, SGIM’s staff will be working with the Council to estimate the resources needed to implement the highest priority initiatives and explore opportunities to make most efficient use of available resources. By the time this column appears in print, all committees and commissions will have received

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MASSIVE TRANSFUSION

Emily April Min, MD

Dr. Min (minea@upmc.edu) is a second-year Internal Medicine resident in the Department of Medicine at the University of Pittsburgh Medical Center.

Her last words to you, her mom, before the breathing tube went in, were, “Don’t let me die.”

I can hear the panic in your voice as you race down Forbes, past Carlow, towards the garage, “Don’t let my baby die!”

You were at the bedside every day (except four days, you’ll admit begrudgingly), for the last month and a half.

We acknowledge the force of your immense love, even as it takes the form of a daily interrogation and careful examination of every lab result. Back in the team room, we mull over the latest round of questioning, but behind our musings is the bright bulb of respect. Some people’s families never come at all.

As I dial the number to your cell phone, it’s becoming apparent that there’s no blood, not enough blood in the world, that can pump the life back into your child. We call for a massive transfusion and watch the telemetry scrunch like an accordion, watch as the QRS complexes undulate.

I hear your ragged breathing and imagine you weaving in and out of traffic. We stay on the line, together, as you arrive at the garage and rush into the building. You’re pleading for the elevator to hurry up—how many times have I joked with other residents about the slow elevators without a second thought? Now each second that drags on is sheer agony.

On the phone, the only thing I can think to say is, “I’m here.”

The hysteria that comes out of the telephone when I tell you we’re doing CPR is too much to bear.

Or that’s what I think, until I see you barreling down the hallway, face red and tortured and tearful, weeping and howling—now this is too much to bear.

When we give bad news, we are taught to state gravely, “I’m worried that...”

I’m worried that the lack of response to CPR and massive quantities of blood means that your child is never coming back. I’m worried that, after spending probably every waking moment of the last six weeks caring for and loving your child, you’re going to fall apart. I’m worried that no massive transfusion—of love, of support, of answers, will heal you from what you experienced today.

I think maybe I should be worried that I can’t forget your child’s face or yours, but instead I’m grateful. Etched in the recesses of my mind are the details of our mutual grief—from very different perspectives we have reached this final conclusion. Weeks later, I’ll hear that you were exceptionally kind and understanding after the initial trauma. I hear that you acknowledge to the grief-stricken medical team, in the face of your own unimaginable loss, that there are fates worse than death. I hear all of this much later—but in the first moment that I saw you barreling down that hallway screaming, I did what I should have done weeks ago and held you in an embrace.

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FROM THE SOCIETY *(continued from page 4)*

feedback and guidance on their plans. We look forward to having a very successful year!

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SGIM ANNOUNCES 2021 AWARD AND GRANT RECIPIENTS

Francine Jetton, MA, SGIM Director of Communications

The Society of General Internal Medicine (SGIM) is pleased to announce its 2021 award and grant recipients.

Recognition Awards

The Robert J. Glaser Award—Presented to **Michael Barry, MD (Massachusetts General Hospital)** for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

Herbert W. Nickens Minority Health and Representation in Medicine Award—Presented to **Inginia Genao, MD (Yale School of Medicine)** for a demonstrated commitment to cultural diversity in medicine.

David Calkins Award in Health Policy Advocacy—resented to **Stefan Kertesz, MD, MSc (University of Alabama at Birmingham School of Medicine)**. This award recognizes the extraordinary commitment many members make when they choose to advocate on behalf of SGIM.

ACLGIM Chiefs Recognition Award—Presented to **Stephan D. Fihn, MD, MPH (University of Washington School of Medicine)**. This award is given annually to the general internal medicine Division Chief who most represents excellence in division leadership.

The ACLGIM UNLTD (Unified Leadership Training in Diversity) Award—Recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM. The 2021 recipients are **Tracey L. Henry, MD (Emory University School of Medicine)** and **Theresa Maatman, MD (Medical College of Wisconsin)**.

The ACLGIM Leadership Award is given to a member of the ACLGIM who is within the first 10 years of faculty appointment. It recognizes skills in leadership in any number of areas of academic medicine, including clinical, educational, research or administrative efforts. The 2021 recipient of this award is **Ryan Greysen, MA, MD, MHSc**

(University of Pennsylvania School of Medicine).

The Quality and Practice Innovation Award—Recognizes general internists and their organization that have successfully developed and implemented innovative role model systems of practice improvement in ambulatory and/or inpatient clinical practice. The 2021 award was presented to **Krisda Chaiyachati, MD, MPH, MSHP (University of Pennsylvania Health System, Penn Center for Connected Care)**.

Research Awards

John M. Eisenberg National Award for Career Achievement in Research—Presented to **Mary M. McDermott, MD (Northwestern Medicine)**, in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator of the Year—Presented to **Seth A. Berkowitz, MD, MPH (University of North Carolina at Chapel Hill School of Medicine)** for early career achievements and overall body of work that has made a national impact on generalist research.

Mid-Career Research Mentorship Award—Presented to **Urmimala Sarkar, MD, MPH (University of California, San Francisco School of Medicine)** in recognition of mentoring activities as a general internal medicine investigator.

Best Published Research Paper of the Year—Presented to **Safiya Richardson, MD (Zucker School of Medicine at Hofstra/Northwell)**. This award is offered to help members gain recognition for their papers that have made significant contributions to generalist research.

Founders' Grant—Presented to **Karla Kendrick, MD (Johns Hopkins Bayview Medical Center)**. The SGIM Founders Award provides \$10,000 support to junior investigators who exhibit significant potential for a successful research career and who need a “jump start” to establish a strong research funding base.

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Lawrence S. Linn Award—Awarded to Benjamin Hayes, MD (Gwinnett Medical Center). This award provides funding to a young investigator to study or improve the quality of life for persons with AIDS or HIV infection.

Clinician-Educator Awards

National Award for Career Achievements in Medical Education—Presented to Diane B. Wayne, MD (Northwestern University Feinberg School of Medicine) for a lifetime of contributions to medical education.

Frederick L. Brancati Mentorship & Leadership Award—Presented to Valerie G. Press MD, MPH (University of Chicago, Division of the Biological Sciences, The Pritzker School of Medicine). The Brancati Award honors an individual at the junior faculty level who inspires and mentors trainees to pursue general internal medicine and lead the transformation of health care through innovations in research, education, and practice.

National Award for Scholarship in Medical Education—Presented to Adam Sawatsky, MD (Mayo Clinic–Rochester) for his individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

Mid-Career Mentorship in Education Award—Presented to Jennifer Corbelli, MD (University of Pittsburgh Medical Center). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician educators.

Presentation Awards

Mack Lipkin, Sr.—Associate Member Awards are presented to the scientific presentations considered most outstanding by students, resi-

dents, and fellows during the 2021 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The following are the award winners for 2021:

- **Adam A. Markovitz** (University of Michigan Medical School) for abstract presentation “Double-Bonuses to Medicare Advantage Plans Do Not Increase Enrollment, Enhance Quality or Promote Equity”
- **Michael Sun** (University of Chicago Medical School) for abstract presentation “Negative Patient Descriptors: Documenting Racial Bias in the Electronic Health Record”
- **Minhee Sung, MD** (Yale School of Medicine) for abstract presentation “The Association of Prescribed Opioids and Incident Cardiovascular Disease in the Veterans Aging Cohort Study”

Milton W. Hamolsky—Junior Faculty Awards are presented to the scientific presentations considered most outstanding by junior faculty during the 2021 SGIM annual meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The following are the award winners for 2021:

- **Paula Chatterjee, MD, MPH** (University of Pennsylvania School of Medicine) for abstract presentation on “Structural Racial Disparities in the Allocation of Medicare and Medicaid Disproportionate Share Hospital Payments”
- **Margaret Lowenstein, MD, MSHP** (University of Pennsylvania School of Medicine) for abstract presentation on “Sustained Implementation of a Multi-Component Strategy to Increase Emergency Department-Initiated Interventions for Opioid Use Disorder”

- **Karly A. Murphy, MD, MHS** (Johns Hopkins University School of Medicine) for abstract presentation on “Outcomes after COVID-19 Diagnosis for People with Versus Without Serious Mental Illness”

SGIM Clinical Vignette Oral Presentation Awards—Recognizes the best presented clinical case by a medical student, internal medicine residents or GIM fellows (not faculty) at the SGIM National Meeting. This year’s recipient is **Omar Moussa, MD** (Montefiore Medical Center) “Watch the Heart”

Distinguished Professor of Women’s Health Best Oral Abstract Award—**Anita Hargrave, MD** (University of California, San Francisco) for the abstract titled “University Screening for Military Sexual Trauma in the Veterans Health Administration May Miss Over 50% of Midlife Women Veterans with Military Sexual Trauma Exposure”.

Distinguished Professor of Women’s Health Best Poster Award—**Tierney Wolgemuth, MD** (University of Pittsburgh School of Medicine) for the poster titled “Are Internal Medicine Physicians Ready to Provide Medication Abortion?”

Distinguished Professor of Geriatrics Best Oral Abstract Award—**Mariah Robertson, MD, MPH** (Johns Hopkins University School of Medicine) for the abstract titled, “Inequities in the Care of Older Adults: Identifying Gaps in the Education of Geriatrics Fellows”

Distinguished Professor of Geriatrics Best Poster Award—**Nancy Schoenborn, MD** (Johns Hopkins University School of Medicine) for the poster titled “Life Expectancy Estimates Based on Comorbidities and Frailty to Inform Preventative Care of Older Adults”

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METHADONE DISPOSITION ON A FRIDAY

Dale Terasaki, MD, MPH

Dr. Terasaki (dale.terasaki@cuanschutz.edu) is an internist and addiction specialist practicing at Denver Health Medical Center and has an academic appointment in the Department of Medicine at the University of Colorado School of Medicine.

The following is adapted from actual patient encounters, illustrating complicated hospital dispositions for some patients maintained on methadone for opioid use disorder (OUD).

It's a spring Friday in Denver, Colorado. Despite flowers blooming a week ago, it snowed an arresting eight inches last night. I trudge my way into Denver Health Medical Center, the city's storied safety-net hospital, and turn on the pagers for addiction medicine consults. We have a physician-led addiction medicine team, providing specialty addiction care¹ to the numerous hospitalized patients suffering from substance use disorders. Our census today—a combination of new evaluations and potential follow-ups—is 46, although in the past it has been up to 65. We do not have the capacity to offer weekend coverage, so many disposition issues need to be *resolved today*.

Ms. G, pregnant and in police custody, is located in the correctional care medical facility (CCMF) at our hospital. She has been using fentanyl, benzodiazepines, and stimulants off and on for years and desires help with cessation. Yesterday, I started her on methadone, but this is a calculated logistical risk. While our hospital's opioid treatment program (OTP) has received a waiver to deliver methadone to the city jail and continue an individual's treatment after release, that is not the case in every county. Unfortunately, Ms. G also has charges in an adjacent county, where methadone is frustratingly not available.

Why not avoid this risk and use buprenorphine instead? Ms. G's last use of fentanyl had been only six hours prior to our initial visit yesterday and she was experiencing withdrawal. Fentanyl is short-acting, but confers a high risk of precipitated withdrawal in buprenorphine inductions.² This is likely related to fentanyl's lipophilicity,³ as chronic use may result in high amounts stored in adipose cells that continuously leak out into the blood stream for days. Ms. G has, in fact, experienced precipitated withdrawal multiple times in the past, even after 24 hours of opioid abstinence. Today, her withdrawal is moderately improved, but her methadone disposition remains *unresolved*.

My pager chirps. Mr. T came in with an intracranial hemorrhage after falling off a bicycle. He is currently connected with a local OTP (not ours) and is maintained on methadone 30mg daily. A surgical resident lets me

know that Mr. T may be discharged next week. The patient is planning to move to Louisiana and live with his parents. I worry about how he will receive his methadone, where he will receive it, and whether his care can be coordinated across state lines. I propose an idea to the patient: "You may have more flexibility in the upcoming move if we get you transitioned to buprenorphine instead of methadone." He listens, intrigued. Buprenorphine, unlike methadone, can be prescribed for opioid use disorder from our discharge pharmacy as a bridge to his eventual follow-up. After further discussion, we agree to begin a microdosing induction of buprenorphine, sparing him the uncomfortable period of opioid withdrawal required in a conventional induction. *Microdosing* involves using small, escalating doses of buprenorphine in combination with his full-agonist opioid (methadone) to avoid significant, abrupt displacement at the mu opioid receptors.⁵ I pull up the order-set and hit sign. Methadone disposition: *resolved for now*.

While evaluating Mr. T, I also noticed Mr. P—another consult patient—roaming gingerly down the hallway. He's all set to be discharged, departing for a city three hours south—bus arrangements are finalized—and continue his methadone at a clinic there. But then, a sudden realization hits me: his clinic may not be open on weekends. I call the clinic and the staff inform me that their clinic will indeed be closed tomorrow (Saturday). They suggest that he present to the emergency room for temporary doses of methadone, but it's hit-or-miss, depending on what hospital in that city he shows up to. This type of emergency dosing is legal⁴ but not universally offered. What would *not* be compliant with regulations is sending him out with a two-day methadone prescription from our discharge pharmacy. I ask if *his* OTP can request guest-doses at *our* OTP, which they seem hesitant about. They ask that written documentation of his dosing in the hospital, with my signature, be faxed over. I type a brief letter, print it out, sign it, fax it, wait. They subsequently need to get in touch with our clinic—which closes soon—*stat!* Methadone disposition: *unresolved*.

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SLOW PULSE, PLEGIA, AND POIKILOTHERMIA: AN UNUSUAL COMBINATION

Blake Brown, MD; Martin Giangreco, MD; Shanu Gupta, MD

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Introduction

Neuromyelitis optica spectrum disorder (NMOSD) is a rare, inflammatory disorder of the central nervous system that results from immune-mediated demyelination and axonal damage, predominantly of the optic nerves and spinal cord neurons. Studies estimate that the prevalence of NMOSD can be up to 10 people per 100,000.¹ Originally thought to be a variant of multiple sclerosis, NMOSD is a distinct entity based on the disease-specific serum NMO-immunoglobulin G that binds selectively to aquaporin-4 (AQP4). NMOSD is frequently associated with a number of systemic autoimmune disorders, such as hypothyroidism, pernicious anemia, ulcerative colitis, myasthenia gravis.² Although typically NMOSD presents with attacks of optic neuritis with transverse myelitis, it has been found that 1.8% of seropositive cases of NMOSD have reported bradycardia during their attack.³ Knowledge of the mechanism and cardiovascular associations with NMOSD could decrease delays in diagnosis and prompt initiation of therapy. Here, we present a patient whose initial presentation with bradycardia preceded the diagnosis of NMOSD.

Case Presentation

A 65-year-old female presented to the emergency department with two to three weeks of progressive generalized weakness, requiring assistance to ambulate by her husband. Two months prior, she experienced recurrent falls and was admitted to an outside hospital with bradycardia. She was diagnosed with sick sinus syndrome and underwent permanent pacemaker placement. Prior to that admission, the patient was teaching workout classes and engaged in moderate intensity exercise multiple times per week. After discharge, the patient reported increasing bilateral upper and lower extremity weakness, tremors, and difficulty ambulating. She had no personal or family history of autoimmune diseases and her only home medication was metoprolol tartrate. On initial physical exam, cranial nerves II-XII were grossly intact. She had hyper-tonia with clonus of the lower extremities bilaterally, left

arm fasciculations, and a resting tremor. Muscle strength was 3/5 in the upper extremities and 4/5 in the lower extremities. Grip strength was 1/5 in the right hand, and 5/5 in the left hand. Reflexes were 1+ at the brachioradialis, triceps, biceps, patellar, and Achilles' tendons. There was positive Babinski bilaterally, severe dysmetria with finger to nose bilaterally, and intact sensation throughout.

Her neurological condition quickly deteriorated, with onset of spastic progressing to flaccid quadriplegia, absence of reflexes, left eye blurry vision and pain with movement, and autonomic dysregulation with hypothermia, urinary retention, and bowel incontinence. Initial non-contrast CT of the head was within normal limits, with CT of the cervical spine revealing multilevel foraminal spondylosis and canal stenosis. Due to the clinical findings out of proportion to the CT results, MRI of the brain, orbits, and cervical spine were conducted, revealing scattered periventricular and subcortical white matter T2 hyperintensities, enhancing plaques adjacent to the lateral ventricles suggestive of demyelination, left optic neuritis, and increased T2 signal noted throughout the cord. Serum studies included ESR 38, CRP 0.86, blood cultures negative, HIV nonreactive, hepatitis panel negative, ANA screen negative. Cerebrospinal fluid was studied, with the following results: meningitis panel negative, lymphocytes 95, protein 174, glucose 73, IgG 16.3, VDRL non-reactive, negative MBP, and faint oligoclonal bands. Anti-aquaporin 4 (anti-AQP4) antibodies were positive, consistent with diagnosis of acquired NMOSD.

The patient was started on alternating doses of intravenous methylprednisolone and plasma exchange for ten days, without improvement in symptoms, followed by one dose of rituximab. She has follow-up with Neuroimmunology as an outpatient for continued rituximab therapy.

Discussion

Our patient initially presented with abrupt onset of symptoms attributed to bradycardia and had no per-

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VIRTUAL CASE-BASED CONFERENCES: AN EARLY COVID-19 EXPERIENCE

Jeffrey W. Redinger, MD; Christopher Ghiathi, MD; Tyler J. Albert, MD; Paul B. Cornia, MD

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With the implementation of social distancing measures during the COVID-19 pandemic, virtual educational formats became standard for many internal medicine (IM) residents.¹ However, most IM residency programs were not using synchronous virtual teaching previously² and little is known about residents' perceptions of the live video conference format. We surveyed our IM residents for their perspectives on live, virtual case-based conferences as compared to the traditional, in-person format, and we used this feedback to make rapid, iterative improvements.

At our hospital, morning report (MR) occurs four times per week and an intern-only conference, or intern report (IR), once weekly—both are led by a chief resident. Early in our local COVID-19 experience, both conferences assembled using Zoom™, with limited in-person attendance. Residents were encouraged to join the conference from their hospital team rooms, other University of Washington hospitals, or home. At the conferences, case information was written on an electronic whiteboard which was screen-shared with all attendees. Residents participated via microphone or a chat box, moderated by a chief resident or an attending. At least once per conference, trainees were placed into virtual breakout rooms for small group discussion of differential diagnoses, clinical reasoning, and/or management.

To determine residents' perceptions of these virtual case-based conferences, we developed a brief survey based on prior studies of MR.³ Prior to survey distribution, we tested the surveys with and obtained feedback from three IM chief residents on question clarity and answerability. The survey included an optional free text response for qualitative feedback. We distributed the anonymous, voluntary, 5-item REDCap™ survey at the end of each conference via chat box and institutional email. Trainees were invited to complete the survey after each conference session to share their perceptions of each virtual session. The survey was deemed exempt by the University of Washington IRB.

Thirty-three responses were collected over a four-week period from April through May 2020—22 for MR and 11 for IR. When compared to traditional in-person conferences:

- 24/33 (73%) responses rated the *overall* virtual MR/IR as “about the same,” while 4/33 (12%) rated it as “better” or “much better,” and 5/33 (15%) rated it “worse” or “much worse”.
- 22/33 (67%) responses rated the *learning environment* as “about the same,” and 7/33 (21%) rated it “better” or “much better,” and 4/33 (12%) rated it “worse” or “much worse”.
- 18/33 (55%) responses rated *personal engagement* as “about the same,” 9/33 (27%) rated it “better” or “much better,” and 6/33 (18%) rated it “worse” or “much worse”.

Additionally, most responses (25/33, 76%) “agreed” or “strongly agreed” that the use of virtual conference features (e.g., virtual breakout rooms, chat) improved the learning experience at MR/IR and 23/33 (70%) indicated a preference for at least some virtual conferences, even when in-person options may be safely resumed.

Twenty-nine of 33 respondents provided qualitative comments, each of which was coded into three different themes: (1) benefits of virtual learning, (2) challenges of virtual learning, and (3) feedback on virtual teaching tools. Forty-five percent of coded comments mentioned the benefit of increased accessibility of conferences and 21% of coded comments provided specific feedback on how to improve virtual technology use during conference. Key representative comments from the three themes included the following:

- (1) Benefits of virtual learning:
 - “I think that conferences should ALWAYS be offered virtually—mostly for us folks who are at home or in clinic with extra time to spare. Love it!”

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- “It’s nice in the virtual mode when we can put stuff in the chat box when we think of it and not interrupt.”
- (2) Challenges of virtual learning:
- “As a virtual participant, it can be difficult to know when to jump in with your audio without the in-person cues and view of the whole room.”
 - “There’s nowhere to participate except from our team rooms, which makes it very challenging to engage in learning fully.”
- (3) Feedback on virtual teaching tools:
- “Having a person running the chat box is really helpful for sorting through comments and allowing the person writing on the board to focus on other teaching things.”

Results of this small-scale survey suggest that our IM residents perceived the learning environment and overall educational quality of our virtual conferences to be similar to pre-COVID in-person conferences. Moreover, most responses noted a preference that conferences include a virtual option even after in-person

teaching resumes. Because we desired to obtain residents’ assessment of each conference, they were able to complete the survey multiple times if desired and this may have biased the results. The survey collection period spanned two rotation blocks permitting sampling of different groups of residents. The qualitative comments suggest that this is due to increased accessibility. Residents also had valuable suggestions to improve technology use, allowing us to perform rapid quality improvement iterations of our conferences. For example, we have worked to improve the team rooms as virtual learning spaces and we also now begin each conference by asking residents to enable microphones and video, if they are comfortable doing so. This feedback has helped to hone our virtual classroom, and we continue to elicit resident suggestions as a rich source of future improvements.

The COVID-19 pandemic forced educators to quickly adapt to the virtual classroom. Our survey data provides insight into the benefits and challenges of virtual synchronous learning. The generally positive responses from our residents to the virtual case-based conferences during

the COVID-19 pandemic, as well as suggestions for improvement, serve as a good starting point for future adaptations. We are aware that many hospitals, including our own, have now begun to shift to “hybrid” conferences (i.e., in-person plus synchronous virtual attendance). Since our learners desire it moving forward, it is essential that we continue to study the hybrid format and optimize our teaching practices for it.

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I receive a computer message from the nurse in the CCMF. Ms. G is being released from custody! Beyond the basic liberties again afforded her, she can now remain on methadone maintenance therapy, which in my opinion will give her the best shot at avoiding withdrawal, entering recovery, and maintaining custody of her future child. I breathe a sigh of relief. Methadone disposition: *resolved*.

I call our OTP with some apprehension for an update on Mr. P. “Did his methadone clinic follow through with requesting guest doses for the weekend in time?” My colleague tells me it’s all set up. He can discharge and pick up his weekend guest doses. Methadone disposition: *resolved*.

Now late Friday afternoon, I receive an urgent page from the OB/GYN service. Ms. L is in our obstetrics triage clinic, 30 weeks pregnant, experiencing opioid withdrawal. I rush down to see her. She was prescribed buprenorphine multiple times during her pregnancy, but it never felt like it was “enough” to curb her cravings. I suspect it’s time to offer methadone, which can be titrated

much higher than buprenorphine. I ask the team to admit her so we can work on dose titration quickly and get her connected with our OTP on Monday. “So, we can’t discharge her after dosing her?” they clarify. The team could technically do that, but our OTP and the state’s central registry (a database of OTP patients that must be reviewed to prevent dosing at multiple locations) are now closed. Ms. L would not be able to dose over the weekend unless she presented to the emergency department each day for a sub-therapeutic dose. I relay that to the obstetricians, thankfully amenable. Methadone disposition: *resolved*.

I leave the hospital, satisfied and bewildered. The snow has melted, but the Denver forecast is nothing if not erratic. Birds are singing. “Or wait, is that...” I think reflexively.

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ANNUAL MEETING UPDATE: PART I (continued from page 1)

care, or education. I encourage all of us to broaden our circles, incorporate new perspectives and ideas, and listen thoughtfully to our students and trainees so we can continue to improve the quality of medical education and its downstream impact on patient care outcomes.

Jennifer Corbelli, MD: Mid-Career Medical Education Mentorship Award. What is your Mentor Origin story?

I started as a mentor when I was a chief resident. This was when I learned how to approach mentoring—when do you need help from others to help your mentees? who needs follow-up? A lot of breadth and occasional depth. In my VA Women’s Health fellowship, I received incred-

ibly valuable training in mentorship, and I also had outstanding mentorship. That helped me think about my practice and I transitioned from “winging it” as a chief.

Before becoming a program director, my mentorship roles were easier and simpler in a way. Now, I work with 180 residents. It’s a dual challenge: For some normal mentorship stuff (imposter syndrome, attending difficulties, career advice) people are less likely to feel comfortable coming to me, and people with serious problems or who are struggling in residency are more likely to come to me. Even though I have fewer of the 1:1 relationships, my mentorship work now looks like when I was a chief, but amplified. It’s rewarding to be a part of that.

How have you continued to grow as a mentor?

One change I’ve had recently is that I’ve realized the effect that being a program director has on my mentees and trainees’ relationship with me. In my second year, I was on service with a very confident resident, and, at the end of the 2 weeks, they said it was hard because, as the program director, it’s intimidating to work with me. Now, I’m aware (that trainees may view me as intimidating or hierarchical) and I manage it, but it took some time for me to adjust and encourage people to see me in a way they can utilize me as a mentor. I have had some people go on academic probation, or fall ill, and I’ve been worried about them—and then you

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chair of SGIM Council, and working alongside Eric Bass, SGIM CEO, as a Society representative, has given me the opportunity to experience the roles of inspirator and director. I am grateful for these opportunities as they have given me skills to use outside SGIM.

SGIM invests in the success of its members through various career development workshops, special symposia, and longitudinal programs that all combine in-meeting and between-meeting educational activities. As noted in previous issues, SGIM is finalizing the implementation of the learning management system, *GIMLearn*, to facilitate career development and the storage of many enduring artifacts.³ This long-term investment will benefit us all in our future career development. Our deepest appreciation goes to Margaret Lo, who now leads these efforts, Mitch Feldman, former

Council member and initial leader of the Career Development Oversight Work Group, and Dawn Haglund, Director of Education, for motivating members and staff in their work to develop and implement this new career development tool.

Over the past few months, I asked you to focus on the skills necessary for ensuring resilience while facing the winds of change. I also challenged you to think about the need for “Love” and to show preparation, fortitude, and mutual support for each other. Further, we look forward to SGIM’s new program year and, as noted by the CEO’s Q &A in this issue of *SGIM Forum*, we are reviewing and committing to our activities of renewal.³ Each of these is part of our daily work as SGIM members and reflects how we demonstrate to our communities the different career roles of the academic general internists.

So, if you were to ask me whether my membership was/is worth it this year...the answer is yes.

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MORNING REPORT

 (continued from page 9)

sonal or family history of autoimmune diseases. The pathogenesis of NMOSD-associated bradycardia is believed to be due to anti-AQP4 antibodies disrupting astrocyte glutamate buffering in the nucleus tractus solitarius, leading to predominantly bradycardic v. excitatory effects on caudovagal neurons. It is important to consider autoimmune neurological diseases, such as NMOSD, in patients with progressive neurological signs and symptoms despite appropriate treatment for autonomic/cardiovascular dysfunction. Initial treatment is intravenous methylprednisolone, with plasma exchange as a rescue treatment in unresponsive patients.⁴ Long-term immunotherapy is indicated for prevention of attacks, to be started as soon as diagnosis is established. Eculizumab, inebilizumab, and satralizumab are approved, but data for optimal regimen and duration remains to be determined. There exists data that shows ritux-

imab has evidence of efficacy in preventing relapse at one and six years compared to other immunotherapies; it was chosen for our patient for this reason as well as physician preference and experience compared to other options.⁵

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see them make it and thrive! It's been rewarding in a new way. It feels like a tremendous privilege.

What advice do you have for people who want to become (better) mentors?

Mentorship is like anything else; it's a skill you develop. The experiences I had [being a chief resident, additional training in fellowship] are valuable but not necessary. Some of my best mentors have done neither of those things. So much of it is being available, engaged, and interested. Think through what you can offer. I also often see junior people not realize the value they have. So, you aren't a full professor—you still have experience and wisdom. And by caring, by being available, by drawing on your experiences, you can have tremendous value. Think about people who mentored you well. Ask people! I ask people for advice all the time.

Adam Sawatsky, MD: Scholarship in Medical Education Award. What inspired you to pursue a research career in medical education?

I knew I wanted to be a general internist, and the internists I admired in medical school at the University of Pittsburgh were all medical educators, so it just seemed natural. During internship, a senior suggested doing a research elective as a way to have time to chill—and then I realized I actually had to do research! I strug-

gled with (my first) project for 3 years trying to figure out how to do qualitative research, but when I finally published it, it was a really satisfying.

My current research in professional identity formation came partially from being a clinician educator, engaging with residents, and trying to reconcile both our struggles. In the end, being a clinician educator and medical education researcher link so beautifully; my research directly applies to my day to day.

What advice would you give to junior clinician educators interested in pursuing a similar career?

You can't do it all (as much as you love to think you can!). I had a lot of aspirations, and it's taken me a while to hone what I really want to spend my time on. For instance, I took on some administrative leadership roles within the residency program, which I loved because it connected me more to the residents. But, I didn't love that the administrative work took away time from the research that I really enjoyed. So recently I took a different position overseeing the medical education research being done in our resident continuity clinic. This aligned my skills and passions in medical education research with my desire to have a leadership role in the program. Some of this was serendipity, but also came from reflecting on how to align my passions and my goals.

Can you describe one of your biggest professional challenges and how you approached it?

One of the biggest challenges in medical education research is finding time and funding. Many avenues to support my work were one-year timeframes and linked to specific projects. As I've learned over the years, having one year to complete a research project is impossible. Having mentors who helped me navigate those challenges has been invaluable. They've advocated for me to find other funded time with more flexibility than my previous funding sources. This allowed me to finish up some of my prior projects and finally have the space to think about starting new projects on my own.

Do you have any other wisdom to share?

I can't overemphasize the importance of getting training in research. Those first years on staff are hard, especially trying to jumpstart a research career, and doing the fellowship gave me two years of protected time to think about my professional development. If you want to do medical education research or leadership, I strongly recommend doing a fellowship and getting a master's in medical education because it gave me the tools to be productive and get to where I am now.

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Distinguished Professor of Health Equity Best Oral Abstract Award—Lisa Mansfield, PhD, MSN, RN (University of California, Los Angeles David Geffen School of Medicine) for the abstract titled “COVID-19 Vaccine Acceptability and Hesitancy in Multiethnic Communities in Los Angeles County”

Distinguished Professor of Health Equity Best Poster Award—Carlos Oronce, MD, MPH (University

of California, Los Angeles David Geffen School of Medicine) for the poster titled “Interventions to Address Food Insecurity Among Adults: A Systematic Review and Meta-analysis”

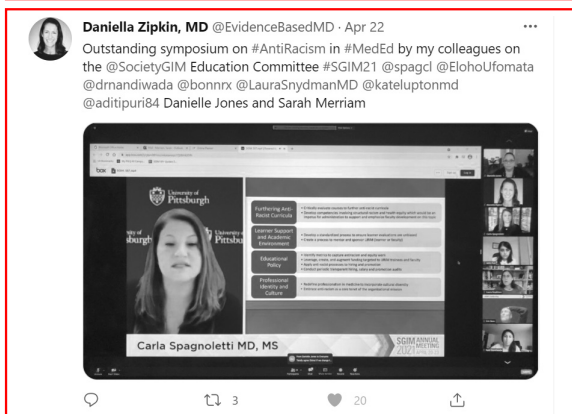
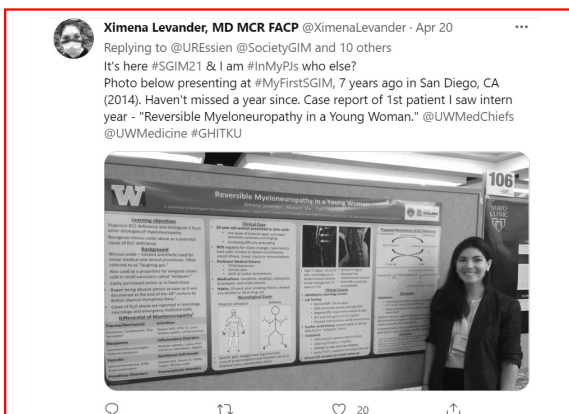
Distinguished Professor of Hospital Medicine Best Oral Abstract Award—Melissa Wei, MD, MPH, MS (University of California, Los Angeles David Geffen School of Medicine) for the abstract ti-

tled “Multimorbidity and 30-day Readmissions Among Medicare Beneficiaries Using a New ICD-coded Multimorbidity-weighted Index”

Distinguished Professor of Hospital Medicine Best Poster Award—Evan Shannon, MD, MPH (Brigham and Women's Hospital) for the poster titled “Investigating Racial/Ethnic Inequities in Interhospital Transfer at a Major Academic Health Care System”

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MEETING HIGHLIGHTS



SGIM members share 2021 SGIM Virtual Annual Meeting Highlights, including #MyFirstSGIM

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FROM THE EDITOR (continued from page 2)

ophies of care and interests just fit. It's the same moment I imagine other SGIM members can recall for themselves when they think about #MyFirstSGIM.

Over the years, I have grown roots in various professional homes—a natural occurrence given the complex systems of care, the synergistic and interdisciplinary aims of different healthcare disciplines and subspecialties, and the evolving nature and scopes of our general internal medicine workforce. Nevertheless, SGIM has a unique and cozy feel, a sense of belonging and connectedness, where so many members can say, “This is where *I* grew up.” This engenders a sense of family, where even if you might be away or distant for an extended time, much like what has occurred over the past one-and-a-half years during the COVID-19 pandemic, there is not only a craving to be

together again to enjoy each other's company; there is also a sense that when we are together again, it's as if little time has passed, that we can flow right back into where we left off last.

Like a family, we can celebrate each other's successes and achievements; this year, we celebrate several SGIM award recipients for their career-long work and contributions to the general internal medicine community, both at SGIM and beyond. Like a family, members engage also in debate and discourse, disagreeing on key issues—but then finding an agreeable pathway forward as a part of the same community. Like a family, members also look out for each other and help each other grow and advance in their careers, especially as SGIM creates a safe space for students, residents, and fellows to develop and find their places in the world as future general internists.

SGIM's first ever virtual annual meeting this year offered the best possible platform for reunion within the SGIM professional home, our professional family. On reflection, when I think about #MyFirstSGIM, perhaps it is not only that moment when I thought, “Aha! I found the place I belong!” It also brings along the memories of the journey that followed and also of the shared views and values we carry with us. Every year we will continue to have debates, celebrations, and foster growth among our members. This is just what the SGIM professional family, and home, does.

What is your #MyFirstSGIM moment or story? Continue the conversation in the Comments on the web version of this article or on Twitter with #MyFirstSGIM and @SocietyGIM in your post.

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