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PERSPECTIVE: PART I

FRONTLINERS INTERNATIONAL: A GLOBAL PANDEMIC AND THE RACE TO VACCINATE

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A year into the COVID-19 pandemic, the world is only just beginning to see true containment of the virus in sight. In a previous Frontliners International article, the pandemic was still in its first few months, but fears for a larger second wave were apparent in countries across Europe, Asia, and the Americas. Now, with vaccination drives in their early stages in many countries, there is optimism around the vaccines' effectiveness. As of March 24, 2021, the official figures stand at 124.95 million cases and 2.75 million deaths globally. However, a new statistic has entered the COVID-19 discourse: vaccination rates: More than 476 million vaccines (either first or second dose) have been administered across 111 countries.[1] While the number vaccinated continues to climb, the number of cases shows no signs of slowing—yet. SGIM spoke with three of our international members to reflect on the COVID-19 pandemic and what their vaccine roll-out plans look like.

What were your countries' initial policies to curb the spread of COVID-19?

Dr. Khoo: A Movement Control Order (MCO) under the Prevention and Control of Infectious Diseases Act 1988 and the Police Act 1967 was promulgated starting on March 18, 2020, in Malaysia to mitigate the spread of COVID-19. Mass gatherings were strictly prohibited. Most businesses were shut down except stores providing necessities. Malaysians were not permitted to travel abroad. For those returning from overseas, a 14-day self-quarantine was required. Schools, colleges, and universities were closed. Only essential services were permitted to continue operating.

Dr. Liakou: Very early during the pandemic, Greece had a crisis management team led by the prime minister. Members were physicians, economists, healthcare executives, and media experts. The lockdown was early, strict, and long. The country acted fast to begin cancelling large gatherings. The government banned all non-essential travel starting March 23, 2020. Standardized consequences for lockdown violators included strict and severe penalties, such as a €150 fine for individuals who did not follow lockdown measures.

Dr. Majeed: Initially, traditional methods of outbreak control were used: testing of suspected cases, contact tracing, and quarantine of suspected cases whilst awaiting test results. However, the public health system in the U.K. was soon overwhelmed by the speed and scale of the COVID-19 pandemic. Community testing and contact tracing were largely abandoned in March 2020. This led to a rapid increase in the number of cases, imposing significant strain on the health system and resulting in the U.K. having one of the world's highest infection and mortality rates from COVID-19.

How did the winter months and holiday season impact the number of COVID-19 cases in your country?

Dr. Khoo: We started seeing an upsurge in COVID-19 cases since October 2020 with approximately 3,000 new cases being detected daily. As of February 2021,

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PUBLISHING IN SGIM *FORUM*: CREDITING YOUR SCHOLARLY WORK

Maria G. Frank, MD, FACP; David Walsh, MD, FHM; Shanu Gupta, MD, FACP; Joseph Conigliaro, MD, MPH; Tiffany I. Leung, MD, MPH, FACP, FAMIA; and the SGIM *Forum* Associate Editors.

Drs. Frank, Walsh, and Gupta are SGIM Forum *Associate Editors. Dr. Conigliaro is immediate past Editor in Chief of SGIM* Forum. *Dr. Leung is current Editor in Chief of SGIM* Forum.

"Peer-reviewed or non-peer-reviewed? Indexed or non-indexed? Findable and citable? Tweetable? Open access?" During an Associate Editors (AE) monthly call in early 2021, we deliberated where *Forum* articles reside in a curriculum vitae (CV). Where do they live to recognize a physician's scholarly work? We agreed that peer-reviewed research articles in an indexed academic or scientific journal are easily categorized as scholarship; however, lines become blurred when addressing non-traditional types of scholarship—including letters to the editor, perspectives, and SGIM *Forum* articles.

The SGIM *Forum* editor team combined our collective experiences as academicians and AEs to make recommendations about how past or prospective SGIM *Forum* authors could list their articles in their CVs.

A Brief History on Scholarship

Classifying scholarly work is as variable as institutions' definitions of what that means. According to Ernest Boyer in 1990,[1,2] a work to qualify as scholarship should have the following qualities:

a) evidence of creativity and leadership;
b) clear objectives;
c) use of appropriate methods to assess quality or measure outcomes;
d) significant results that can be reviewed; and
e) evidence of impact and dissemination of the results, through articles or presentations or integration into current practice.

The CV is seen as a universal place to chronicle one's scholarship and professional trajectory; however, the concept of scholarship has broadened considerably. Many institutions are adapting promotion and tenure guidelines

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THE WINDS OF CHANGE

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

. . . I will continue to reach out to the members and use the most important skill a general internist has, active listening. The answers to many questions will be in SGIM webinars, commission, committee, and council meetings. It is fortitude that keeps me focused and resolute on the SGIM vision, "A just system of care in which all people can achieve optimal health." Every act for me as president will be focused on leading the organization in this direction. And finally support—the support is articulated in our mission, "cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone."

The only thing for certain is change….This statement has never been truer than during the past year which has been filled with so much change for all of us. For several weeks, the anticipated change of entering into the SGIM president-elect position came with thoughts of traveling to Birmingham, greeting old friends, establishing new relationships, and planning an enriching year with Jean Kutner with whom I have served before on Council. We were looking forward to transformational meeting focused on Social Determinants developed with Karen DeSalvo's guidance. Little did we know that the 2020 program committee's focus on "Just Care: Addressing Social Determinants of Health for Better Care" would be the wind that we would need to get through three-quarters of 2020.

For internists, 2020 was filled with waves of uncertainty and disbelief and 2021 continues to be a surreal experience. As hospitalists, we continue to maintain compassion, become experts in just-in-time clinical application, and protect ourselves and our families from exposure to the SARS-CoV2 virus. As leaders in health services research and systems science, at times our work was paused and at other times we were asked to speak to the public, explain our findings, and translate our decades of expertise into more digestible sound bites that would improve the policies enacted to care for our patients.

As parents in medicine we have struggled daily with the needs of our families and our patients and we

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Q & A WITH SGIM'S CEO AND THE CHAIR OF THE LEARNING MANAGEMENT SYSTEM (LMS) TASK FORCE

Eric B. Bass, MD, MPH; Margaret C. Lo, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Lo (Margaret.Lo@medicine.ufl.edu) was the chair of SGIM's Learning Management System Task Force.

Why is SGIM adopting a Learning Management System (LMS)?

SGIM Council acquired an LMS with two goals in mind: 1) serve existing members and 2) recruit new members by providing an effective platform to share content, offer scholarship, and provide continuing medical education (CME) and maintenance of certification (MOC) credits for professional development.

What was the LMS Task Force asked to do?

The Council created a task force in late 2020 that was charged to: 1) provide recommendations regarding revision of current committee and commission responsibilities related to educational content; 2) identify procedures and criteria that would enable effective governance, review, selection, and maintenance of content development; and 3) present a report to the Council by March 2021. The task force included members of SGIM Council, ACLGIM, and SGIM staff.

What is the LMS Task Force recommending?

The first recommendation calls for SGIM to develop a formal business plan for the LMS that includes an analysis of the potential return on investment and can help determine its financial value to the organization over time. The business plan should be part of the initial LMS implementation in partnership with the Finance Committee and should include fiscal goals for the LMS with specification of data needed to track the return on investment. The LMS should enhance the value of SGIM members' work, but not all LMS products should be free to members. Free content can impact perceived value and we believe SGIM can find creative ways to provide content to members and ensure a return on investment for the organization. The fiscal value of the LMS to SGIM's annual revenue should be a factor but not primary driver in content selection and delivery. The primary driver will be the delivery of content that supports SGIM's mission and vision.

The second recommendation calls for a new steering group to provide leadership in the identification, implementation, and curation of content for the LMS. The charge of this steering group includes the following:

1. develop clear rubrics, policies and procedures for selection and curation of LMS content;
2. develop operational structures and forms to assure that SGIM committees and commissions understand the process by which content gets submitted for LMS approval;
3. develop guidelines for offering CME/MOC credits;
4. develop evaluation quality metrics and a dashboard by which LMS products are reviewed;
5. develop evaluation criteria for the full life cycle of the content to ensure materials are continually updated for relevance and timeliness;
6. communicate quarterly, at minimum, with SGIM's committees, commissions, and regional leaders; and
7. report regularly to the Council in the next three years, with an expectation that the role of the group will evolve over time.

Group members will represent a diversity of expertise and perspectives, including content strategists, content planners, experts in CME/MOC, experts in educational program evaluation, and a business strategist. The work to develop, manage and maintain an LMS will require substantial effort by SGIM members and staff. As such, the task force believes that this new organizational entity is needed to build the infrastructure and oversee the development, delivery and evaluation of content that honors SGIM's mission and vision, while generating new revenue for the organization. Initially, Council will need to approve major strategic decisions and policies while generally entrusting content selection to the steering group.

How will content be selected for the LMS?

The task force recommends that the steering group deploy a staged process for content development, tak-

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FACULTY SELF-DIRECTED LEARNING: COVID-19 AS A CATALYST

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The COVID-19 pandemic is a humble reminder of the continuous nature of personal clinical growth. While hospitalist faculty see value in self-directed learning (SDL)—setting predetermined goals, eliciting feedback, and promoting repetition—most cite multiple barriers to such practice, including immediate demands of patient care that constrain time and cognitive bandwidth, exposure to a wide range of low prevalence diseases, and limited access to tools and programs.[1]

Prior to the COVID-19 pandemic, our hospitalist group was developing a program to foster self-directed learning through patient follow-up and shared group-learning. In a small group setting, hospitalists would review evidence-based guidelines, reflect on the clinical courses of prior patients, and evaluate their practice for concordance or discrepancies. The SDL cohort had a single session prior to the abrupt alteration in practice due to COVID-19. At our institution, this upheaval actually facilitated a rapid and iterative learning environment. On a much larger scale than pre-pandemic, hospitalists adopted behaviors associated with master clinicians: daily reading of primary literature, rehearsing clinical reasoning scripts, tracking patient outcomes, rigorously analyzing cases, and learning from peers in real-time.[2] Intrinsic motivation became more pronounced, driven by three key domains of autonomy, competence, and relatedness.[3]

We describe insights into these domains as they relate to COVID-19, and how this experience may be used to optimally foster intrinsic motivation for SDL in future faculty development efforts:

1. *Autonomy*: The pandemic created a "need to know" (or "need to learn") for everyday clinical decisions that could not be answered by calling on experts or looking to a guideline. This resulted in heightened sense of self-reliance or autonomy for hospitalists. The associated marked increase in SDL behaviors raised the question of how a hospitalist program could leverage autonomy when focusing on diseases where guidelines and specialists are widely available. While our program initially planned to focus on the general application of guidelines, after further appreciating the importance of autonomy, we pivoted to include discussion of more nuanced applications, such as a focus on guideline exclusion criteria. Using discussion and debrief of participants' cases, we aim to both refine clinical judgment and highlight the role of hospitalist autonomy by focusing on warranted and unwarranted exceptions to guidelines linked to actual patient outcomes.
2. *Competence*: In addition to the autonomy afforded to hospitalists by being de facto experts for patients with COVID-19, the opportunity for repetition ("practice") due to the unfortunate reality of surges inspired confidence that competence could be achieved. Knowledge gained through self-directed learning was utilized, extended, and reinforced daily while on the COVID-19 service. The positive feedback loop drove what appeared to be an insatiable need to gain more knowledge and more competence. This observation reinforced the programmatic importance of focusing on disease processes that are highly relevant (prevalence-based), urgent (due to gaps in care or adverse events), and allow for hospitalist ownership. Such topics may include addiction medicine, community acquired pneumonia, venous throm

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MEDICAL EDUCATION UPDATE FROM SGIM20 ON-DEMAND

Rachel Bonnema, MD, MS; Rachel Stark, MD, MPH; Katherine Lupton, MD; Milad Memari, MD; Attila Nemeth, MD; Eva Rimler, MD

All authors are members of the SGIM Education Committee

We report on the Medical Education Update presented during the virtual national meeting SGIM20 On-Demand. Six members of the SGIM Education Committee reviewed all manuscript titles from 14 major medical education journals published in 2019. Fifty-four (54) articles were assessed based on the following criteria: relevance to a GIM audience, importance of the study question, quality of methodology, and generalizability. Two reviewers independently assessed each article with 10 identified as finalists; group consensus identified the six papers chosen for presentation. Manuscripts spanning the scope of undergraduate, graduate, and continuing medical education were included. We offer a brief synopsis of each of the presented papers below.

Medical Student Access to EHR[1]

Electronic health records (EHR) are ubiquitous in today's healthcare environment and learning clinical documentation skills during medical school is essential. This study used a web survey of medical students to gather descriptive data to understand their use of the EHR.

Key Messages:

Students were randomly assigned surveys upon completion of USMLE Step 2 Clinical Knowledge (CK) between July 2011 and August 2016—16,602 responses were collected and analyzed. The authors created nine dichotomous variables that ranged from type of EHR access to specific activities performed by students. The authors compared responses between inpatient and outpatient settings and different levels of training (core IM clerkship v. sub-internship). Most students interacted with the EHR with a trend towards more interaction over time. Generally, students had more than "read only" access, but decreased access occurred more frequently in the outpatient setting. During this study period overall access improved, order entry dropped during core clerkships and increased during the sub-internship.

Strengths/Limitations:

The survey collected descriptive data and occurred prior to new Centers for Medicaid and Medicare Services (CMS) guidelines for medical student documentation. While there is hope that new guidelines will provide medical students more robust access, inconsistent uptake of these practices continues nationally. Cultivating medical students' skills in EHR use is important, determining CMS guideline change impact remains to be seen.

Resident Milestone Ratings and Training Progression[2]

Competency-based medical education rests on the assumption that learners must achieve a defined standard of performance before promotion. This mixed methods analysis examined milestone progression of a single cohort of internal medicine residents utilizing end-of-rotation assessments; 828/1869 (44%) assessments included narrative comments. Quantitative data was broken down by competency and PGY year, with a mixed-effects regression utilized to examine longitudinal trends across training years; qualitative data was coded into themes.

Key Messages:

The quantitative analysis indicated that resident ratings increased slightly but significantly in all but one ACGME competency—interpersonal and communication skills—over training. Ratings moderately correlated with narrative comments. The qualitative analysis identified work ethic as most common theme among all learners. Nearly all comments were praising, and three quarters of them classified as relevant. Results suggested that themes identified by narrative comments changed as residents progressed, reflecting changes in expected roles and competencies of residents.

Strengths/Limitations:

This is the first longitudinal study examining milestone progression within a single cohort of residents over the

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course of training. Limitations include: single institution study, only half of evaluations included narrative comments, and the absolute magnitude of variation was small in the final analysis.

Flipped Classroom v. Traditional Didactic Teaching[3]

The flipped classroom is an asynchronous learning experience where learners self-study basic concepts, preserving face-to-face time with instructors to strengthen concepts through active learning. This randomized study compared knowledge acquisition and retention of the flipped classroom method with that of standard didactic teaching utilizing a knowledge test distributed pre-intervention, post-intervention, and delayed post-intervention.

Key Messages:
The flipped classroom group performed significantly better than the standard group and this persisted at the delayed post-intervention assessment. Interns spent more time preparing for the flipped classroom, averaging 12 additional minutes, but felt the flipped classroom would not be feasible on inpatient rotations.

Strengths/Limitations:
A flipped classroom in a controlled residency setting improved knowledge without sacrificing satisfaction. Generalizability is the major limitation and results do not delineate whether the impact of the flipped classroom derived from the pre-work or the active learning experience.

Novel PrEP Curriculum[4]

The authors describe a curriculum teaching residents inclusive sexual history taking and HIV prevention care in a dedicated pre-exposure prophylaxis (PrEP) clinic at a single institution. They present mixed-methods evaluation data measuring participants' comfort and experience with sexual history taking, safer sex counseling and discussion of PrEP, specifically addressing LGBTQ patients.

Key Messages:
Of 34, 19 participants completed paired pre/post self-assessment surveys showing statistically significant increase in confidence in HIV prevention topic areas with greatest increases seen with initiating discussions about PrEP and sexual history taking with LGBTQ patients. In addition, 58% reported no prior training in providing PrEP. Semi-structured interviews highlighted increased confidence; this new awareness and comfort led to improved attitudes toward working with LGBTQ populations.

Strengths/Limitations:
This study addresses important and underrepresented curricular areas in residency training. Provision of PrEP is an important skill for primary care physicians and all physicians must be able to work sensitively with LGBTQ patients. Generalizability is questionable and it is unclear if self-reported comfort translates to improved observable skills or patient care.

Work Hour Restrictions and Patient Outcomes[5]

Since 2003, the Accreditation Counsel for Graduate Medical Education (ACGME) has proposed work-hour reforms though concern exists they will result in less robust clinical experience. This study examined whether physicians trained after 2003 ACGME work hour reforms had worse patient outcomes or higher costs of care in their first year of independent practice compared with physicians who completed residency before the reforms.

Key Message:
This retrospective observational study compared the 30-day mortality, 30-day readmission rate, and inpatient Medicare Part B spending between patients treated by first-year internists fully exposed to work hour reforms and those treated by first-year internists with partial/no exposure to the reforms. The authors created a difference-in-difference model, which compared the post-2006 period with the pre-2003 period. The authors examined a random sample (n=485,685) of hospitalized Medicare beneficiaries > 65 years treated by general internists. They found no significant differences between either group of first-year internists in 30-day mortality, 30-day readmissions, and inpatient Medicare Part B spending.

Strengths/Limitations:
The main strength is the access to Medicare data. One limitation was the use of Medicare Part B spending as a proxy for overall inpatient resource use. Another limitation was that this analysis focused solely on the impact of the 2003 ACGME reform, and the difference-in-difference approach assumed that reductions in work hours occurred sharply in the first year of the reform.

Primary Care Training Programs[6]

The authors examined how primary care internal medicine (PC IM) programs and tracks define ambulatory training and whether graduates of PC IM programs pursue careers in PC. They conducted a cross-sectional survey of primary care program directors between September 2012 and April 2013. Programs were identified by the NRMP and FREIDA databases and via website review. Further, 64% of program directors at 70 programs completed the survey.

Key Messages:
Most were affiliated with a categorical training program (98%), university affiliated (78%), and 38% reported HRSA funding. PC residents average 22.8 weeks/year training in the ambulatory setting. Most report specific curricula, most commonly: patient-physician communication, cultural competency, social determinants of health, and quality improvement. Regarding graduates: >50% pursued careers in PC or GIM, 10% pursued PC-oriented fellowships (i.e.,

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WE CANNOT ADDRESS COVID-19 WITHOUT ADDRESSING HOMELESSNESS

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The homelessness crisis in the United States is accelerating in the wake of economic hardships spurred by the COVID-19 pandemic. Many states, including our own of Colorado, had already seen a steep rise in the number of people experiencing homelessness (PEH) in advance of the pandemic, particularly among at-risk subpopulations such as those experiencing chronic homelessness and those living unsheltered.[1] Importantly, these point-in-time estimates do not reflect the impact of high rates of unemployment and the resulting wave of evictions, which has left many more Americans without secure housing, and strained already overburdened systems and resources.

As frontline internal medicine physicians, we witness firsthand the detrimental impact that lack of housing has on our unhoused patients—whose health is routinely compromised by stigmatization and marginalization, restricted access to resources, crowded and unsafe living conditions, and exposure to serious environmental and situational hazards. Tragically, these factors have only intensified during the COVID-19 pandemic. If we are to end this pandemic and meaningfully address health inequities, we must understand the growing threats faced by our unhoused patients, and acknowledge the ways in which they have been left behind in the public health response to COVID-19.

Living without secure housing is a potent determinant of individual health, and lack of housing has emerged as an important risk factor for contracting COVID-19. Congregate shelters, which thousands of people rely on for emergency shelter and vital services, are often crowded, poorly ventilated indoor spaces with hundreds of people passing through each day and sleeping on cots just a few feet apart. Not surprisingly, shelters were identified as hotspots for COVID-19 transmission early in the pandemic, with positivity rates of 25-66% in some shelters.[2] Some cities responded by attempting to de-densify shelters, but this reduces a city's total shelter capacity and necessitates the development of temporary shelters, an expensive and time-consuming undertaking limited by staffing shortages. With a decrease in shelter capacity, community encampments in some cities have expanded. Such encampments may be the only option for some unhoused people, particularly when shelters are overwhelmed or perceived as unsafe, and where the risk of viral transmission remains high.

People living in homelessness—who are disproportionately Black, Indigenous, and people of color—are at higher risk of being hospitalized with COVID-19, because of the presence of co-morbidities and systemic barriers that prevent equitable access to health care.[2] According to Denver Public Health data, PEH who contract COVID-19 in our city are over three times more likely to be hospitalized than the general population. Other U.S. cities have reported similar trends. When hospitalized, PEH face substantial obstacles to safe discharge and recovery, particularly amidst this pandemic. Patients discharged to the streets risk rapid worsening of their condition, re-hospitalization, or death. Despite the creation or expansion of medical respite and other recuperative and transitional housing options, the sheer demand and infectious concerns that accompanied COVID-19 have some all but exhausted these resources, contributing to excess length of hospital stays, morbidity and costs, and limiting acute care access within some communities.

While recovery after COVID-19 infection is highly variable, it is clear that symptoms may persist for weeks to months, or longer, resulting in substantial physical and mental health hardships, which may further limit employment, housing and other opportunities for social and medical aid for PEH.[3] Despite these risks; there has not been a clear, coordinated national strategy around vacci-

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nating PEH. Instead, determinations of eligibility for priority groups have been left to individual states to decide. The result is that Colorado and many other states have not yet prioritized PEH to receive vaccination. Unfortunately, this decision leaves a highly vulnerable population unprotected (which may further exacerbate health inequities), and directly undermines public health efforts to reduce community transmission.

As physicians and stewards of public health, we must act quickly to protect our unhoused patients by urging our elected leaders to consider housing status as an important factor in an equitable response to COVID-19. This includes immediate prioritization PEH, especially those residing in congregate settings, for vaccination. In our experience, vaccine acceptability among PEH is at least as high as the general population. A low-barrier, facility-based vaccination strategy for homeless shelters, similar to the approach utilized in other high-risk congregate settings such as long term care facilities, is likely to be the most efficient and equitable approach. The use of peer supporters, community leaders and shelter staff as "vaccine ambassadors" may enhance trust and increase vaccine uptake among vaccine hesitant individuals.

We must also call for an end to routine "sweeps" of our unhoused patients' encampments under the auspices of public health. Such actions destabilize patients' health and jeopardize trust at a time when building trust is essential to public health efforts to ending this pandemic. As physicians, we believe the swift creation of safe outdoor spaces and other options that allow for incorporation of hygienic resources and support in these communities will provide better health and protections for PEH with barriers to accessing emergency shelters, while longer-term solutions are being sought.

In this pandemic and beyond, we must collectively reach beyond the walls of our clinics and hospitals to create meaningful cross-sector partnerships with municipal leaders, public health partners, homeless services providers and members of the unhoused community. Such partnerships, which arose through necessity or were bolstered by the multi-agency pandemic response, may improve communication regarding impending threats and strengthen the community safety-net, and promote more effective advocacy.

Within these collaborations, we *must* advocate for large-scale funding for both short and long-term housing and support tailored to meet their unique needs of our unhoused patients. Such dedicated funding would provide a more proactive means of addressing homelessness. As with California's Project Roomkey, subsidized housing can serve as a conduit to meaningfully connect PEH with medical, psychiatric, and social supports necessary for longer-term recovery.[4] The City of Denver recently took similar steps by supporting a new, modest sales tax increase to fund the Homelessness Resolution Fund, which will support housing, shelters, outreach and supportive services for those experiencing or exiting homelessness.[5] We must also call on our elected leaders to expand evictions protections and rental assistance programs, to prevent our patients from falling into homelessness in the first place.

We cannot address COVID-19 without addressing the homelessness epidemic. The numbers in our unhoused communities are growing, their resources are jeopardized, and the fate of public health depends in large part on this population's prosperity. We must not abandon those at greatest risk during times of public health crisis. By joining our community partners in advocating for and procuring support for those experiencing homelessness, the medical community may do more than just conquer this pandemic. Indeed, we stand to reconnect with our humanity by serving a population in great need.

The views and opinions expressed by the individual authors do not represent those of Denver Health or the University of Colorado School of Medicine or Department of Medicine.

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ing into consideration the 2019 Career Development Oversight workgroup report and the 2018 CaREER Workgroup proposal.[1,2] The group will start by prioritizing existing content, then transition into new material after developing clear rubrics, procedures and plans for content selection, review and integration into the LMS. The task force recommends use of an evaluation tool similar to that proposed in the 2019 Career Development Oversight Workgroup report. The group will need to develop communication strategies to disseminate the rubrics, procedures, and plans to SGIM committees/commissions and membership-at-large. Materials should be deemed high quality by considering the timeliness of the content, its relevance to members, its practice-changing potential, and its impact on current clinical practice and policy. The content may include Annual Meeting content, longitudinal career development programs, webinars, courses, journal self-study, and CME/MOC assessments. Revenue generating content should expand over time with increasing external dissemination and outreach.

Many thanks to members of the LMS Task Force: Suzanne Brandenberg, Mitch Feldman, Reena Karani, Erika Baker, and Dawn Haglund!

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boembolism, and prognostication and advance care planning in patients with malignancy.

3. *Relatedness*: Motivation for SDL is spurred by a sense of relatedness.[4] In our initial program design, we anticipated that clinicians would experience a sense of relatedness by following up on patients with whom they felt a connection and/or those that added social meaning to provider's work.[5] During the COVID-19 era, however, we discovered that the social aspects of learning could extend beyond the traditional institutional walls. Meaningful collaboration and connections formed with colleagues at other institutions, many of whom experienced overwhelming surges of COVID-19 patients. There was a profound empathy for our colleagues and a sense of duty of sharing learning with one another. COVID-19 learning has demonstrated that relatedness, as a driver of SDL among clinicians, can extend beyond the accountability and interdependence with our patients and local colleagues to include connections with hospitalists at other institutions and with society more broadly.

COVID-19 acutely transformed our learning climate, and while we may not want to model all aspects of this education disruption, the pandemic has offered us the opportunity to improve our approach to faculty development by more deliberately considering and incorporating principles of autonomy, competence, and relatedness. By developing programs that focus on common and urgent diagnoses and incorporate nuanced guideline application as well as expanded peer engagement, intrinsic motivation is cultivated and emergence of self-directed learning more likely.

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we are in the third wave of the COVID-19 pandemic. The case fatalities are creeping up and the death toll [continues to climb] as of March 2021.

Dr. Liakou: At the beginning of November 2020, Greece experienced an acute increase of the COVID-19 cases [so] we entered a new lockdown that stopped at the end of January 2021. Therefore, we did not have any other public health emergencies during holidays. Schools were 100% on tele-education and all private and public companies on 70% mandatory teleworking. Shopping, restaurants, bars are still on lockdown (as of February 4, 2021). There were strict regulations that only six people from the same family could gather during Christmas and New Year's days. Additionally, there was a strong recommendation for these gatherings to involve the same people on both days.

Dr. Majeed: During the winter of 2020 and the holiday season, we saw a large increase in the number of Covid-19 cases in the U.K., with more than 50,000 new cases on many days. Pressures on the National Health Service also increased with a large increase in the number of hospital admissions during December 2020 and January 2021.

What factors (social, political, cultural, or otherwise) do you attribute to the success or failing of your country's response to COVID-19?

Dr. Khoo: Regardless of ethnicity, religion, or political affiliation, numerous organizations and companies work selflessly to optimize the PPE supply for the frontline workers. Fundraising events help provide medical personnel with the necessities. Frontline workers are constantly thanked for their sacrifices and dedication. We are thankful to Dr. Noor Hisham Abdullah (Director-General of Health) for his outstanding leadership in handling the pandemic in Malaysia.

Dr. Liakou: In Greece, the strong feeling of community and family values kept the patients and society safe early in the pandemic with a manageable 20-25 new cases daily. Even during the Christmas period, people followed strict lockdown with only 6 people able to gather from the same family.

Dr. Majeed: The U.K. is highly urbanized with many travelers to and from the country. This resulted in COVID-19 rapidly spreading across the U.K., overwhelming the public health infrastructure. In England, reductions in public health budgets in 2013 and consequent departure of, many highly experienced, medically qualified public health specialists weakened the public health infrastructure, including services for infectious disease control. A lack of COVID-19 testing capacity meant that people with COVID-19 did not get a test early in the pandemic when infection rates were the highest. Finally, for ideological reasons, the government relied heavily on commercial companies to implement its public health response (testing and contact tracing), rather than building on the existing infrastructure in the National Health Service (NHS) and local government.

Does your country currently have access to any of the COVID-19 vaccines, and if so, what is roll-out plan?

Dr. Khoo: The COVID-19 vaccines are estimated to be available in our country in the first quarter of the year. An agreement has been finalized to purchase the vaccines from Pfizer. A vaccination priority list has been created to protect the most vulnerable people, frontline workers from the healthcare and security sectors and then senior citizens 60 years and above and those with chronic diseases.

Dr. Liakou: We have access to the Pfizer and Moderna vaccines. Healthcare workers and those 85+ get the first doses. We started vaccinations on January 9, 2021 and 140,000 people have received the first dose of vaccine. Vaccination centers are located throughout the cities on public and private hospitals.

Dr. Majeed: The U.K. began its COVID-19 vaccination program on December 8, 2020, with the Pfizer vaccine. In January 2021, the AstraZeneca vaccine also began to be used. The Moderna vaccine is also approved for use in the U.K. The U.K. is currently ranked fourth in the world for the number of vaccine doses administered per person. Vaccines are delivered from a range of sites, including hospitals, general practices, pharmacies, and large vaccination hubs.

What do you perceive as the biggest challenge to getting your country's population vaccinated?

Dr. Khoo: Vaccine hesitancy. Not only does this happen to the new COVID-19 vaccines, but also occurs in our existing vaccines. Moreover, we do not know exactly if these new vaccines will be able to protect the people from severe infections. There is no skimping on the long-term safety data.

Dr. Liakou: I am not sure if we will have enough doses to vaccinate. Production is not adequate as of March 2021.

Dr. Majeed: The biggest challenge currently is a lack of vaccines as of March 2021. The NHS has considerably more capacity to vaccinate than it has vaccines. In the longer term, vaccine hesitancy will be a key issue, particularly once the U.K. starts vaccinating younger people.

Have you received the vaccine as of March 2021, and if so, what was your experience?

Dr. Khoo: I have not yet.

Dr. Liakou: I received the first dose. I developed a minor topical reaction on my arm for two days, and some myalgias for three to four days. Nothing serious, I am looking forward to the second dose!

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geriatrics), 25% pursued traditional subspecialty fellowship, 27% pursued careers in academic medicine. There was no correlation between pursuing PC/GIM employment and program size/age, having inpatient duties during ambulatory, a dedicated PC curriculum, and number of clinic sessions/sites/patient encounters per session. More weeks in the ambulatory setting was inversely correlated to pursuing subspecialty training.

Strengths/Limitations:
The study provides important information about primary care training programs, curricular time for trainees, and career choice of graduates, though survey responses relied on recall. The authors did not inquire about hospital career choices.

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"Greening" sculpture by Monique Donckers; Spa, Belgium. (*Tiffany I. Leung, MD)*

Seen while walking in the woods one Sunday morning near Ligonier, PA. (*Gaetan Sgro, MD)*

Dr. Majeed: I have received my first dose of Pfizer vaccine from a local hospital vaccine clinic. I had some mild side effects (sore arm, tiredness) that resolved in 2-3 days. I am awaiting my second dose as the U.K. government has decided to delay second doses of the Pfizer vaccine to 12 weeks compared to the usual 3 weeks.

Closing

As the pandemic continues into its second year, there is a sense of hope that the end of COVID-19 is finally near. Numerous vaccines have been approved for use, vaccination plans are being enacted around the world, and the hunger for a return to normalcy may finally be abated. However, vaccine hesitancy and a lack of vaccine access for many around the world may slow the decrease in COVID-19 cases. Around the world, SGIM members are aware of the challenges of the vaccination roll-out plans, but like us all, they are hopeful for a future in which the world is not controlled by the COVID-19 pandemic.

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to include works beyond traditional journal articles, including digital scholarship.[3] Additionally, imperatives to modify CVs to better reflect scholarship's breadth have been influenced by external factors, for example, the COVID-19 pandemic.[4]

"Traditional" scholarship or *scholarship of discovery* typically refers to classical, hypothesis-driven research that results in the generation of new knowledge. Successful "discovery scholarship" usually results in peer-reviewed scientific publications.

"Non-traditional" scholarship includes three types: [1, 2]

- *Scholarship of Application*: includes activities that build bridges between theory and practice or that apply knowledge to practical problems. Examples include development of new medical treatment modalities or clinical care pathways; activities that address community health care needs, shaping healthcare and public policy; or activities that promote patient safety and care quality.
- *Scholarship of Integration*: includes creative synthesis or analyses that define "connections across disciplines" or bring new insights to bear on original research. The scholarship of integration seeks to interpret, analyze, and draw together the results of the original research. Review articles and book chapters are examples of the scholarship of integration.
- *Scholarship of Education*: focuses on the development of new teaching methods, assessment of learning outcomes and dissemination of highly effective curricula or other instructional materials.

Although the consensus and understanding of scholarship has evolved since 1990, the CV structure resisted the passage of time. Academic institutions do not share a standard CV structure. The unintended consequence is that academic clinicians list their SGIM *Forum* published articles under a myriad of umbrellas or headers on their CVs. It is time to rethink how we document one's academic life course as the needs of our community change.

SGIM *Forum* Articles Are Peer-Reviewed

In academia, peer-reviewed publications are considered a scholarly gold standard. However, the reality is that peer review is heterogeneous: the number of reviewers, reviewers' expertise, the amount of time spent reviewing, and standards applied during review can all vary. Some journals use desk review—and desk rejection—by an editor to decide if a submitted article is timely and aligned with interests and content of the journal's audience. Desk rejection by an editor means no further peer review follows. Such variability suggests that there is no enforcement, auditing, or credentialing of the peer review process, even though there may be voluntary community norms.

Accompanying peer review, the assignment of a digital object identifier (DOI) to the work adds luster to such publications in a CV. DOIs permit indexing in a bibliographic database (e.g., PubMed) that can be beneficial for rapid dissemination of scientific work and raising the authors' scholarly profiles. To facilitate this process, many scientific journals use editorial management platforms with built-in pipelines for high-volume submission management and peer review. Using such complex manuscript submission processes in itself seems to add value to a peer-reviewed publication.

Most submissions to SGIM *Forum* are peer-reviewed—and often rigorously. The editor in chief reviews all articles and AEs volunteer to review, edit, and comment on submissions, working as a team to shape strategic direction and content of the newsletter. AEs also frequently correspond one-on-one with authors iteratively, akin at times to a concierge service, until the articles are ready for publication. In addition, AEs are frequently engaged with SGIM committee work and serve in leadership or

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realize there is no single perfect solution.[1] As women in medicine, we have banded together to understand the impact of the pandemic on our own lives, those of our families and academic medicine in general. More importantly, not just for those of us in academic internal medicine but for women in general. Members should continue look out for upcoming webinars, especially from the Women and Medicine Commission.[2]

As dedicated health policy advocates, we continue to put our values as the north star and vigorously promote policies that cultivate fair reimbursement and expand resources for health services research and health professions training.[3] As leaders and members of ACLGIM, we must continue to guide our divisions, departments, teams and colleagues through this period of great uncertainty while maintaining the hope that keeps us all going. Consider joining ACLGIM, to participate in excellent monthly sessions.[4]

As educators, we confronted the reality of virtual learning to ensure our patients' optimal care by the next generation of healthcare providers. This month, follow up with members of the Education Committee to hear about their work on anti-racism in medical education.[5]

As clinical managers, we have created new systems of care using technology when possible but emphasized to our healthcare systems that many of our patients are left without optimal healthcare options in that transformation. This month, check out the Health Policy and Clinical Practice Committees' continued advocacy on payment reform.[3]

We all witnessed the ways in which the pandemic brought historical frameworks that ensured injustice to the forefront. In response, our members banded together to ensure justice in their local, regional, and national environments. Our Board of Regional Leaders partnered with virtual learning experts to deliver high-quality content across SGIM regions. Our members committed to health equity, taking the work they had been doing for decades—most of which was the brainchild of former SGIM President JudyAnn Bigby and the Disparities Taskforce (now the Health Equity Commission)—to the boardroom, Twitterverse, and newsroom to highlight the ravishes of COVID-19 on the communities this organization is committed to serve. Consider joining the Heath Equity Commissions seminar series, for which the next planned sessions are advertised online when available for registration.[6]

As members of this organization, we are identifying unique ways for community building which is typically done at our annual meeting. It is a time when we gather as a group, nourish ourselves for the year ahead, and create a clear collaborative vision, lasting connections, research agendas, and fellowship. When we missed out on that opportunity in May 2020, not only did we lose out on the human need to socialize and create but also our organization had its financial vulnerability exposed. Again, we had to uphold our values and principles and move forward.

It was only two years ago or so, when then President Giselle Corbie-Smith, CEO Eric Bass, and Deputy CEO Kay Ovington worked to provide structural stability to our organization and to the work of commissions and committees—little did they know that their systematic approach to stabilization would soon be tested. This community is committed to SGIM, as seen through the lens of the initial success of the new Philanthropy Committee. Again, as we were challenged with the winds of change and financial hardship, SGIM focused on our values, those of staff engagement, the needs of our membership, diversity, equity, and inclusion to lead the way for the upcoming year.

As a sign of the Society's resilience, our main vehicles of dissemination remain robust. SGIM's eNews continues to keep us all abreast of the latest happenings. The transition to a new *Forum* Editor was seamless despite the necessity of an all virtual handoff. The *Journal of General Internal Medicine*, undaunted by the influx of submissions, continues to provide our community and those beyond with state of the art trustworthy research. Rita Lee and Yael Schenker used this energy to ensure we had a robust learning and collaborative environment for the annual meeting, "Transforming Values into Action." This meeting refreshed our commitment as leaders to effect positive change.

In looking ahead toward the upcoming year in this headwind of change, I have given much thought to what it takes to go outside. I hail from the "Windy City," and in that part of the world, it takes preparation, fortitude, and support. For preparation, I will continue to reach out to the members, and use the most important skill a general internist has, active listening, as I approach my year as president. The answers to many questions will be in SGIM webinars, commission, committee, and council meetings. It is fortitude that keeps me focused and resolute on the SGIM vision, "A just system of care in which all people can achieve optimal health." Every act for me as President will be focused on leading the organization in this direction. And finally support—the support is articulated in our mission, "cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone."

It is the members, in critical collaborations with the SGIM staff, that make SGIM go….so grab your hat, adjust your coat…the Winds of Change are ongoing.

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PRESIDENT'S COLUMN (continued from page 14)

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FROM THE EDITOR (continued from page 13)

at-large roles across the Society: they are often content experts and provide high-quality peer review. Ultimately, SGIM *Forum* publications are peer-reviewed scholarship.

Why Publish in SGIM *Forum*?

Publishing in SGIM *Forum* is a peer-reviewed scholarship activity. Reflecting on the scholarship categories, most SGIM *Forum* articles belong to at least one scholarship type. Perspectives, clinical updates, or policy updates lend themselves well to *scholarship of integration*. Timely topics in medical education frequently fall under *scholarship of education*. Research in progress is a form of *scholarship of discovery*. Sharing a morning report or institutional experiences that may be valuable to stimulate system change elsewhere can be a form of *scholarship of application*. Keeping SGIM *Forum* as a home for important reflective pieces, updates, and perspectives remains unique and distinguishing compared to traditional indexed, peer-reviewed original research content.

As the Society of General Internal Medicine's official newsletter, SGIM *Forum* provides a unique space for SGIM members to express opinions, ideas, or thoughts or report early stage findings from ongoing projects. Early career and trainee physicians may find this a welcoming space for scholarly publishing early in their academic careers, providing opportunities for exposure to academic writing and success.

We believe this newsletter offers a high-quality and suitable alternative to the gold standard. SGIM *Forum* is a non-traditional publishing platform that we believe has comparable academic currency. Furthermore, SGIM *Forum* has always been free for public access, with an abbreviated non-member account registration to access all current and archived content.

What We Recommend

How do we ensure SGIM *Forum* authors are well-positioned to receive appropriate academic value for their peer-reviewed publications? We concluded that the most accurate presentation for SGIM *Forum* articles on a CV is this:

- Peer-reviewed publications
  - *Non-indexed publications, Newsletters and Bulletins of Professional Societies*
    - Gupta, S. (2016) Reflections from a LEAD Scholar. *SGIM Forum*. 9 (12): 5.

In the absence of the embellishments of a traditional peer-reviewed publication, SGIM *Forum* still offers the value and prestige of peer review and should be readily acknowledged as such. We offer an ideal sandbox for thoughtful and critical dialogue: kindling leads to flames of thought and dialogue on contemporary issues relevant for SGIM members and our patients.

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