

SIGN OF THE TIMES

IF TRUST IS TO BE THE MANNER IN WHICH WE ASSESS, WE NEED TO LOOK INWARD

Katherine A. Gielissen, MD, MHS-MedEd; Benjamin R. Doolittle, MD, MDIV

Dr. Gielissen (katherine.gielissen@yale.edu) is an assistant professor of medicine and pediatrics, Yale Teaching and Learning Center Associate for resident and fellow development in medical education, and director of assessment for the Yale Primary Care Internal Medicine Program, New Haven, CT. Dr. Doolittle (benjamin.doolittle@yale.edu) is a professor of medicine and pediatrics and program director of the Yale Combined Internal Medicine-Pediatrics Program, New Haven, CT.

Imagine this: You attend on an inpatient medicine unit and assess a resident's ability to interpret an electrocardiogram (ECG) in a patient presenting with chest pain. As part of this assessment, you are asked to report the degree to which you trust the trainee to do this task, unsupervised. What thoughts run through your mind as you make this decision? Do you consider the trainee's board score or how long you have worked with them? Do you weigh the context of your decision or the complexity of the case? Or do you bring something else to the table, hidden even from you: Your own propensity to trust, biases, and beliefs? We believe a supervisor's ability to trust is a crucial element in accurately assessing the competency of our trainees.

Increasingly, Entrustable Professional Activities (EPAs) have been used to leverage competency-based assessment in graduate trainees. Indeed, some professional societies have initiated the groundwork to use EPA assessment as a basis for high stakes decisions, including readiness for graduation and board certification. EPAs show promise by creating moments of objectivity ground-

“Why do some preceptors trust more easily than others? Examining our own biases with authenticity opens ourselves to our own insecurities, our own failures, and our own moments of untrustworthiness.”

ed in our daily work. Did the resident obtain an ECG in that patient with chest pain and identify ST changes? Did they evaluate and manage the patient with new hyponatremia? Despite the general thrust towards EPA assessment in graduate medical education (GME), current validity evidence suggests we are not as objective as we believe.

Trust is the vehicle for trainee autonomy and the basis of entrustment; yet trust is a complex construct. Mayer, et al, previously defined trust as “the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party.”¹ In ancient Greek, the word for trust—πίστις (*pistis*)—can be interpreted as *faith*. The Christian New Testament describes trust as “the substance of things hoped for, the evidence of things not seen” (*Bible*, Hebrews 11:1).² The very nature of trust is belief in a reality for which we do not have direct evidence. Therefore, to trust a trainee to

continued on page 14

MORE TO LEARN, MORE TO TEACH

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

Preparing this month's issue of *SGIM Forum*—a second volume on the theme of “Medical Education Innovations and Explorations” from October 2022—happily coincided with a singularly important medical education milestone in the annual life cycle of SGIM: the #SGIM23 submission deadline for clinical updates, workshops, and interest groups. The Special Symposium submission deadline always seems to sneak up on us quickly at the summer's end. This second deadline can do the same, although it also seems to crescendo more slowly as a self-reinforcing sense of anticipation up until 11:59 pm ET on that fateful submission due date. Just in time, teams prepare and send in their best work for the upcoming annual meeting, serving their work up for peer-review judgment. Will that workshop or clinical update be accepted into the prestigious upcoming annual meeting of SGIM?

SGIM excels at diversifying educational offerings and ensures they are in keeping with contemporary issues and learning modalities. LeRoi Hicks, SGIM President, encourages us to explore various SGIM platforms for learning. Shelly-Ann Fluker and Milda Saunders, co-chairs of the SGIM 2023 Annual Meeting, share a glimpse of #SGIM23 ahead—and offer a gentle nudge on the early bird registration end date of December 1 (another date that sneaks up on us!). Each article in this issue seeks to support faculty in their routine work as growth-oriented and continuously learning professionals. For example, Greenberg, et al, describe daily teaching tips despite busy clinical demands, and Haynes, et al, suggest ways to go outside the standard learning box to challenge learners. Gielissen, et al, ask us to look inward at how we trust to become better educators. Also, when leading a division or department, one can work to systematize faculty support and development, as Ruff, et al, and Sakumoto and Dunn suggest in their articles. Eric Bass, SGIM CEO, and William Tierney, SGIM Philanthropy Committee Chair, remind us how valuable philanthropy efforts, like Forging Our Future, enable additional learning and career development programs possible for SGIM members.

There is always more to do, more to teach, and more to learn. This month's issue is loosely focused on aspects of faculty development and skill development as a clinician-educator. And SGIM always has much more to

continued on page 16

CONTENTS

1. Sign of the Times	1
2. From the Editor.....	2
3. President's Column.....	3
4. From the Society: Part I	4
5. From the Society: Part II	5
6. Medical Education: Part I.....	6
7. Medical Education: Part II.....	7
8. Medical Education: Part III.....	8
9. Medical Education: Part IV	10

SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

President

LeRoi S. Hicks, MD, MPH, FACP | Wilmington, DE
LeHicks@ChristianaCare.org

President-Elect

Martha S. Gerrity, MD, MPH, PhD, FACP | Portland, OR
Martha.Gerrity@va.gov

Past-President

Monica L. Lypson, MD, MHPE | New York, NY
mll2215@cumc.columbia.edu

Treasurer

Patrick G. O'Connor, MD, MPH, MACP | New Haven, CT
patrick.oconnor@yale.edu

Secretary

Gail Daumit, MD, MHS | Chevy Chase, MD
gdaumit@jhmi.edu

Secretary-Elect

Arleen F. Brown, MD, PhD, FACP | Los Angeles, CA
abrown@mednet.ucla.edu

COUNCIL MEMBERS

Vineet Chopra, MD, MSc | Ann Arbor, MI
vineetc@med.umich.edu

Marshall Fleurant, MD | Atlanta, GA
docfleurant@gmail.com

Cristina M. Gonzalez, MD, Med | Bronx, NY
crgonzal@montefiore.org

Margaret Lo, MD | Gainesville, FL
margaret.lo@medicine.ufl.edu

Brita Roy, MD, MPH, MHS | New Haven, CT
brita.roy@yale.edu

Eleanor (Bimla) Schwarz, MD, MS | Sacramento, CA
ebschwarz@ucdavis.edu

EX-OFFICIO COUNCIL MEMBERS

Chair of the Board of Regional Leaders

Thomas Radomski, MD | Pittsburgh, PA
radomskitr@upmc.edu

Co-Editor, *Journal of General Internal Medicine*

Steven M. Asch, MD, MPH | Palo Alto, CA
sasch@stanford.edu

Editor, *SGIM Forum*

Tiffany I. Leung, MD, MPH, FACP | Maastricht, NL
Editor.SocietyGIMForum@gmail.com

ACLMG President

Mark A. Earnest, MD, PhD | Aurora, CO
mark.earnest@cuanschutz.edu

Deputy Chief Executive Officer

Kay Ovington, CAE | Alexandria, VA
ovingtonk@sgim.org

Chief Executive Officer

Eric B. Bass, MD, MPH, FACP | Alexandria, VA
basse@sgim.org

Director of Communications and Publications

Francine Jetton, MA, CAE | Alexandria, VA
jettonf@sgim.org

MAINTAINING OUR CONTINUED EDUCATION: EFFORTS AT SGIM TO PROVIDE VALUE TO OUR MEMBERS

LeRoi S. Hicks, MD, MPH, FACP, President, SGIM

"Like many SGIM members, I am happy to have a diverse mix of job activities to keep me engaged and fulfilled. However, with all the work-related activities, a persistent gap is the lack of protected time I've carved out for maintaining my continued medical education..."



I thoroughly enjoyed my recent visit back to Boston, Massachusetts. It felt like forever since I sat in a room with so many people from other institutions, learning about the most recent medical advances and strengthening my clinical knowledge. In between learning about the effectiveness of SGLT-2 inhibitors in

heart failure and updates in VTE prophylaxis during the SGIM New England regional meeting, I reflected on how difficult it has been for me to carve out time to stay on top of the growth of medical advances and maintain my continuing medical education (CME). Routinely, I look through my calendar to map out my administrative priorities for the week. My calendar is often filled with meetings about medical and surgical departmental requests, quality and safety performance measures, healthcare labor shortages, concerns about coordinating transitions in

care, burgeoning virtual models for healthcare delivery in both acute and ambulatory settings, resident education priorities, and grant funding and philanthropic activities. In addition, I do my best to regularly meet with trainees and attendings physicians from underrepresented backgrounds and attempt to carve out time to meet with our system-embedded research unit to examine our portfolio and ensure it's appropriately aligned with our system's population health priorities. Like many SGIM members, I am happy to have a diverse mix of job activities to keep me engaged and fulfilled. However, with all the work-related activities, a persistent gap is the lack of protected time I've carved out for maintaining my continued medical education.

A few months ago, I was asked to be commencement speaker at a local high school and had the opportunity to speak to the kids about wonderful advances in science

continued on page 12

SGIM Forum

Editor In Chief

Tiffany I. Leung, MD, MPH, FACP, FAMIA
 Editor.SocietyGIMForum@gmail.com

Managing Editor

Frank Darmstadt
 frank.darmstadt@ymail.com

Past Editor In Chief

Joseph A. Conigliaro, MD, MPH
 jconigliaro2010@gmail.com

Editorial Board

Yousaf Ali, MD, MS
 Yousaf_Ali@URMC.Rochester.edu
 Seki Balogun, MD, FACP
 sab2s@virginia.edu
 Lauren Block, MD, MPH
 lblock2@northwell.edu
 Alfred Burger, MD, MS
 aburger.md@gmail.com
 Ricardo Correa, MD, EdD, FACP
 riccorrea20@hotmail.com
 Michele Fang, MD
 michele.fang@uphs.upenn.edu
 Maria Gaby Frank, MD, FACP
 maria.frank@dhha.org

Kittu Jindal Garg, MD
 jindal.kittu@gmail.com
 Shanu Gupta, MD, FACP
 shanugupta@usf.edu
 Tracey L. Henry, MD, MPH, MS
 tlhenry@emory.edu
 Christopher D. Jackson, MD, FSSCI
 cjacks67@uthsc.edu
 Francine Jetton, MA, CAE
 jettonf@sgim.org
 Eric Kutscher, MD
 eric.kutscher@nyulangone.org
 Megan McNamara, MD, MS
 Megan.Mcnamara@va.gov

Somnath Mookherjee, MD
 smookh@u.washington.edu
 Susana Morales, MD
 srm2001@med.cornell.edu
 Shobha L. Rao, MD
 shobha_rao@rush.edu
 Jorge A. Rodriguez, MD
 jarodriguez1@partners.org
 Gaetan Sgro, MD
 gaetan.sgro@va.gov
 Elisa Sottile, MD, FACP
 Elisa.Sottile@jax.ufl.edu
 David Walsh, MD
 dawalsh@augusta.edu

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 PHILANTHROPY COMMITTEE CHAIR ABOUT THE "FORGING OUR FUTURE" PROGRAM

Eric B. Bass, MD, MPH; William M. Tierney, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM.

Dr. Tierney (wtierney@iu.edu) is the Chair of the Philanthropy Committee.

EB: What do you see as the main goal of SGIM's Philanthropy Committee?

WT: The main goal of the committee is to instill a culture of giving among members who value what the organization has contributed to their careers and to the mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.¹ The committee pursues this goal through the "Forging Our Future" program that was launched in November 2020.

EB: Why did you agree to serve as the Chair of the Philanthropy Committee at this stage in your career?

WT: In 2000, right after becoming Chief of the Division of General Internal Medicine and Geriatrics at Indiana University, I was diagnosed with stage 3 non-Hodgkin's lymphoma with only a 50 percent chance of survival. I got pretty down in the dumps, and then my e-mail exploded with messages of support and comfort, mostly from my SGIM friends from all over the country. This went an enormous way to raising my spirits and getting me through the mental anguish of having a life-threatening disease. Not only did SGIM provide me with close friends I would never have known otherwise, it gave me opportunities for leadership and connections to successful people in my field that allowed me to grow as a leader. I'm convinced that without SGIM and its professional development programs and opportunities, I might not have become a department chair and an associate dean. Such programs allow us to meet and interact with new friends and colleagues and develop our professional and leadership roles. They are value-added but often can't be supported by SGIM's dues and meeting fees, which serve mainly to keep SGIM running with its many committees, commissions, and interest groups. Developing and scaling new initiatives takes philanthropic giving beyond dues and fees. Even amounts as small as \$10-25 per person make an enormous difference if most of SGIM's members contribute. I accepted the opportunity to succeed my dear friend Martha Gerrity as the Chair of the Philanthropy

Committee because I saw it as a great way to give back to the organization that did so much for me.

EB: What are your specific objectives for the Philanthropy Committee in the coming year?

WT: My specific objectives for the "Forging Our Future" program in fiscal year 2022-23 are to raise a total of \$250,000 in donations and pledges by the end of the year, to increase the rate of participation in the "Forging Our Future" program to at least 10 percent of members, and to recruit at least four more members to join SGIM's Legacy Circle for those who have made a commitment to a bequest or planned giving.

EB: Why is it important to support the "Forging Our Future" program?

WT: Professional organizations like SGIM succeed only through the generous contributions of their members' time, energy, talents, and resources. Donations help SGIM expand initiatives, doing for our more junior members what SGIM has done for you and me—promoting our careers in ways that have been challenging, rewarding, and impactful. Indeed, the funds raised by the "Forging Our Future" program last year enabled SGIM to invest in a new platform to facilitate mentoring activities beyond SGIM's Annual Meeting, double the number of participants in the Unified Leadership Training for Diversity (UNLTD) Program, increase the number of complimentary memberships for first-year general internal medicine fellows, and increase the number of scholarships for medical students and residents to attend the Annual Meeting. I hope members will consider an annual donation of any amount to allow SGIM to continue helping its members, especially its more junior members, to advance their careers in general internal medicine. I look forward to having more members join me in thinking of SGIM as part of their legacy.

References

1. Bass EB. Q & A with SGIM's CEO: Launching the forging our future philanthropy program. *SGIM Forum*. 2020; 43 (12): 4-5.

SGIM

THE 2023 SGIM ANNUAL MEETING: CRAFTING A VISION FOR GENERALIST INTERNISTS TO MEET THE PROMISE OF TOMORROW

Shelly-Ann Fluker, MD; Milda Saunders, MD, MPH

Dr. Fluker (shelly-ann.fluker@emory.edu) is an associate professor of medicine at Emory University School of Medicine and the J. Willis Hurst Internal Medicine residency program's primary care track director. Dr. Saunders (msaunders@uchicago.edu) is an associate professor of medicine at University of Chicago Medicine, a clinician-investigator, and the Associate Dean for Health Equity, Diversity and Inclusion at the Pritzker School of Medicine.

We are excited to be the chairs for the 2023 SGIM Annual Meeting to be held May 10-13, 2023, at the Gaylord Rockies Resort in Aurora, Colorado. When we look back at notes from our first meetings where we crafted the meeting theme, some phrases we wrote down stand out:

- “Our world has fundamentally changed”;
- “Generalists need to take a leadership role in innovation in research, education, and clinical practice”; and
- “The opportunities ahead of us are vast.”

From these phrases emerged our meeting theme: “General Internal Medicine: Meeting the Promise of Tomorrow.”

The theme acknowledges that we need to lead at the same time we navigate the rapid changes in how we prepare trainees, care for patients, and gather, translate, and implement the evidence that informs patient care and education. Our theme is a rally for members to highlight all the challenges the past two and half years have brought into stark relief, including mistrust of the medical and public health community, racial injustice, a rapidly changing political landscape, and changes to our climate and environment. Our theme is a call for members to explore, propose, and implement solutions that will forge



a future where everyone achieves better health.

The annual meeting program committee is hard at work structuring an inspiring meeting that will nurture a spirit of innovation. Our plenary speakers will each focus on key mission areas of medical education, research, and patient care/public health. For the first time, two speakers will kick-off our opening plenary—Drs. Reza Manesh and Rabih Geha, co-founders of the Clinical Problem Solvers—by discussing innovative ways to educate and inspire learners to find joy and fulfillment in their careers.

Our Malcom L. Peterson lecturer is Dr. Nakela L. Cook, Executive Director of the Patient-Centered Outcomes Research Institute (PCORI), who will discuss lessons learned from engaging patients, clinicians, and other healthcare stakeholders at one of the nation’s largest public health research funders.

We will keep prior innovations, such as the POCUS pre-course, Distinguished Professor poster walk and talks, Clinical Problem Solvers and Curbsiders podcasts, and trivia night. In addition, we added new features to this year’s meeting, including a Mary Horn Oral abstract session, physicians in government careers mentoring panel, and an SGIM community discussion. The Mary Horn Oral abstract session will highlight abstracts that

continued on page 11

THE MEDICAL EDUCATION LIAISON: IMPROVING LEARNER AND FACULTY EXPERIENCES IN THE AMBULATORY SETTING

Allison Ruff, MD, MHPE; Cornelius A. James, MD; Eve Kerr, MD, MPH

Dr. Ruff (alliruff@med.umich.edu) is a clinical associate professor and medical education liaison for the Division of General Medicine, Department of Internal Medicine, the University of Michigan. Dr. James (jamesca@med.umich.edu) is a clinical assistant professor of internal medicine, pediatrics and learning health sciences, University of Michigan. Dr. Kerr (ekerr@med.umich.edu) is professor and division chief in the Division of General Medicine, Department of Internal Medicine, at the University of Michigan, and research scientist at the Center for Clinical Management Research, VA Ann Arbor Healthcare System—both in Ann Arbor, MI.

Academic general medicine physicians frequently enter practice aspiring for participation in medical education for personal and professional fulfillment, but often experience barriers to incorporating meaningful teaching in their careers. Frequently, these faculty have competing interests focusing on clinical productivity and other non-teaching roles.¹ Some hesitate to engage in teaching because of limited formal training.² Many report a lack of familiarity with proven strategies to maintain efficiency and productivity while instructing learners.³ Others have difficulty identifying teaching opportunities. Additionally, the COVID-19 pandemic, and virtual care, have created deterrents to taking on teaching responsibilities as clinicians seek stability in their clinical practice and personal lives.

The ambulatory general medicine experience remains a key component of undergraduate (UME) and graduate medical education (GME), as ambulatory learning experiences are required by the Accreditation Council for Graduate Medical Education and Liaison Committee on Medical Education. Therefore, the recruitment and development of teaching faculty is key to maintaining both professional satisfaction of faculty and the long-term viability of learners' ambulatory general medicine experience. We present a novel approach—the medical education liaison (MEL) to support academic general internists in becoming effective and committed educators who improve the educational experiences of medical students and residents in an ambulatory setting. Two authors (AR and CJ) have served in this role for the past four years, and one (EK) has served as division chief in support of the MEL program.

Competing Priorities Detract from the Education Mission

You are a mid-career General Internist at your University position for the past six years. After residency, you wanted to be an educator, but felt it was important to establish your clinical practice first. You want to get involved in clinical education, but don't know where to begin.

Resident precepting is popular with your colleagues within the division, but you question your ability to effectively teach advanced learners. You'd love to teach medical students, but do not know how to connect with medical school programs and worry students will cause you to run behind in clinic.

The role of the Academic Medical Center has typically been defined by the tripartite mission: patient care, research, and education. Academic physicians subscribe varying amounts of time to this mission, with most physicians in academic General Internal Medicine (GIM) pursuing a clinician educator career path.⁴ Faculty may be further differentiated into “BIG C” and “BIG E” clinician educators: “BIG C” clinician educators see a high volume of patients while also teaching and mentoring learners. These faculty do not typically receive protected clinical effort to pursue training to improve teaching skills, or scholarly activity. “BIG E” clinician educators often lead educational programs or curricula, and actively participate in scholarly activity, including education research.⁴

Most GIM educators identify as “BIG C” educators. Sustaining a productive clinical practice, while simultaneously teaching in the clinic, challenges those desiring to continue down the clinician educator path. Unfortunately, many talented GIM educators stop teaching in the clinic because of the perceived unequal tradeoff between pursuing their passion for medical education and maintaining clinical productivity. This may leave learners with sub-optimal GIM clinical experiences, or worse, no GIM experience at all. Therefore, GIM division leaders must intentionally support faculty committed to the integral role of educating the next generation of physicians in an ambulatory setting.

Navigating the education landscape at a large academic institution can be daunting. Physicians may find it challenging to simultaneously keep up with medical advances affecting their practice and local and national policies and procedures at the UME and GME levels—this is especially

continued on page 13

EDUCATING BEYOND TRAINING: STRUCTURE AND TOOLS TO SUPPORT FACULTY DEVELOPMENT AND LIFELONG LEARNING

Matthew Sakumoto, MD; Andrew Dunn, MPH, MD, MACP, SFHM, FRCP

Dr. Sakumoto (matthew.sakumoto@ucsf.edu) is a virtualist primary care physician and assistant clinical professor at UCSF and co-leads the Medical Education Work Group of the Hospital Medicine Reengineering Network (HOMERuN). Dr. Dunn (andrew.dunn@mountsinai.org) is the chief of the Division of Hospital Medicine at Mount Sinai Health System in New York.

Introduction

Medical education extends beyond medical school, residency, and fellowship, and encompasses learning throughout a physician's career. General Internal

Medicine faculty need multiple drivers to support lifelong learning beyond the formal educational stage of their career. First, physicians who are not advancing their knowledge are falling behind; medical discovery and innovation requires physicians to remain current on the newest advances. Second, physicians who may become leaders need to use their knowledge and be skilled at applying it. Third, faculty can only become and remain outstanding educators by developing their own clinical and teaching skills. Lastly, faculty members who have a sense of confidence and expertise are less likely to develop burnout and more likely to find long-term career satisfaction. Despite the importance, faculty development typically does not receive similar emphasis as the education of students and trainees, and often lacks the same level of evaluation rigor as undergraduate or graduate medical educational programs.¹

Start with Structure

In a recent focus group with hospital medicine leaders, we found that many centers do not provide a formal faculty development program or only provide a brief onboarding session or hodgepodge of lectures. The lack of fully developed programs stems from a lack of evidence of specific interventions or frameworks. Our recommendation is to start early with an onboarding checklist that sets the tone of development and support immediately; your department or division can use this chance to make a great first impression.

The benefit of an onboarding checklist is that it literally gets everyone on the same page. As stated in

“#FacDev is the cornerstone for lifelong learning beyond the formal educational stage of a physician's career. See our suggestions for a structured and competency-based approach here!”

The Checklist Manifesto, “The volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely, or reliably. Knowledge has

both saved us and burdened us.”² For example, at the Mount Sinai Division of Hospital Medicine, the checklist includes elements related to clinical service logistics (e.g., how to assign new patients, how to bill) and the essentials of leading a teaching team and working with advanced practice providers (APPs) such as nurse practitioners or physician assistants. The number of items is a main hurdle to full understanding, as there are competing needs to be comprehensive and to be comprehensible.

A structured time for delivery, preferably by an experienced faculty member, is important. Getting new faculty members off on the right foot can also be facilitated by an “Early Start” system. This approach allows new faculty to pair with an attending on-service and be assigned a portion of their patients prior to their first full clinical week. Sharing a service for several days allows time for review of the checklist and hands-on learning of key facets of the service.

Competency-based Faculty Development

The authors recommend a move toward competency-based faculty development. By developing and adopting competencies and milestones in faculty development, our field can use a shared language to identify and disseminate best practices in faculty development. For example, Ripley, et al, in “A competency-based approach to faculty development” identify five key areas of competency, including Teach, Discovery (including research), Service (both clinical service as well as academic contributions), Advancement, and Leadership.³ A multi-faceted

continued on page 15

ELEVATE YOUR AMBULATORY TEACHING: SUPPORTING HIGH-PERFORMING LEARNERS

Christine Haynes, MD, MPH; Sarah Christensen, MD; Yasmin Sacro, MD

Dr. Haynes (Christine.Haynes@dhha.org) is an assistant professor in the Department of Medicine at the University of Colorado School of Medicine and the assistant program director of the Primary Care Track of the University of Colorado at Denver Health.

Dr. Christensen (Sarah.Christensen@dhha.org) is an associate professor of clinical medicine in the Department of Medicine at the University of Colorado School of Medicine and the senior resident clinic director for the internal medicine residents at Denver Health. Dr. Sacro (Yasmin.Sacro@dhha.org) is an associate professor of medicine in the Department of Medicine at the University of Colorado School of Medicine and the primary care track program director for the University of Colorado at Denver Health.

There is a large body of medical education literature that provides critical resources for educators focused on supporting struggling learners. However, we also teach many superstars—medical students and residents who are already exceeding expectations. These learners equally deserve to be challenged, to have their knowledge grow by confronting unfamiliar situations, and to practice new skills. As educators, we need resources and ideas to help us support the learning and growth of our high performers.

As part of our faculty development curriculum for our ambulatory preceptors, we organized strategies to use when teaching the learner who already has mastered the knowledge domains for a particular patient. We used the pharmacy, business, and medical education literature to identify overarching principles (avoid boredom, offer autonomy, provide both positive and constructive feedback, take a collaborative approach).¹⁻⁴ However, the limited number of articles available offers a small number of specific suggestions and lacks more detailed resources. We aimed to build on this framework and use our own clinical experience to provide a more extensive list of tangible strategies educators can use. We organized concepts into groups to make them easier to remember (improvise related learning points, individualize your teaching, make the learner the teacher, miscellaneous). We then refined this list through interactive sessions with our experienced clinical faculty. While not comprehensive, the following provides a starting point for those who are searching for ways to challenge these learners.

Improvise Related Learning Points

These strategies aim to challenge learners who have already mastered a particular skill by improvising creative teaching points while taking advantage of the base case.

- *Complicate the scenario.* What if the patient did not have insurance? What if she was allergic to amoxicillin, or the A1c was actually 10%, or he was traveling out of the country tomorrow?
- *Probe the thought process.* Ask for their reasoning to ensure they understand the clinical decision making and are not just repeating what they have been taught in the past.
- *If/then documentation.* Residents often provide coverage for each other's primary care patients. Clear "if/then" documentation in their clinic notes ensures they are thinking one step ahead to challenge themselves while also making follow-up easier for their colleagues.
- *Share interesting cases.* If one learner has an exciting case during a clinic day otherwise filled with common presentations, encourage them to share the details with the group.
- *Expanding resource horizons.* Even if a learner makes a correct treatment decision, there is often an opportunity to refer them to a resource to help guide similar decisions in the future, such as the American College of Radiology Appropriateness Criteria for choosing an imaging study or major society guidelines when treating a nuanced condition.
- *Inbasket cases.* Learners often request exposure to medical conditions that may not just walk through the door. Having them call patients to review DEXA or PFT results, for example, gives them the opportunity to explain and treat osteoporosis or COPD via telemedicine.

Individualize Your Teaching

The following strategies utilize more involvement from the learner to help adjust your teaching to their needs:

continued on page 9

- *Ask learner to self-identify learning goals.* This often provides an easy opportunity to teach about something you may not have known they wanted to learn about.
- *Ask learner to self-identify feedback goals.* Learners who are doing well may not get enough specific feedback. Offering feedback options (appreciation, coaching, or evaluation)⁵ allow you to probe what might be most helpful to a particular learner at their current stage.
- *Prepare for next stage in career.* High-performing learners who are going on to residency programs or fellowships that seem disconnected from their current clinical experience may struggle to find relevance in their work. Knowing about their plans and helping them to recognize why anemia is still relevant in emergency medicine or having the budding cardiologist optimize the patient's heart failure and save the elbow pain for another visit can keep them engaged and improve learning.

Make the Learner the Teacher

Teaching is a strategy both to reinforce learning points and to learn new material. It is also a challenging skill which many learners, especially residents, will need in their future outpatient practices but will have limited experience practicing in the ambulatory setting during their training.

- *Teach thought-process to adjacent learner.* If a resident demonstrates advanced knowledge in managing a particular patient, have them turn to a co-resident or student sitting nearby and teach them about the case.
- *Have resident teach you.* Encourage residents to look up primary literature or society guidelines and then share with you or with other learners in clinic. Alternatively, residents

pursuing subspecialty careers often already have significant knowledge in their future subspecialty area ready to share.

- *Precept another resident's scenario.* Near-peer precepting offers advanced residents the chance to precept interns in the ambulatory setting, a skill heavily valued and practiced in the inpatient setting but infrequently offered in the ambulatory setting. This provides attendings the opportunity to also give residents feedback on their teaching skills.
- *Supervise medical students.* Residents are often ideal student preceptors, as they are closest to the medical student experience and remember which teaching techniques are most effective, while simultaneously challenging them to teach to the student's level.

Miscellaneous

There are many other strategies that do not fall neatly into one of our three main areas, but that can prove invaluable.

- *Bask in praise/solidify positive experience.* Imposter syndrome is rampant in medical training. Even our most impressive learners can benefit from specific praise. Identify a clinic session in which you highlight the ways they excelled and encourage them to remember that positive experience in the future.
- *Direct observation.* For high-performing learners, this often may feel unnecessary. But sometimes it can identify unrecognized opportunities for improvement—or even just more opportunities for praise. To help find time for direct observations, options include standardizing it (once/week or month), aiming to do it at the beginning of a session (before things get too busy), focusing on procedures or specific exam skills, or aiming to

do just a partial visit.

- *Build relationships.* Help learners recognize the valuable input of all team members and think about more effective ways to utilize their interdisciplinary team. Encourage them to reach out to social workers or consultants to directly communicate and learn from each other.
- *Promoting equity.* Encourage the learner to think about ways in which social and structural determinants of health may be impacting the patient's care and brainstorm potential solutions.
- *Panel management.* Residents can be encouraged to outreach patients on their panel and try quality improvement interventions to improve their population health metrics.

Teaching high-performing learners is a rewarding and challenging opportunity. Utilizing some of these strategies can help ensure that we continue to support all our learners and help them to excel. Embracing the growth mindset means that we must recognize that we can grow as preceptors, and that even our highest achieving learners still have more they can take away from their training. We hope that this structured and specific list of techniques to use with high-performing learners serves as a resource for preceptors to expand their teaching. This will help us cultivate the next generation of outstanding clinicians, researchers, and teachers.

We would like to acknowledge the incredible General Internal Medicine faculty members at Denver Health whose commitment to ongoing faculty development as well as to helping advance the learning of our amazing residents helped us generate this list.

References

1. Guidry CM, Medina MS, Bennett KK, et al. The other side of “challenging learners”:

continued on page 11

BUSY CLINICIANS CAN STILL CONTRIBUTE TO MEDICAL EDUCATION

Garred Greenberg, MD; Mayce Mansour, MD

Dr. Greenberg (garred.greenberg@mountsinai.org) is a chief resident in the Department of Medicine at the Icahn School of Medicine at Mount Sinai. Dr. Mansour (mayce.mansour@mountsinai.org) is the associate program director for ambulatory medicine at the Icahn School of Medicine at Mount Sinai.

Looking at the pattern on the electrocardiogram, my own heart rate started to climb after I heard, “so what’s the rhythm?” My attending sat down next to me and quickly walked me through every step of reading an EKG, giving me a framework that I still use to this day. Despite the responsibilities of managing a busy inpatient service, he still made medical student education a priority. Later, as an internal medicine intern in New York City during the onset of the COVID-19 pandemic in 2020, I found my clinical responsibilities all-consuming. However, my passion for medical education remained. As the surge passed, I started to plan a medical education project to teach clinical problem solving on high-yield cardiology topics to third- and fourth-year medical students, while keeping in mind both my time limitations as a resident and the students’ rigorous schedule.¹ This is when I was presented with the challenge faced by all clinician-educators: how could a physician with significant clinical responsibilities create a time-efficient intervention to contribute to medical student education?

Tip #1: Use the Flipped Classroom Model

While the bulk of medical education traditionally involves large group lectures, poor attendance reflects an important limitation of this modality. The Association of American Medical Colleges 2021 survey of second year medical students revealed that fewer than 30% of respondents attended in-person pre-clerkship lectures most of the time, and only 43.1% attended virtual lectures most of the time.² Novel educational techniques, such as the flipped classroom model (FCM), have been developed to improve learner engagement.³ In an FCM, students prepare for an educational session on their own time. Time with the instructor is reserved for problem solving using higher-order thinking. I utilized the FCM to teach cardiology topics to maximize the time in group sessions that was spent on clinical problem solving. The medical students who participated in my course proficiently acquired basic knowledge on their own by reviewing pre-selected materials. This allowed us to

focus our in-person session on the complex nuances of clinical cases.

Tip #2: Teach Small Groups

Small group sessions are essential to engaging your learners. While teaching smaller groups may seem less time efficient, as it involves less learners per session, it can increase learner engagement and result in a greater impact on each student. When teaching over an online videoconferencing platform, commonplace during the pandemic, participation is more difficult as groups of students are often unable to focus on the presented material.

My FCM cardiology sessions were conducted via videoconference, with roughly four medical students per session. I set the expectation at the beginning of each session that everyone should have their video on and that we would participate in a fixed rotation. This allowed everyone in the group to be continuously involved and engaged.

Smaller group sessions have many advantages—for example, they are more flexible to schedule and provide the opportunity to connect with your learners on an individual basis. This enables you to diagnose your learners and teach to their level. Further, students are provided with more airtime to actively participate, helping them build communication and teamwork skills and providing them with the individualized attention needed when teaching complex topics.

Tip #3: Recycle Existing Resources

It can be exciting to think about creating a new resource for trainees, whether it be an instructional video series, a question set, or an interactive app. However, there are already a plethora of high-quality learning resources available to medical trainees. To save time, I recommend searching for existing guides, reviews, apps, online videos, or question sets to provide to your learners. MedEdPORTAL can be a great resource for identifying successful educational interventions.⁴ I provided my medical students with snippets of review articles, descrip-

continued on page 11

embody the values of the Mary Horn Award program that promotes a healthy balance between personal and professional responsibilities. The physicians in government careers mentoring panel will include Dr. Nakela L. Cook as well as SGIM members who have held roles in local and federal government. Our SGIM community discussion will be facilitated by our president, LeRoi Hicks, and will include a panel of SGIM members. We will discuss how

SGIM can best support our members who live and work in states whose policies run counter to their own and SGIM's core values.

We are grateful to our program committee members as well as all of you who have already submitted your work for consideration or volunteered to serve as a peer reviewer. Our special symposia, VA special series workshops, clinical updates, and interest groups have been selected. Submissions are now

open for scientific abstracts, clinical vignettes, and innovations in medical education and healthcare delivery. The submission and review periods for scientific abstracts, clinical vignettes, and innovations in medical education and healthcare delivery is earlier this year than in past years. The submission deadline is now *December 19, 2022*, and the peer-review period will occur from *January 3-17, 2023*. This change

continued on page 12

MEDICAL EDUCATION: PART III (continued from page 9)

- Strategies for teaching and precepting the overachiever and high performer. *Am J Health-Syst Pharm.* 2022;79(2):17-22. doi:10.1093/ajhp/zxab348.
2. Knight R. How to manage your star employee. *Harv Bus Rev.* <https://hbr.org/2017/06/>

- how-to-manage-your-star-employee. Published June 30, 2017. Accessed October 15, 2022.
3. Morgan S. Supervising the high-light performing general practice registrar. *Clinical Teacher.* 2014;11(1):53-57.

4. Seehusen DA, Miser WF. Teaching the outstanding medical learner. *Fam Med.* 2006;38(10):731-5.
5. Stone D, Heen S. *Thanks for the Feedback.* Penguin Books; 2014.

SGIM

MEDICAL EDUCATION: PART IV (continued from page 10)

tive graphics, and links to helpful YouTube videos.

Tip #4: Stick to High Yield Topics

I recommend sticking to high yield topics when teaching medical students. It can be tempting to discuss a rare and exciting condition. However, common topics are more likely to be tested and employed in clinical practice. Therefore, a session teaching common topics will result in a greater impact for the time invested. Management of rare conditions can be addressed during specialty training. Using my own experiences as an internal medicine resident on the wards, I knew that heart failure, acute coronary syndrome, and tachyarrhythmias were common medical conditions that students could expect to encounter during their rotations. I focused only on these three topics for my flipped classroom sessions.

A key role for physicians is to provide education to new trainees to

help sustain the field and improve the size and skill of our workforce. As our population ages, the demand for skilled physician labor will increase significantly; but, with busier clinical practices, our supply of time to teach will become more limited. As a result, we must plan our educational interventions carefully to maximize the impact of our time. Keys to time efficiency include utilizing the flipped classroom model to increase the value of time in the classroom, teaching small groups to increase learner engagement, focusing on high yield topics, and making use of pre-created resources instead of starting from scratch. With these techniques, we can focus our time to coach our learners through activities that require higher-order thinking and will have a greater impact.

Acknowledgements: We thank Dr. Alfred Burger for useful discussions and helpful feedback.

References

1. Greenberg GS, Mansour M. Evaluation of a novel cardiology undergraduate medical education curriculum. *Cureus.* 14(7): e27360. doi:10.7759/cureus.27360.
2. AAMC. Medical School Year Two Questionnaire 2021 All Schools Summary Report. <https://www.aamc.org/data-reports/students-residents/report/year-two-questionnaire-y2q>. Accessed October 15, 2022.
3. Hew KF, Lo CK. Flipped classroom improves student learning in health professions education: a meta-analysis. *BMC Med Educ.* 2018;18(1):38. Published 2018 Mar 15. doi:10.1186/s12909-018-1144-z.
4. AAMC. *MedEdPORTAL.* <https://www.mededportal.org/>. Accessed October 15, 2022.

SGIM

they'll see over the coming years. In the mid-1990s, during the time I was in residency training, there was great debate about the appropriateness of coronary artery bypass surgery versus coronary angioplasty in multivessel heart disease, drug eluting cardiac stents had yet to be commonly used, and AZT was a relatively new treatment option for HIV. In the decades since, science has evolved so quickly that being a minimally competent physician requires consistent effort to learn to avoid atrophy and one's skill set, potentially placing patients at risk. Research shows that physicians who maintained their board certification (one measure of ongoing clinical competency) are more likely to: (1) improve their clinical knowledge, (2) improve their patients' clinical outcomes, and (3) avoid disciplinary action and medical license suspension.¹⁻² Thus, prioritizing ways of promoting continuing medical education among our members is a critically important priority for our society. Prior literature has shown that physicians report the lack of dedicated funding, limited time available for travel to educational meetings, limitations on protected time, and limited options for asynchronous education as barriers to maintaining their CME.³ I am pleased with the efforts educational leaders and staff within SGIM have taken to address so many of these barriers thereby facilitating opportunities for our members to continue

developing their skill sets as clinicians, educators, and researchers.

My recent experience at the regional meeting provided examples of a few ways that New England region members could benefit from well-organized primary care updates and provided meaningful content for members with a hospitalist focus and did so with a low cost of attendance and without the burden of extensive travel time to more distant locations. Additionally, many of our upcoming regional meetings will take place virtually enabling content to be delivered in a way that offers a wide range of opportunities to those who are unable to travel or don't feel safe traveling in the current environment. SGIM also continues to see growth in the impact of the *Journal of General Internal Medicine*, our official journal, a great source of peer-reviewed science of interest to the academic internal medicine physician. Another way that SGIM is working to deliver value to its members as through our online platform GIMLearn. Through the hard work of our education committee and GIMLearn steering committee we have a platform that now contains highlights from #SGIM22, free webinar series on a wide range of clinical and policy topics and the ability to earn many CME/MOC credits related to sex and gender wellness. Also, I strongly believe in the focus on educational opportunities that presented in our annual meetings. In the issue of the *Forum*, our

#SGIM23 program committee leadership provides an update as to the meeting activities and speakers, many of which are intended to maximize the educational value of your society membership.

This is a great time to participate in SGIM meetings, both regionally and nationally, as so much is being delivered as an efficient means to promote CME. I urge each of us to further explore GIMLearn and contemplate ways in which we can share our academic teachings to the broader society.

References

1. Price DW, Biernacki H, Nora LM. Can maintenance of certification work? Associations of MOC and improvements in physicians' knowledge and practice. *Acad Med.* 2018;93(12):1872-1881.
2. McDonald FS, Duhigg LM, Arnold GK, et al. The American Board of Internal Medicine maintenance of certification examination and state medical board disciplinary actions: A population cohort study. *J Gen Intern Med.* 2018;33(8):1292-1298.
3. Pott MO, Blanshan AS, Huneke KM, et al. Barriers to identifying and obtaining CME: A national survey of physicians, nurse practitioners and physician assistants. *BMC Med Educ.* 2021;21(1):1-8.

SGIM

FROM THE SOCIETY: PART II

 (continued from page 11)

will allow SGIM members and staff an opportunity spend uninterrupted time with their families and friends over the winter break.

To those of you who have not done so, we ask you to submit your scientific abstracts, clinical vignettes, and innovations in medical education and healthcare delivery and/or to volunteer as a peer reviewer. Our SGIM meeting is most vibrant

when all members of our society participate.

Please join us at the Gaylord Rockies Resort in Aurora, Colorado, from May 10-13, 2023, as we push the frontiers of general internal medicine. The resort stands at the edge of the Front Range offering numerous opportunities for outdoor recreation while still being near the vibrant city of Denver. We encourage you to

register and reserve your hotel room early—reservations can be altered if your plans change. Early meeting registration opens on *November 30, 2022*—be sure to register before *March 14, 2023*, when standard registration rates go into effect. We invite you to partner with us as change agents crafting a vision for the future of health care. Join us in meeting the promise of tomorrow!

SGIM

true for “BIG C” clinician educators. Accentuating this knowledge gap, medical students and house officers often receive most of their clinical training in hospitals which are physically detached from the community-based clinics housing many GIM faculty. These are but a few factors contributing to the communication gap between academic GIM physicians and training programs. Similarly, medical school leadership, residency program leadership, and department vice chairs of education may lack understanding of both the unique circumstances at each GIM ambulatory site and the specific faculty development needs. The MEL can serve as a navigator to facilitate the development of “BIG C” educators.

The Role of the Medical Education Liaison

Your reach out to your MEL who facilitates connection with the clerkship coordinator. A student is placed in your clinical site and your MEL recommends a one-hour virtual workshop on giving feedback before you start. This gives you the confidence to start teaching more regularly.

To bridge the gap between GIM faculty and local education leadership, the University of Michigan (U-M) division of general medicine developed the MEL position in 2018. The MEL ensures that the teaching and learning experiences of faculty and learners in GIM clinics are mutually rewarding, while also providing efficient and effective patient care. To this end, specific characteristics are essential for the success of an MEL. Ideally, an MEL should be a well-respected “BIG C” or “BIG E” clinician educator. This person should be well-connected and willing to engage regularly with leadership and staff at the UME and GME levels; therefore, excellent communication skills are essential. Specialized education training can be considered but is not essential. In addition, a MEL should be visible in educational roles in the division and respected clinically—a frontline medical

educator and educational champion. Finally, MELs must be committed to diversity, equity, and inclusion to ensure that all faculty and learners feel welcomed and valued in GIM educational spaces.

U-Ms inaugural MELs were “BIG C” educators, selected to oversee GIM faculty interactions with learners and the development of the MEL role. These opportunities have influenced the careers of the inaugural MELs to become “BIG E” educators, and this role may serve as a steppingstone for other junior faculty interested in this trajectory.

In addition to serving as a link between GIM faculty and local medical education leadership, MELs facilitate education-based faculty development. For example, the U-M MELs have led conferences teaching faculty to provide effective feedback, write teaching scripts, and use precepting models. Other important contributions of MELs include maintaining a division medical education website (featuring latest medical education news, policies, and procedures, a repository of relevant medical education literature, and other useful medical education resources), recruitment of new faculty, developing scheduling templates for teaching, and identification and notification of teaching opportunities for faculty.

The MEL program has had measurable results—MELs were instrumental in securing a financial incentive for GIM faculty hosting medical students in their clinic. This departmental commitment demonstrates an appreciation for the valuable efforts of GIM clinician educators. Additionally, since beginning the MEL program, the number of faculty teaching medical students in clinic has increased, as has the number of clinical sites accepting learners for teaching. At U-M, a close working relationship with the Internal Medicine residency program allowed our MELs to play an active role in establishing a new continuity clinic site, introducing new opportunities for both faculty and resident learners.

To ensure the success of MELs, they must receive support from their division. At U-M, the MEL is a part of the divisional leadership structure. This not only increases the credibility of the MEL but also highlights the emphasis that the division places on education. MELs receive protected time for their role.

Conclusion

The MEL program gives attention to the unique needs of GIM faculty and ensures optimal educational experiences for learners in GIM clinics. While more study is needed into diversity and inclusivity in teaching as well as faculty experiences, codifying MEL programs for clinical educators in GIM can expand opportunities for quality ambulatory general medicine education for learners, encourage learner interest in primary care fields, and nurture the educational interests, professional development, and satisfaction of GIM faculty.

References

1. Fazio SB, Chheda S, Hingle S, et al. The challenges of teaching ambulatory internal medicine: Faculty recruitment, retention, and development: An AAIM/SGIM position paper. *Am J Med*. 2017;130(1):105-110. doi:10.1016/j.amjmed.2016.09.0042.
2. Steinert Y, Mann K, Centeno A, et al. A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8. *Med Teach*. 2006;28(6):497-526. doi:10.1080/01421590600902976.
3. Chung MK. Tuning up your patient schedule. *Fam Pract Manag*. 2002;9(1):41-45.
4. Chang A, Schwartz BS, Harleman E, et al. Guiding academic clinician educators at research-intensive institutions: A framework for chairs, chiefs, and mentors. *J Gen Intern Med*. 2021;36(10):3113-3121. doi:10.1007/s11606-021-06713-9.

perform tasks on their own requires some degree of faith on the part of the supervisor.

Our medical system is designed to assume trust, and educators have long accepted some amount of risk to afford trainee autonomy with an eye towards growth.³ Existing data suggests the system works for most trainees. Most residents meet their milestones and successfully graduate; however, EPAs add a different weight to our assessments in which they ask us to report the degree we trust our trainees. It has been suggested that such trust is a potent vehicle for trainee growth.⁴ Yet, as supervising physicians we must also ensure patient safety and proper care. Every patient needs a safe follow-up plan, but not every patient needs a workup for a pheochromocytoma. How much do we trust our graduate trainees? Do we have faith in them? How does our own discomfort with letting go affect trainee progression towards autonomy? Importantly, how much does it bias our assessment?

Previous conceptualizations of supervisor-learner trust describe factors such as the clinical context, nature of the task, trainee competence, supervisor bias, and the underlying relationship between both parties; however, the relative weight of these variables has not been closely examined.⁴ Existing evidence suggests that a substantial amount of variability in EPA assessment may come from the assessors themselves, and qualitative studies have shown that supervising attendings' internal processes do indeed guide entrustment decisions—a “reflexive trust” grounded in prior experiences with trainees, internal rules, and personal biases.⁴ While many such studies have emphasized faculty development as an avenue to mitigate this variability, these strategies do not closely examine faculty members' internal trust processes, their propensity to trust, or their implicit biases. In assessing a trainee, the question is not only, “How trustworthy is the trainee?”

but also, “How comfortable am I with trusting others?” Awareness of our proclivity to trust others (or not), our biases, and our prior experience become crucial for accurate evaluation of trainees.

In 1995, Mayer, et al, described a model of trust that argued measuring a supervisor's willingness to be vulnerable to the actions of others was key to understanding trust decisions.¹ Their work further clarified an individual's willingness to trust correlated with whether they ultimately entrusted tasks to others. In Mayer's model, a supervisor's propensity to trust (considered to be a relatively stable personality characteristic of an individual) impacts all aspects of the trust process, including the trustors perceptions of the trustee's ability, benevolence, and integrity. This is deeply subjective territory and makes every evaluation vulnerable to a supervisor's “comfort.” We propose that a close examination of frontline assessors' willingness to trust is critical to accurate EPA assessment. Currently, there are no validated metrics for this purpose, but previously defined scales in social science literature might serve as a useful start.⁵ Faculty development efforts should focus not only on EPA frameworks but also allow participants to reflect on their own biases towards trusting trainees and the process of arriving at trust. This is a delicate issue. Why do some preceptors trust more easily than others? Examining our own biases with authenticity opens ourselves to our own insecurities, our own failures, and our own moments of untrustworthiness. At our intuition, we created an exercise of faculty self-reflection adapted from Frazier, et al, 2013⁵ to initiate these conversations. A downloadable version of this document can be found at <https://tinyurl.com/3ta86y25>.

There must be a balance between trust and autonomy. Endowing trust upon a trainee is essential for their growth and sense of identity as a developing physician. Their auton-

omy must, of course, be balanced by patient safety. As educators we have attempted to objectify this practice: chart stimulated recall, didactics, direct observation, modeling, mentorship, narrative medicine—the list goes on. However, EPAs add a newer and potentially deeper facet to the assessment paradigm. Informally, we have been doing EPAs for years. We have allowed our residents to enter the room without us—perhaps by some instinct that we did not recognize at the time. Only in recent years have we attempted formally to proscribe EPAs as objective exercises in vetting autonomy. Because EPAs are not as objective as we believe, supervisors must be aware of their own comfort with trust. They must reflect on how willing they are to be vulnerable to the actions of others to truly ground their assessment in objectivity. They must—at times—have *pistis*. Faith.

References

1. Mayer RC, Davis JH, Schoorman FD. An integrative model of organizational trust. *Acad Manage Rev*. 1995;20(3):709-734. <https://doi.org/10.2307/258792>.
2. *The Bible: Authorized King James Version*. Eds. Robert Carroll and Stephen Prickett, Oxford UP, 2008.
3. Abruzzo D, Sklar DP, McMahon GT. Improving trust between learners and teachers in medicine. *Acad Med*. 2019;94(2):147-150.
4. Gielissen KA, Ahle SL, Wijesekera TP, et al. Making sense of trainee performance: Entrustment decision-making in internal medicine program directors. *Yale J Biol Med*. 2020 Aug 31;93(3):403-410. eCollection 2020 Aug.
5. Frazier ML, Johnson PD, Fainshmidt S. Development and validation of a propensity to trust scale. *J Trust Res*. 2013;3(2):76-97.

faculty development program will address each of these domains.

The lack of established tools is daunting for practice leaders but allows freedom to innovate and adapt concepts for local settings. In the authors' experience, tools that have been developed, implemented, and found to be valuable, include the following:

- *Faculty development lecture series (Teach, Discovery, Service, Advancement, Leadership).* A faculty development lecture series entails topics essential to early success. This can include a range of topics like billing and coding, patient satisfaction, teaching at the bedside, providing feedback to learners, working with NPs and PAs, steps towards career advancement and promotion, and other sessions crucial for local success.
- *Works-in-Progress (WIP) sessions (Discovery, Advancement).* WIP sessions allow one or more faculty to discuss their work in an informal setting. This provides feedback to the faculty member plus allows the entire faculty to gain ideas on their own work. WIP sessions can afford opportunities for the “big tent” of hospital medicine activities, such as developing a new clinical program, a quality improvement (QI) project, research, or a new educational curriculum.
- *External conference and courses (Teach, Discovery, Advancement, Leadership).* Practice leaders need to be selective when determining whether they can provide funding for a faculty member to attend a conference. The key determinant is often whether the conference will or can help shape their career path or will increase skills applicable to their career path. For example, a hospitalist with an interest in medical education can be supported to attend SHM's Quality & Safety

Educators' Academy or a faculty member interested in medical consult may benefit from attending a conference on perioperative medicine.

- *Mentorship program (Service, Advancement).* A practice leader (e.g., division chief or chair) is a *de facto* mentor for every member of their faculty. This is insufficient in most large groups. Motivated faculty often find organic mentors in areas in which they have an interest, such as a more senior colleague who leads a medical school course and needs someone to precept students in small group learning. Organic mentorship is an essential component of faculty growth. However, other faculty may need more encouragement in reaching out to colleagues. A structured mentorship program provides a foundation with specific roles and expectations for every group member. A structured mentorship program pairs faculty with a more senior physician (within or external to the hospitalist group) and sets baseline expectations. These may include meeting regularly (e.g., quarterly) and providing a range of possible topics, such tips on their career advancement, enhancing or problem-solving for their current project, addressing potential burnout, and facilitating connections to other faculty. It is also important to note that a mentorship program does not stop with junior faculty; even mentors need mentors. In addition to the primary mentor, identifying a roster of auxiliary mentors (QI mentor, clinical teacher, research grants mentor) can provide additional avenues to mix-and-match mentor roles and provide a personalized team approach for each mentee.
- *Peer observation (Teach).* Given the pace of academic medicine, most physicians do not reflect and assess their educational skills. A

line from Robert Burns' poem, *To a Louse*, laments our inability to understand how we are perceived by others: “Oh the gift that God could give us to see ourselves as others see us.” Peer observation can help address this deficiency by pairing group members and having each assess the other. This is most used in an educational setting, such as leading teaching rounds, though it can also be applied to observation of patient care. Essential elements are to ensure the burden is minimal, such as requiring only one observation per year, and focusing on formative feedback. A structured assessment tool can be used to promote a constructive approach and ensure key behaviors are assessed in a standardized manner.

Conclusion

Faculty development forms a strong foundation for all medical education endeavors. Energy and attention spent growing your educators, your researchers, and your leaders are an investment in a formidable education infrastructure that learners of all stages will tap into. Creating formal programs with structure and tools will provide a visible cue to the faculty of the dedication to their success and a culture of lifelong learning.

References

1. Leslie K, Baker L, Egan-Lee E, et al. Advancing faculty development in medical education: A systematic review. *Acad Med.* 2013;88(7):1038-1045. doi:10.1097/ACM.0b013e318294fd29.
2. Gawande A. *The Checklist Manifesto: How to Get Things Right.* Metropolitan Books; 2009.
3. Ripley B, Bailey J, Warren K, et al. A competency-based approach to faculty development. *Int Conf Resid Dev.* https://scholarscompass.vcu.edu/medicine_dean_pubs/2/. Published January 1, 2019. Accessed October 15, 2022.

FROM THE EDITOR (continued from page 2)

offer. I'm grateful that many SGIM members contribute every year to the annual meeting's high-quality continuing education every year at the annual meeting as well as at regional meetings and virtual live or asynchronous activities. As a remind-

er for us all: Keep calm and keep on learning!¹

References

1. Leung TI. Keep calm and keep on learning. *SGIM Forum*. <https://connect.sgim.org/sgimfo->

[rum/viewdocument/keep-calm-and-keep-on-learning](https://connect.sgim.org/sgimforum/viewdocument/keep-calm-and-keep-on-learning). Published April 2021. Accessed October 15, 2022.

SGIM