

MEDICAL EDUCATION: PART I

## STRATEGIES TO PROMOTE PRIMARY CARE AND DEVELOP ACADEMIC GENERALISTS OF THE FUTURE

Nancy M. Denizard-Thompson, MD; Kirsten B. Feiereisel, MD

*Dr. Denizard-Thompson (ndenizar@wakehealth.edu) is an associate professor in the Department of Medicine at the Wake Forest University School of Medicine and vice chair of faculty development. Dr. Feiereisel (kfeierei@wakehealth.edu) is an associate professor in the Department of Medicine at the Wake Forest University School of Medicine and section chief of General Internal Medicine.*

General Internal Medicine (GIM) is a unique field that offers a range of possibilities for career fulfillment through varied clinical settings and focus areas such as medical education, informatics, health services research, policy, and administration. Multiple factors have impacted the landscape of general medicine careers and the pathways that trainees pursue post-residency. Hospitalists have emerged as the fastest growing group of practicing physicians in the United States.<sup>1</sup> Gray, et al, reviewed the American Board of Internal Medicine (ABIM) board certification database and reviewed general internists certified between 1990-2017 who did not pursue fellowship as of 2020.<sup>1</sup> The authors found that as of 2018, 71% of newly certified generalists practiced hospital medicine, 21% mixed practice, and 8% outpatient only. While 21% were identified to do mixed practice, the retention rate was 57% v. 86% for hospitalist v. 95% for outpatient only. Fewer newly certified internists are selecting outpatient-only practice; however, the retention rate was 95% for those selecting this practice type. There is a need to explore solutions to build and sustain the nation's primary care infrastructure. In addition to preparing the primary care workforce of the future, it is equally important that we promote the field of Academic GIM. Academic generalists play key roles in research, education, leadership, patient safety, information technology, and clinical care. However, many residents are not aware

of the breadth of a generalist career. Many recent graduates are interested in career variety and have an increased awareness of work-life balance. We took a multi-pronged approach to grow interest in GIM. We will highlight the following areas: enhancing our Primary Care (PC Track), identifying a chief resident champion, and creating diverse job opportunities in general internal medicine.

### Enhancing Our Primary Care Track

We aimed to enhance our PC Track by developing a Primary Care Scholars program to expose residents early in training to facets of an academic generalist career. The PC Track at Wake Forest University was established as a separate training program in 1986. Up to four medical students are competitively accepted into the three-year program through the National Residency Matching Program for a maximum of twelve PC Track residents.

Our redesign focused on four main priority areas: mentorship, networking, scholarship, and enhanced clinical experience with some opportunities supported by a donor fund. Each PC Track scholar is paired with an academic generalist mentor who provides clinical and career mentorship. The scholars meet quarterly with academic GIM faculty for a journal club and at a faculty's home for a combined medical student, resident, GIM faculty, and GIM leadership networking event. Scholarly

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## FROM THE EDITOR

# MY CHOICE

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

When I was a child, a Chinese American born of immigrant parents, I was constantly reminded while under their roof: “*Focus on studying. Don't get distracted by boys.*” My teenage mind was driven to excel and always achieve. I obeyed, and for that, I was given a gentle pat on the head for being a *gwaaai neoi* (Cantonese for a “well-behaved” or “good” daughter/girl). As I progressed from college through medical school, that expectation transformed. I am still perplexed by when or how it happened, but at some point I came of age and was soon queried: “*When are you going to find a nice Chinese boy/doctor to bring home?*” In fairness to my parents, these probes mostly came from grandparents, aunts, or uncles, not them. They didn't move that goal-post on me. They didn't even address that goal post at all: we never spoke of dating or relationships at that time, let alone have a dialogue about finding a partner and planning a pregnancy.

Today, I have no children. I divorced and remarried.<sup>1</sup> I realize that I am well into a phase when, if I become pregnant, I will likely see in my medical record: “*O09.51: Supervision of elderly primigravida.*” For a long time, I successfully dodged answering relatives' interrogations about my love life. Yet somehow the topic of parenthood—and by implication, pregnancy or potentially alternative pathways to parenthood—isn't too taboo to ask about (“*Do you have kids?*”). In fact, I discovered several years ago that in some cultures, it is acceptable in a professional setting to include mention of one's children in a self-introduction. As a childless person, I made light of this unexpectedly personal self-presentation with professionals who I had never met before: “*Hi, I'm Tiffany. I'm a general internist. I have two rabbits, Piet and Steffi, and no children.*” That usually garnered a laugh, which is all I needed so introductions could move on.

For women, bearing children is a deeply personal choice. So far, I have chosen not to. Beyond that, the reasons are no one else's business but that of me and my partner, both the responsible parties (parents) in this hypothetical situation. (To be clear, I am always open to a thoughtful discussion with anyone who is struggling with a similar choice—and the stigma associated with it.) One consequence I may have to bear is that I may never become pregnant, should I change my mind now or in the coming years. I accept the consequences of my choice. I also accept that if I *were* to have an unplanned pregnancy, I believe in my competency and right to decide how that goes.

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# DIVERSITY, LENSES, AND MY COMMITMENTS

Martha S. Gerrity, MD, MPH, PhD, FACP, President, SGIM

*"Diversity is our strength. It provides us with opportunities and stimulates problem-solving and innovation.... it requires people to be open to each other's perspectives, have a willingness to collaborate, and be aware of our own biases and lenses."*



**A**s I listened to a recent discussion among SGIM Council members, I was struck by how diverse we are as a Society and proud of our efforts to reflect that diversity in our governing Council. Although we aren't perfect and have work to do, we *are* ahead of many other medical professional societies.

Diversity is our strength—it provides us with opportunities and stimulates problem-solving and innovation. Diverse groups outperform homogeneous groups because they bring different perspectives, knowledge, and experiences to the table.<sup>1</sup>

However, for diversity to be a strength, people must be open to each other's perspectives, willing to collaborate, and aware of our own biases and lenses, the filters we use when considering a topic. During the Council discussion, I realized that I need to be acutely aware of my lenses, the way I see the world and the work of SGIM,

to be an effective leader and member of SGIM's Council. After all, we are a society of academic general internists with wide ranging activities and interests.

Here are my lenses. I am a cis-gender older white woman. I was raised with the privilege of an upper-middle-class life in a family that valued education. Not going to college never occurred to me. My father was a primary care physician at a Chicago Public Health clinic and came home every evening at 5:00 pm to have dinner with our family. He spent evenings with us, instead of doing clinic work. We lived with my paternal grandfather in inner-city Chicago until his death, and I spent summers with my maternal grandparents on a small farm in Iowa. At a young age, I saw the differences in life and priorities in these two settings and their similarities, especially when you got down to what really mattered to people. I never thought this geographic difference would divide a country.

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## SGIM Forum

### Editor In Chief

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

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**Taylor Wise, SGIM Social Media and Communications Specialist**  
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# Q & A WITH SGIM'S CEO AND PAST PRESIDENT ON THE NOTABLE ACHIEVEMENTS OF 2022-23

Eric B. Bass, MD, MPH; LeRoi S. Hicks, MD, MPH

*Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Hicks (lehicks@christianacare.org) was the President of SGIM in 2022-23.*

**EB: Looking back on your year as SGIM's President, what achievements are most important to you?**

LH: When we compiled the annual summary of SGIM's notable achievements,<sup>1</sup> I was amazed at what the organization was able to accomplish thanks to the extraordinary efforts of our membership and staff. I am particularly proud of the work done by Council and our committees and commissions to create a more diverse, equitable, and inclusive professional home for our members. A few examples of that work include: revisions of our career development programs to address diversity, equity and inclusion (DEI) and anti-racism topics; creation of a new program funded by the Harrington Trust to support the career development of academic primary care leaders from racial and ethnic backgrounds underrepresented in medicine (UIM); expansion of ACLGIM's United Leadership Training in Diversity (UNLTD) Program for UIM racial and ethnic groups; election of DEI chairs to lead DEI efforts in our regional activities; nomination and election of a diverse slate of new Council members, and development of better processes for collecting, analyzing, and sharing data on the gender, race, ethnicity, and other characteristics of our members, leaders, and awardees.

I also appreciated the commitment our Council and Program Committee (PC) demonstrated in taking seriously the concerns expressed by SGIM members about the national meeting. The PC addressed concerns about the environmental impact of the meeting by incorporating suggestions from our Environmental Health Interest Group and increasing PC membership to include a liaison with the interest group. Council addressed concerns about how we selected meeting sites by working diligently to develop a more clearly defined process for selecting future meeting sites.<sup>2</sup>

**EB: What stands out to you about the work of SGIM's committees in the last year?**

LH: I am very proud of the tremendous scope of work done by our committees, commissions, and interest groups at a time when all members are feeling enor-

mous stress from changes induced by the pandemic. For example, the Health Policy Committee was extremely active in preparing or signing on to more than 80 letters or statements on federal legislative issues of importance to members, including women's health, discrimination, gun violence, telehealth, and primary care. The Clinical Practice Committee hosted three webinars, continued to publish Bottom Line Summaries in JGIM, and collaborated with the Education Committee and Health Policy Committee to prepare a position statement on telehealth policy, practice, and education recommendations. The Education Committee published papers on telehealth competencies in medical education,<sup>3</sup> and changing the assessment paradigm,<sup>4</sup> in addition to submitting comments on major education-related policies such as proposed standards for improving the transition from undergraduate medical education to gradual medical education. The Research Committee continued its development of a novel certificate program on partnered research and conducted a national survey on the needs of GIM research fellows that resulted in specific recommendations for Council to act on identified problems. The Ethics Committee published an article in the *SGIM Forum* on caring for an incarcerated patient and hosted a webinar on how physicians should respond to colleagues who disseminate misinformation.<sup>5</sup> The Membership Committee launched a successful new committee and commission competition for membership renewal and began efforts to expand membership from underrepresented institutions, including historically black colleges and universities. The Finance and Philanthropy Committees worked synergistically to help SGIM weather the financial stress imposed by loss of in person meetings during the pandemic.

**EB: What stands out about the work done by SGIM's commissions during the last year?**

LH: SGIM's commissions have an important role in fostering collaboration with core committees, interest groups, and other organizations on topics relevant to

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# LEADERSHIP PERSPECTIVE WITH DR. ELEANOR BIMLA SCHWARZ, SGIM'S DISTINGUISHED PROFESSOR FOR WOMEN'S HEALTH 2023

Alia Chisty, MD, MS; Megan McNamara, MD, MS; Deborah Kwolek, MD

*Dr. Chisty (achisty@pennstatehealth.psu.edu) is an associate professor of medicine at Penn State Health Milton S. Hershey Medical Center/Penn State College of Medicine. Dr. McNamara (megan.mcnamara@va.gov) is a professor of medicine at Case Western Reserve University School of Medicine. Dr. Kwolek (dwkwolek@gmail.com) is an assistant professor of medicine at the Massachusetts General Hospital. All co-authors are members of the SGIM Women and Medicine Commission.*

**D**r. Eleanor Bimla Schwarz is the Distinguished Professor for Women's Health for the Society of General Internal Medicine Annual Meeting 2023. Dr. Schwarz is Chief for the Division of General Internal Medicine at Zuckerberg San Francisco General Hospital and Professor in Residence at the University of California, San Francisco. She is also an Associate Editor for *Women's Health for NEJM Journal Watch*, serves on SGIM Council, and is council's liaison to the Women and Medicine Commission.

## Discovering a Passion for Women's Health

Dr. Schwarz completed her undergraduate and master's degrees at the University of California, Berkeley. As the oldest of five children, she found that college life freed up time for a variety of volunteer activities. Before the days of Uber or Lyft, she joined the Access Practical Support Network which offered free babysitting and rides to individuals seeking health care. To her surprise, essentially all those seeking practical support were seeking abortion services. Through these experiences, Dr. Schwarz came to recognize that people seeking abortions were often "living very complicated lives, and doing the best that they could." These experiences inspired her Masters' thesis titled "Clinic-controlled Factors Affecting Experiences with Abortion," as the clinics she visited varied in multiple ways. For example, recognizing that most women who seek abortion services are parents, some had toys in the corner of their waiting rooms while others had a sign chillingly stating "children are only allowed in clinic if they are here for a procedure."

During medical school at the University of California, San Francisco, Dr. Schwarz had a few other memorable experiences. In the emergency department, she met a young woman who had attempted to terminate a pregnancy by inserting a metal coat hanger into her cervix. This experience, at a time when abortion was legal, covered by Medicaid in California, and theoretically

widely available in San Francisco, was a powerful illustration of just how harmful stigma can be. Dr. Schwarz resolved that "my patients should never have to feel they must manage such a difficult situation on their own." This has led her to be proactive in sharing a willingness to help patients get the care they need, and to embrace a non-judgmental approach to empowering patients and supporting them regardless of the choices they make.

Dr. Schwarz completed residency training in primary care internal medicine at UCSF. Deciding during internship that "motherhood was on my bucket list," Dr. Schwarz gave birth to her first child as a second-year resident. After residency, she joined the UCSF faculty as a part-time clinician educator and then decided to complete a fellowship in Women's Health Services Research at the San Francisco VA. She then spent close to a decade with a wonderful group of colleagues at the University of Pittsburgh. In 2014, she returned to California to serve as the Medical Director of the Department of Health Care Services' Office of Family Planning and a professor at University of California, Davis. At UC Davis, Dr. Schwarz led the Quality, Safety, and Comparative Effectiveness Research Training in Primary Care fellowship until 2021, when she returned to UCSF as the chief of general internal medicine at San Francisco General Hospital. A well-respected mentor, Dr. Schwarz continues to foster the growth of the next generation of clinicians and scholars.

## Current Projects Improving Women's Health and Primary Care

Recently, with PCORI funding, Dr. Schwarz and colleagues looked at alternatives to permanent contraception, in particular comparing outcomes between intrauterine devices (IUDs) and tubal ligation among patients with Medicaid in California. They found that IUDs were as effective as tubal ligations at preventing pregnancy and caused less pelvic pain and other side effects. She and her

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# CREATING A UNIVERSAL EXPECTATIONS SHEET FOR TEACHING TEAMS

Catherine Callister, MD; Caitlin Dietsche, MD; Jason John, MD; Marisa Echaniz, MD

*Dr. Callister (catherine.callister@cuanschutz.edu) is assistant professor and director of education for the Division of Hospital Medicine at the University of Colorado Hospital. Dr. Dietsche (caitlin.dietsche@cuanschutz.edu) is assistant professor and service line director for medicine wards in the Division of Hospital Medicine at the University of Colorado Hospital. Dr. John (jason.john@cuanschutz.edu) was a chief resident in the University of Colorado Internal Medicine Residency Program and is now completing his first year as a senior instructor in the Division of Hospital Medicine. Dr. Echaniz (marisa.echaniz@dhha.org) is an associate professor at Denver Health and is the assistant director of education for the Division of Hospital Medicine.*

*“Who runs rounds—the senior resident or the attending? And how many patients should a medical student follow?”*

Questions like these made us realize we had not clearly defined expectations on our wards’ teams. In addition, there were situations where learners felt they received below-average evaluations or negative feedback because they did not understand the expectations of the rotation. We might assume that faculty and learners know what is expected of them. However, medical students report feeling like they are constantly being evaluated and the feedback process is arbitrary and subjective.<sup>1</sup> Struggling learners benefit from setting clear expectations early and providing ongoing feedback around expectations.<sup>2</sup> Additionally, when faculty are aware of what is expected of them, they are more likely to improve their performance as clinician educators.<sup>3</sup> Due to a scarcity of uniform, clear expectations on the wards teams at our institutions, we created and piloted an expectations sheet to set a standard for all members on an inpatient general medicine service.

Below are the five steps we followed:

## 1) Convenience Sample Gap and Thematic Analysis

We initially gathered expectations sheets from 14 Division of Hospital Medicine (DHM) faculty. Ranging from 1-4 pages, they were aimed at different types of teaching teams (medicine wards, acute care of the elderly, etc.). There were differences in structure (e.g., bulleted v. paragraph form), level of detail (e.g., “I will teach for 10 minutes” v. “teaching will occur”), and rounding style preferences (e.g., hallway v. bedside and formal presentation v. pertinent facts only).

Next, we identified common sections or themes. Most expectations sheets started with an overall vision statement identifying broad team goals and objectives. This was typically followed by sections detailing specific expectations for attendings, senior residents, interns, and medical students. Additional sections included details on rounding, teaching, when to call your attending, and diversity, equity, and inclusion statements.

## 2) Engagement of Key Stakeholders

We solicited feedback from stakeholders including leadership of the Division of Hospital medicine, the Internal Medicine Residency Program (IMRP), the School of Medicine (CUSOM) and the Hospital Medicine Advanced Practice Fellowship (HMAPF). We wanted to ensure that the expectations we crafted matched the expectations each program had already set for their learners. These conversations highlighted the specific needs of each group.

A priority for the School of Medicine was ensuring that there was a clear distinction between these expectations and the specific clerkship grading criteria that were provided to students. We also discussed the idea of prescriptive formats and time limitations for presentations. We had an opportunity to collaborate with the medical school to create shared expectations as they were revising their own expectations. From the IMRP perspective, priorities included ensuring rounds ended on time, interns could focus on patient care, attendings were available after rounds, and the team had faculty support for smooth discharges, especially on “intern only” days. Our meeting with the HMAPF leadership helped us draft a description of the role of nurse practitioner and physician assistant fellows on a wards team given many residents and medical students had not previously worked with Advanced Practice Fellows.

## 3) Standardized Expectations Sheet Development

The expectations sheet begins with a section where faculty can provide contact details and personalize their philosophy towards wards and team culture. This is followed by individual team member sections that detail each member’s responsibilities from second-year medical students to attending physicians. Each section begins with a brief description of the team member’s role within the team. The attending’s role description reads “The attending’s main job is to coach and support the team in delivering excellent patient care while providing opportu-

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# OUR EMERGENT CRISIS WITH EMS CARE

Harnoor Mann, MD

Dr. Mann (Mannhk@upmc.edu) is a third-year internal medicine resident at UPMC.

*“Where I’m at, I don’t get a response very quickly by ambulance... And while my insurance pays for transportation to medical things, there’s nobody around here to provide that transportation, so, yeah, it’s a rough spot.”*

Reading this quote stopped me in my tracks while sifting through qualitative data for a research project. As a resident, I had heard from patients before that they avoided calling 9-1-1 because ambulance costs were too expensive. But this idea of a complete lack of access to emergency medical services (EMS) was both new and frightening.

A quick Google search of “EMS shortage” reveals headlines expressing emergent care shortages in New York, Southern California, Wisconsin, Iowa, New Jersey, North Carolina, Maine, and Indiana, all within the first set of results. Even in Boston, a medical mecca, on-time EMS response rates declined to 58% at the end of 2021.<sup>1</sup> In rural areas, depletion of resources exacerbated by the COVID-19 pandemic and hospital closures have translated into a dire dearth of emergency services for regions throughout the county, as described by our rural focus group participant above.<sup>2,3</sup>

## What is causing this crisis?

To start, emergency medical technicians’ (EMT) and paramedics’ salaries are grossly insufficient. The U.S. Department of Labor Bureau of Labor Statistics stated the median wage for EMTs and paramedics in May 2021 was \$35,470 and \$46,770 respectively.<sup>4</sup> Per hour, average EMT pay is \$17.76.<sup>4</sup> Limited wages has prompted many EMS staff to leave the field, with no likely salary increases on the horizon. EMS agencies are strikingly underfunded, and report that their private and governmental insurance reimbursements do not cover the cost of providing services. Donald DeReamus, the Legislative Chair for the Ambulance Association of Pennsylvania, stated in a March 2023 interview that if an ambulance call cost an EMS agency \$550, the agency may only receive \$350 in reimbursement.<sup>2</sup> EMS funding is also often associated with regional call volumes, leaving rural areas at further disadvantage, and increasingly reliant on volunteers and local fundraising efforts, such as bake sales.<sup>3</sup>

Considering these extreme shortages, 40 state legislatures in 2022 considered bills in relation to increasing state-funding for EMS. The Centers for Medicare & Medicaid Services are to examine a new payment model to increase funding for EMS services, but this process is still underway.

I carried these ruminations into my primary care clinic the next day, and with a no-show on my schedule, I had extra time to spend with my next patient who arrived early. He and his wife travel more than an hour and a half across state lines to see me. He had recently called EMS after experiencing dyspnea at home alone. We reviewed his hospital stay and his medication changes, but at the end of our encounter he sensed I had another question to ask him.

## “Doc, what’s on your mind?”

“Mr. P, how long did it take for the paramedics to get to your house?”

He laughed. He told me he couldn’t remember exactly, but he stated “Where I live, I know better than to wait to call.”

The structure of EMS agencies, run either by private/for profit companies or by the local municipalities they serve, propagates inequity in sparsely populated and underfunded parts of the country. Reliance on either the free market or, alternatively, on safety nets improvised by neighbors and volunteers, is woefully inadequate when lives are on the line.

This begs the question: how can we ensure just and equitable allocation of EMS resources? First, we must understand the EMS crisis as a microcosm of the systemic failures in American healthcare. As a country, the United States spends more of its gross domestic product on healthcare than any other country while experiencing higher rates of chronic disease and hospitalizations from preventable causes.<sup>5</sup> Americans’ out-of-pocket spending and the private sector’s spending on healthcare is also higher than other first-world countries.<sup>5</sup> The end result is a disorganized healthcare system rife with misaligned incentives in which Americans pay more but get less.

Our system supposedly relies on interconnectedness, but physicians’ siloed awareness has prevented us from appropriately acknowledging the EMS crisis and from advocating on behalf of our EMS colleagues and patients.

Our advances in healthcare, particularly emergent care, are futile if patients cannot reach us to receive them.

*I wish to acknowledge Gaetan Sgro, MD, for his thoughtful review of this manuscript.*

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# REVISITING THE ROLE OF CLERKSHIP DIDACTICS: A CALL FOR REFORM

Madeline Garb, MS; Elaine Cruz, DO

*Ms. Garb (madeline.garb@case.edu) is a third-year medical student at Case Western Reserve University School of Medicine.*

*Dr. Cruz (exc406@case.edu) is a Health Professions Education Evaluation and Research (HPEER) fellow at the Louis Stokes Cleveland VA Medical Center and an assistant professor at Case Western Reserve University School of Medicine.*

I am a medical student in the era of active learning. Our curriculum, grounded in small group learning and patient simulations, was designed with consideration of the adult learning theory, acknowledging that knowledge retention is poor from traditional lectures.<sup>1</sup> Despite the extensive changes implemented at the pre-clinical level, the third-year clerkship didactics remain for the most part in the traditional lecture-based format. These didactics are approximately 4 hours per week during clerkship and typically cover common clinical conditions. The lecturer speaks about a topic and the learners passively sit in the audience and listen. The only interactive portion is when the lecturer called on a student to answer a question. There is a consensus among my colleagues that clerkship didactics in this format are unhelpful. If they are not helpful, then why should students spend so many hours in didactics? What are they adding to the clerkship experience? If didactics are intended to fill in gaps in our clinical knowledge or to help us prepare for the shelf exams, then it has fallen short of its purpose. It is not uncommon for students to have their computers out completing question banks during the didactics paying little attention to the speaker. As a third-year medical student, I aim to share my perspectives on didactics in undergraduate medical education and offer suggestions to reform these sessions to meet students' needs through a collaborative effort between faculty and students.

## Are Didactics Important to the Clerkship Experience?

The value of clerkship didactics to clinical performance and/or shelf exam score is not well studied. Additionally, researchers often group structured learning time of all formats into the same category limiting the ability to determine if one format is more effective than another. In a study of 1,817 students from 17 medical schools in 2002-03, researchers separated didactics by their format to determine if there was an association with the internal medicine shelf exam score. Time in traditional lectures during the clerkship was not associated with the shelf exam score. In students with "high" step 1 scores, clinical factors (i.e., patients cared for and length of rounds) were most important; however, in students with "low" step 1 scores, time in small groups, separate structured learning time with a teaching attending, and length of the

clerkship were related to the shelf exam performance.<sup>2</sup> This suggests that students who struggled with test taking benefited more from structured learning time than those who did not. While structured learning time within the clerkship may be important depending on the type of student, lecture-based learning as a format does not seem to be helpful for anyone.

## How Can Didactics Be Modified to Meet Students' Needs?

I believe didactics should improve clinical knowledge and performance on the shelf exam, and if they do not, then they should be omitted to allow students to spend more time on the wards to learn from patients or to independently study. I think the first step in redesigning didactics is to determine the purpose of each session (i.e., is it to gain practical knowledge for the wards or to help with the shelf exam). The next step is to determine the best format for the given session based on its purpose. In my experience, the following have been the most memorable didactics:

1. **Simulation.** On my neurology rotation we learned to use the NIH stroke scale through simulation on a standardized patient. There is a large body of evidence to support the use of simulations for improving performance in medical emergencies, resuscitations, surgical skills, and in functioning on an interprofessional team.<sup>3</sup> Practicing skills in a lower stress environment may improve confidence participating in high stakes events.
2. **Team-based (TBL) or case-based learning.** In my internal medicine clerkship we applied an approach to anemia through patient cases. The benefits of TBL include application of knowledge, experience working on a team, and opportunity to practice self-reflection and peer feedback. When TBL is compared to lecture-based learning, there is improvement in engagement and knowledge retention.<sup>4</sup> Perhaps students are more engaged during these sessions and thus more likely to participate and retain material.
3. **Gamification.** In my family medicine clerkship we played a game of jeopardy to learn commonly tested

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# THE FINANCIAL VULNERABILITY OF RESIDENT PHYSICIANS DURING THE COVID-19 PANDEMIC

Cameron Kahn, DO

Dr. Kahn (Cameron.kahn@jax.ufl.edu; Twitter: @ufjaxim) is a PGY-3 internal medicine resident at the University of Florida College of Medicine, Jacksonville, FL.

One unexpected consequence of the COVID-19 pandemic was the exacerbation of the financial disparity between resident physicians (residents) and allied healthcare professionals (i.e., nurses and non-physician practitioners). By 2020, the American Medical Association (AMA) released guidance and expectations for the well-being of residents as the pandemic began systematically disrupting the American health-care system. The AMA acknowledged specific financial responsibilities including hazard pay equitable to other healthcare workers. At a time when resident physicians were needed on the frontlines, too often hospital systems excluded residents from equal compensation under the premises of the current student-employee model, the nature of residency as an “apprenticeship,” and the inherent duty to patient care. This posed significant financial vulnerability concerns for residents at a time when other frontline healthcare workers received inflated hazard benefits for providing patient care.

In a survey of 429 U.S. Internal Medicine Program Directors (PDs), only 19.5% of PDs reported hazard pay provisions for their residents.<sup>1</sup> Hazard pay occurred more commonly where PDs supported hazard pay (74.5% vs. 22.1%,  $p=0.018$ ).<sup>1</sup> Of the PDs who opposed, the most common reason was professional obligation.<sup>1</sup> Even asking for hazard pay was taboo. An exposé published in *The New Yorker* described the tense situation between residents who circulated a letter in support of hazard pay and the administration at New York University (NYU) Langone.<sup>2</sup> In the article, residents were genuinely worried about retaliation for bringing up their hazard pay concerns. NYU Langone eventually offered a compensation package, but it excluded residents and fellows. My program had a similar response to resident/fellows, offering a 3% salary increase and bonuses to guarantee staff retention but excluded doctors-in-training. Similar exclusionary stances led to a profound dissatisfaction with current salaries according to a Medscape survey of resident physicians. Nearly 6 in 10 residents felt they needed to be adequately compensated and did not believe their salaries reflected the number of hours worked or was comparable with what other medical staff were paid.<sup>3</sup> Could you blame them? Travel nurses were making

on average \$3,000-8,000 per week (more than a month’s salary for a doctor-in-training) while working less hours. Interestingly, at the height of the pandemic (2020-21), residents and fellows experienced the lowest percent change in their salary, a 0.6% (\$358) increase from the previous surveyed year (see table).<sup>4</sup>

## AAMC Survey of Resident/Fellow Stipends and Benefits Reports 2022

Survey Year	Mean Unweighted Stipend	Percent Change from Prior Survey Year	Dollar Change from Prior Survey Year
2022	\$ 60,942	2.8%	\$ 1,664
2021	\$ 59,279	0.6%	\$ 358
2020	\$ 58,921	3.0%	\$ 1,730

(AAMC Survey of Resident/Fellow Stipends and Benefits Report 2022.<sup>4</sup> The data was collected from July 1, 2020-July 1, 2022 involving 350 non-profit institutions that responded to the survey.)

Hospitals were overwhelmed with patients and hemorrhaging money to retain staff; yet doctors-in-training saw the smallest change in salary in greater than 50 years? This demonstrated that the Medicare Graduate Medical Education (GME) system wrongly presumes that GME payments for claims made by hospitals will pass through to the residency programs. The Coronavirus Aid, Relief, and Economic Security (CARES) Act funds were set up to defray losses in health care to hospitals but did not specify any assistance to the GME; thus, the funds likely were used to meet non-GME shortfalls instead of boosting resident wages or funding hazard pay.<sup>5</sup> The only GME funding proposed by Congress was the 2021 Consolidation Appropriations Act which acknowledged the physician shortage with funding for future expansion in residency program positions but did not address an increase in salary per resident.

Fortunately, resident physicians did not have to worry about loan repayment. The CARES Act temporarily put federal loans into forbearance, and interest rates froze. This helped thousands of residents count \$0 monthly payments towards their Public Service Loan Forgiveness (PSLF). On August 24, 2022, President Biden

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## BREADTH: PART I

# MUTED CRASH

Reed Nerness, MA, MD

*Dr. Nerness (nerness@ohsu.edu) is a resident in internal medicine at Oregon Health & Science University in Portland, Oregon.*

The crashing doesn't make a noise  
We thought it would  
That it would be deafening

No beds for admissions  
Narrow hallways are rooms too  
Transferring a thin dream

"When the system fails" then  
It will be raucous  
We will have big change

Capacity threadbare, red banners glare  
Primary care follow-up becomes  
Gossamer hope for continued care

After the blast all will know  
When the structure is rubble  
To be built anew, for everyone

The person in room "hallway H"  
Screams out for change  
It's quite outside the ER doors

## BREADTH: PART II

# HOW WONDERFUL IT IS TO BE A GENERAL INTERNAL MEDICINE PHYSICIAN

ChatGPT; Tiffany I. Leung, MD, MPH, FACP, FAMIA

*ChatGPT is a large language model created by OpenAI in San Francisco, CA.  
Dr. Leung (editor.societyGIMforum@gmail.com) is Editor-in-Chief of SGIM Forum.*

**Prompt (Tiffany):** Please write a haiku about how wonderful it is to be a general internal medicine physician.

**Response (ChatGPT):**

"Patients' trust earned deep  
Their health in my hands to keep  
Gratifying work"

**Prompt:** Can you write lyrics to a song that would express how wonderful it is to be a general internal medicine physician? And also offer an actual song with a tune that fits the lyrics?

**Response:** "I'm sorry, I'm not able to create an actual song with a tune as it goes beyond my capabilities as a language model. But I can write lyrics that express how wonderful it is to be a general internal medicine physician.

Verse 1:

I wake up each day, with a mission in mind  
To help those in need, and to be kind  
I am a general internal medicine physician  
Bringing comfort and care to those in need

Chorus:

It's a wonderful thing, to be able to heal  
To help others find their way, and to feel  
The satisfaction of a job well done  
Being a general internal medicine physician is second to none

Verse 2:

I listen to stories, and help them find their way  
By treating not just the disease, but the person today  
I am the first line of defense  
For many illnesses and pretense

*continued on page 12*

team are currently creating resources to disseminate this important information with funding from AHRQ. “This real-world data is really important for clinical decision-making,” she said. “Tubal ligation should no longer be viewed as the gold standard for pregnancy prevention. Options that preserve a patient’s reproductive autonomy—such as IUDs, which patients can remove themselves – are important when our goal is reproductive justice.”

### Future Challenges Facing General Internal Medicine and Women’s Health

Following the *Dobbs v. Jackson Women’s Health Organization* decision there has been more widespread discussion of abortion. Although 25% of U.S. women have had an abortion by age 45,<sup>1</sup> and abortion services are particularly important for women with chronic conditions that increase the risks of pregnancy,

national discussions of maternal mortality rarely highlight the relevance of abortion care to general internal medicine. Twenty years ago, Dr. Schwarz found that many general internists were willing to provide medications for abortion,<sup>2</sup> but few had received the training they needed. Unfortunately, this continues to be the case in many residency programs, although there is now free training available.<sup>5</sup> In states that have restricted abortion services, it is important that patients know that abortion pills can be safely obtained by mail (e.g., PlanCPills.org).<sup>3,4</sup> As Dr. Schwarz notes, “deconstructing stigma doesn’t require a prescription, it means we are talking to our patients.”

As the Distinguished Professor for Women’s Health for the SGIM 2023 Annual Meeting, Dr. Schwarz gave a Keynote Lecture titled, “Stigma, Sanity, and Maternal Mortality,” on Friday, May 12, 2023, from 12-1PM MT.

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### PERSPECTIVE (continued from page 9)

announced student debt relief that would grant up to \$20,000 in debt cancellation to borrowers with annual income during the pandemic of under \$125,000 or under \$250,000 who received a Pell Grant in college. While the debt relief bill continued into litigation, the COVID federal loan forbearance remained in effect, extending beyond its initial expiration date.

The COVID-19 pandemic led to significant financial well-being concerns for resident physicians. The healthcare system relied heavily on residents and fellows to be frontline workers, but they were often excluded from hazard compensation. The 2021 Consolidated Appropriations Act will only expand the number of residency spots but it’s unlikely to see any increase in residents’ salaries. Further reform must address the wage gap between training physicians and other allied healthcare workers. With the pandemic expos-

ing vulnerabilities within the student-employees model, a growing interest in unionization has come into the limelight. It will be interesting to see the exact impact, if any, these financial concerns have on GME funding over the next few years.

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nities for teaching and feedback” and serves as an example for additional role descriptions. Subsequently, a series of specific expectations are listed for each role. Specific expectations are centered around efficiency, responsibilities, and communication. Regarding responsibilities, learners want to know “who does what” so that they can better understand what they are responsible for and how to prioritize their daily tasks. For example, many interns want to teach medical students, but their priority was direct patient care tasks, such as calling consults and putting in orders. Medical teaching can occur after duties to the patient were finished.

Following descriptions of individual roles, presentation formats detailing recommended content and dedicated time for an initial H&P vs. subsequent encounters are provided. Additional sections cover expectations regarding education, conference attendance, “when to call your attending,” and a diversity, equity, and inclusion clause.

#### 4) Management of Conflicting Priorities

As we created our expectations sheet, we identified conflict prone topics that needed special attention. First, consider which items were of universal importance versus attending personal preference. We agreed that this section including the attending’s vision statement could be personalized. However, to standardize

expectations, the remaining document was not be edited. We identified the idea of a firm ending time for rounds each morning to be the most contentious topic. At our institutions, rounds typically begin 8:00-8:30 am, with a required noontime educational conference for learners. The CUSOM and IMRP favored a strict end time of 11:00 am for rounds, facilitating attendance at educational conferences while still having sufficient time to complete clinical tasks. Many attendings were supportive of a cutoff time, while others were opposed to it. Upon prolonged deliberation, we opted to recommend for rounds to be completed by 11:00 am.

#### 5) Implementation and Adaptation

We originally asked a few hospitalists, residents, and medical students to pilot the expectations sheet on medicine wards and to provide us feedback. Currently, the expectations sheet is shared electronically with all learners and faculty rotating on inpatient wards teams at the beginning of their rotation. It has been presented as the standard at DHM business meetings and is also introduced to new faculty during their orientation to the division. Faculty are encouraged to add their own vision and review with learners at the start of the rotation. Whether or not faculty are routinely reviewing the expectation sheet with learners, our division intends to use it as a reference if any issues around roles and expectations

on our wards teams arise. Next steps may include a survey of faculty to assess for: 1. awareness and utilization of the expectations sheet; 2. challenges or barriers for its use; 3. opportunities for improvement.

Though individual programs may have expectations for their learners, these expectations are often not presented in a uniform way to faculty and learners. A universal expectations sheet is an important tool to set a clear performance standard on medicine wards, clarify team members roles and responsibilities, and provide a guide for remediating the struggling learner or faculty member.

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## BREADTH: PART II (continued from page 10)

Chorus:

It’s a wonderful thing, to be able to heal  
To help others find their way, and to feel  
The satisfaction of a job well done  
Being a general internal medicine physician is second to none

Verse 3:

I am the one who can bring relief  
From the pain and the grief  
I am the one who can bring hope  
To those who need it the most

Chorus:

It’s a wonderful thing, to be able to heal  
To help others find their way, and to feel

The satisfaction of a job well done  
Being a general internal medicine physician is second to none

Outro:

Being a general internal medicine physician  
Is a wonderful and fulfilling profession  
I am honored to be a part of it

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I value the people around me who remind me when I forget about my lenses, use language that is less inclusive, or don't reach out to people who should have a voice in a discussion or decision. I've asked them to keep it up—I do learn. I don't shy away from different opinions and ideas. These are opportunities to learn and grow. Senior residents give me strange looks when I tell an inpatient team that I like it when we don't agree. I know we will learn from each other by talking about why we don't agree.

I am firmly committed to continue and extend our work on diversity, equity, and inclusion that started with Dr. Kutner's SGIM presidency in 2020. During Dr. Lybson's presidency, SGIM developed a DEI statement.<sup>2</sup> Dr. Hicks broke new ground for SGIM at the Southern Regional meeting when he met with pre-medical college students from Xavier University, one of the historically black colleges and universities (HBCUs), during the meeting's first HBCU day.<sup>3</sup> These will be large shoes for me to fill. I am grateful that Dr. Hicks will continue to lead our work on DEI and developing an anti-racist culture and inclusive environment, and I will add my support in whatever ways I can.

Sheryl Sandberg's advice about overcoming gender barriers in her popular book *Lean In: Women, Work, and the Will to Lead* missed the mark. She encouraged women to

embrace their strengths and abilities and be assertive.<sup>4</sup> She forgot an important barrier for those of us who have been "leaning in"—cultural and systemic biases in our institutions and leaders especially for women of color, LGBTQ+ women, and those with disabilities. I will follow the advice of Drs. Jacobs, Linder, and Denizard-Thompson in their viewpoint, "Stepping Up by Stepping Back to Promote Equity in Academic Medicine."<sup>5</sup> They challenge leaders to mentor, sponsor, and promote people from systemically minoritized groups and give them a voice and influence in organizations, even if it means stepping back from their positions of power. I have had a rich career because leaders, many of whom are SGIM members, who tapped my shoulder and asked me to step up. They introduced me to collaborators, gave me opportunities to lead, and believed in me. I will work hard to do the same for others in SGIM.

I am a connector who finds joy in introducing people who share work or interests but have never met. I am excited to find opportunities and sponsor people for positions and programs that advance their careers. It is the most important part of my job as a GIM section chief. I also see connections in ideas and opportunities that on the surface don't seem connected—I can't help myself. I am hoping that I can use this strength to bring SGIM's diverse groups and ideas together to strengthen our

work as a society and especially our work on an inclusive environment and anti-racist culture. Please join me!

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## BREADTH: PART II (continued from page 12)

And to be able to make a difference in the lives of my patients.

Note: The lyrics may not match with any particular song and can be written in any format, so you can use it in any song that you like or you can look for similar lyrics that you can find in an existing song."

Transcription of human-written

queries and ChatGPT<sup>1</sup> responses above are provided without alterations. Although ChatGPT and generative artificial intelligence (AI) tools cannot be accountable for their writing, which is a generally accepted criterion for co-authorship, I've chosen to include ChatGPT as a co-author for now since I have not altered the transcription and accept

accountability for the prompted poetry enclosed. I also welcome written debate as submissions to *SGIM Forum* about the role(s) of AI in scholarly writing from SGIM members. I also recommend reading poetry previously published by SGIM members<sup>2-5</sup> in *SGIM Forum* and submitting poetry for publication! continued on page 16

work in the form of Clinical Vignettes is developed in partnership with their mentor to present locally at our residency Research Day and to submit to the North Carolina American College of Physicians (ACP) meeting and nationally to the Society of General Internal Medicine (SGIM). In addition, all Primary Care Scholars attend a National SGIM meeting during their intern year to see firsthand the opportunities and breadth for Academic GIM scholarship. The PC Track residents have an enhanced continuity clinic experience across two sites allowing them to provide care at an under resourced clinic and an academic private practice clinic. Since the initiation of the program in 2017, we have had an increase of residents interested in generalist careers and academic medicine. We have had 4 Academic GIM, 1 Academic Hospitalist, 2 Academic Geriatrics and 1 Academic Obesity Medicine which is 36% of the PC track residents. In total, we have had 68% pursue generalist careers (Academic GIM, Primary Care, Academic Hospitalist, Hospitalist, Geriatrics) and 32% pursue fellowships (Obesity, Nephrology, Hematology/Oncology, and Gastroenterology).

### Chief Resident Champion

As an academic medical center, there is a lot of pressure for residents to pursue subspecialty training. There has also been a decline in interest in primary care over the past 25 years.<sup>2</sup> With success in recruiting strong residents in our PC Track, many became candidates for a chief resident position allowing us to elevate the PC Track as they rose to leadership positions. Chief residents as leaders and advocates for generalist careers can be a powerful driver of interest in generalist careers in the residency program. The creation of the role of ambulatory chief resident can be a good way to sustain this role. However, just identifying one of the chief residents to take on this role can be very important. If they are in-

vested in PC Track, they enhance resident clinic experience which can be a big driver of maintaining interest in primary care. Kryzhanovskaya, et al, looked at primary care residencies supported by Health Resources and Services Administration (HRSA) and found that 35% of primary care residency alumni lost interest in primary care due to their continuity clinic experience.<sup>3</sup> In addition, the chief resident adds things to the general curriculum that emphasize ambulatory care and general medicine topics which increases exposure to all residents. This role has also been a good avenue of recruitment for these chief residents to a career in academic GIM. It has allowed them to interact with GIM faculty and see the opportunities in a generalist career.

### Creating Job Opportunities in General Internal Medicine

The approach to career building and recruitment process for the general medicine section has also been important to increasing interest in generalist careers and Academic GIM. The section has a strong retention rate with minimal turnover and has been expanding yearly. Many new faculty have come internally from our residency program. Therefore, section morale is high, and faculty have strong job satisfaction. There is also a sense of collegiality, mutual respect, and support among faculty in the section. Simpkins, et al, looked at physician wellness and found that respect and sense of value for employees outweighed compensation and financial incentives for job satisfaction.<sup>4</sup> Another key principle we found important in our section has been allowing faculty to balance careers to allow them to explore both medical education opportunities, informatic roles, research interest, or leadership positions while maintaining clinical duties. Career satisfaction and allowing faculty to explore interests has been important in faculty maintaining enthusiasm for teaching, mentoring learners, and mentoring junior faculty. This also

has decreased burnout and enhanced the joy of practice.

In conclusion, exposing residents early to the opportunities of a generalist career and an academic career is key to expanding the breadth and depth of the pool of generalist clinicians, educators, and researchers. Our reengineered PC Track provides a Scholars Program through enhanced mentorship, networking, focus on scholarship and clinical experiences to promote Academic GIM careers. Early feedback and career choice data suggest this may be an effective model to expose residents to the breadth of opportunities in GIM early in their training. In addition, it is paramount to this mission to create a strong culture of general medicine through ambulatory chief residents and supported GIM faculty.

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scenarios on shelf exams for women's health. There is evidence to suggest that incorporating elements of games into didactics improves engagement. It is hypothesized that the use of points/leaderboards may improve learning outcomes by improving attitude and participation.<sup>5</sup> The use of games is ideal for learning common test scenarios and buzzwords.

My reflection offers a first step in opening a dialogue between faculty and students to redesign clerkship didactics. I believe it is time to investigate the purpose of clerkship didactics and take the necessary steps to make them meaningful and help students focus their self-learning. I recognize that this is not an easy task

and will require significant faculty participation. However, if the true purpose of didactics is to enhance clinical knowledge and to improve performance on the shelf exam, then reforming didactics would be a step in the right direction.

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## FROM THE SOCIETY (continued from page 4)

multiple aspects of our mission. The Academic Hospitalist Commission worked with the Society of Hospital Medicine to hold a successful in person meeting of the Academic Hospitalist Academy Level 1 in Denver and prepared a proposal for an innovative virtual approach to next year's version of the Academic Hospitalist Academy Level 2. The Geriatrics Commission collaborated with the American Geriatrics Society on telehealth advocacy and prepared sessions on geriatric care topics for the national meeting. The Health Equity Commission collaborated with other committees in producing four webinars on advocating for equity, and developed new programming on equity for the Student, Resident, and Fellow Track at the Annual Meeting. The Women and Medicine Commission collaborated with the Sex-and Gender-Based Women's Health Education Interest Group to complete a very timely and comprehensive position paper on "Sex and Gender Based Women's

Health Core Competencies" that was approved by Council and submitted for publication.

I hope members will take time to read the posted summary that provides more details about the achievements of each committee and commission.<sup>1</sup> I also want to thank the leaders and members of the committees and commissions for their outstanding work that advances our mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.

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In a time when reproduction and the individual choices related to it are disturbingly in dispute, I hope that we find our ways to support women's choices, whatever those choices may be.

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