

MEDICAL EDUCATION

A LETTER TO TODAY'S ACADEMIC GENERALIST MENTOR

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Mentorship in academic medicine is associated with promotion, scholarly productivity, and career satisfaction.¹ We recently surveyed our Division of General Internal Medicine (DGIM) faculty on mentorship experiences, preferences, and barriers as a needs assessment for our mentorship program. We presented our findings at the 2023 Society of General Internal Medicine Annual Meeting.² The literature review informing the survey revealed an unexpected gem: a survey of mentorship needs performed by our DGIM colleagues more than 20 years ago.³ Differing survey methods prevent a direct comparison of survey results, but discovering our colleagues' prior work on mentorship offered an opportunity for reflection: how has mentorship for Academic Generalists changed in 20 years?

The 2023 authors invited the 2003 authors to discuss what has changed in faculty mentorship since their work published. We referred to our latest survey results for comparison and discussion. Despite the informality of our conversation, several cohesive themes emerged: the profound (and unpredictable) changes in the clinical work of academic generalists, the diversification of non-clinical opportunities for academic faculty, a broadened perspective of what *mentorship* means, the persistence of inequities in advancement and promotion, and a growing recognition of the desire of junior faculty to derive meaning and satisfaction from work. We share these reflections

with the hope that they will stimulate further conversations on the state of mentorship in academic GIM.

The scope of what it means to be an “academic generalist” has evolved over the past 20 years. Since Chew et al. described their findings on the junior clinician-educator mentorship needs, our division has seen enormous growth, especially in the proportion of full-time clinical faculty, who spend most of their time in patient care and clinical teaching rather than scholarship or research. This trend is also seen nationally across academic medical centers. Clinical GIM faculty are not subject to publication requirements and may have more freedom to develop innovative niches and focus on filling critical roles in quality improvement and patient safety, transitions of care, education, and diversity, equity, and inclusion. The demands of the clinical workload have also changed due to increased asynchronous work with the electronic medical record, greater emphasis on RVUs, and higher need to maximize access to care. Consequently, many senior faculty feel ill-equipped to mentor the growing numbers of this new phenotype of academic generalists, or even understand what their mentorship needs are.⁴

We believe that mentors 20 years ago were considerate of career satisfaction, and that junior faculty were interested in meaning and satisfaction. Nevertheless, reflecting on the past 20 years, it seems to us that junior

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FROM THE EDITOR

MENTORING 101

Michael Landry, MD, MSc, FACP,
Editor in Chief, *SGIM Forum*

One-on-One Mentoring, year-long mentoring, peer mentoring, panel mentoring, speed mentoring, LEAD mentoring, informal mentoring. All of these are mentoring programs available to members through SGIM and ACLGIM programming as well as regional and national meetings. I have participated in all these offerings and found great value and satisfaction at both the mentor and mentee level.

"A mentor is someone who sees more talent and ability within you, than you see in yourself, and helps bring it out of you."¹ This principle and the ability to deliver or receive mentoring guidance is a significant strength of SGIM. A keyword search for "mentoring" on the SGIM homepage reveals 39 pages of prior meeting presentations, *Forum* articles, and interest groups, etc., demonstrating the importance of mentoring to SGIM members. Most members are willing to give their time and thoughts to a colleague or junior member when asked. SGIM members are easily approachable either through e-mail or discussion at a regional or national meeting. This aspect of SGIM was one of the most important elements to me as a resident and junior faculty as I could obtain guidance from those established in the field.

Mentoring relationships evolve as the needs of the mentee change over time. As the mentee advances in their career, new mentors with specific skill sets or shared experiences may be added, while relationships with other mentors advance. "To sustain our love of medicine we need to have mentors throughout our careers, not just when we're in training. Likewise when we become mentors ourselves, we can continue to be mentored by others. Individuals need to find their own mentors. They need to see them in action whether at the bedside or in the OR or giving a lecture or teaching a seminar or reading something they've published. Something inside gets sparked."²

A successful mentor-mentee relationship reflects a shared understanding of the roles and responsibilities for the mentor and mentee. The Harvard T.H. Chan School of Public Health offers a helpful and concise two-page summary on this topic as well as how to ask an individual to become your mentor.³ A common misconception in mentoring relationships is that mentors do not enjoy or benefit from this relationship. Dr. Wright's article references this concept as "mentees tended to believe that their mentors received fewer benefits from project-based mentorship than they did, suggesting the need to highlight what mentors receive back from mentoring

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BUILDING RELATIONSHIPS AND ADVANCING ADVOCACY

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

"The 2024 Annual Meeting committee is hard at work putting together a program we hope will help you develop your skills and strategies for your own advocacy work and build and strengthen relationships to advance that work."



I have been immersed in SGIM's health policy efforts over the past two months. Our Health Policy Committee (HPC) has been especially active due to the Centers for Medicare & Medicaid Service (CMS) Calendar Year (CY) 2024 Medicare Physician Fee Schedule Proposed Rule, and their request for comments.¹ Between preparing SGIM's comments for CMS and managing requests from like-minded organizations (e.g., Primary Care Collaborative) to sign on to joint comments, the HPC has been quite busy. This is in addition to other requests for SGIM to participate in letters, amicus briefs, and consortia related to reproductive rights; diversity, equity, and inclusion; decreasing firearm injury; and challenges to Medicare's ability to negotiate prices for some high-cost prescription drugs.

This flurry of work prompted me to review my personal advocacy goals for my mid-year column and reflect

on my journey. When I wrote these goals, I knew they were ambitious. (Yes, I have been accused of tilting at windmills.) I also knew that I had a lot to learn before I could work to advance advocacy at the Society level.

I had three goals:

1. Articulate a vision of a thriving general internal medicine practice and why it is important to our patients and the health of populations.
2. Build relationships at regional and state levels for eventual national coalition building.
3. Support institutional, local, and state advocacy efforts by SGIM members.

Articulating a vision. Articulating a vision of a thriving general internal medicine practice solidified the "what" I would ask others to support and prompted me to gather key articles that I could use to help others learn more about why generalist internists' care is important.

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

Q & A WITH SGIM'S CEO AND THE CHAIR OF THE BOARD OF REGIONAL LEADERS (BRL) ABOUT REALIGNMENT OF SGIM'S REGIONS

Eric B. Bass, MD, MPH; Thomas R. Radomski, MD, MS

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EB: What changes are being made in the alignment of SGIM's regions?

TR: SGIM's Council recently approved recommendations from the BRL for realignment of the regions. Instead of having seven regions, we will now have six regions (see figure). The biggest changes involve states west of the Mississippi River. The new Southwest Region will include Arizona, California, Hawaii, New Mexico, and Nevada. The new Northwest Region will include Alaska, Colorado, Idaho, Montana, Oregon, Utah, Washington, and Wyoming. The Southern Region will gain Oklahoma and Puerto Rico, while the Midwest Region will have no change other than losing Oklahoma. West Virginia will move from the Southern Region to the Mid-Atlantic Region. The New England Region will have no changes.

EB: When will the changes be effective?

TR: Council has asked the BRL to implement the changes starting in May 2024. However, due to the timelines for electing regional officers and planning regional meetings, the BRL will begin preparations for the changes during the current academic year. We plan to create new regional communities on GIMConnect by the spring of 2024. The realigned regions will begin meeting in Fall 2024 or Winter 2025.

EB: Why are these changes being made?

TR: In 2021, Council asked the BRL to reassess the alignment of the regions because some of the regions had much lower rates of participation in meetings and leadership activities than other regions. In addition, the regions varied a lot in the savings they had accrued to support their activities. The pandemic also prompted us to reassess how geographic factors affected the ability of members to attend the regional meetings, given that some regions covered much larger areas than others. The BRL acted upon the request from Council by conducting surveys of members in the regions with lower participation. The survey results confirmed that many members were concerned about having to travel longer distances to attend a meeting, but they also had a strong desire for in person networking. To offer the networking and connections that members desire, it is important to have a sufficient level of participation from multiple institutions within a region.

We believe that the realignment will help to create better parity across regions in the number of members and level of participation as well as in the programming, networking, and fiscal support available within each region. The realignment should help to enrich the programming within regions that had lower levels of participation and help to ensure that a sufficient pool of active senior members exists to support networking and mentoring within each region. More consistent programming and better networking at the regional level should also help members succeed in gaining more national recognition for their work. We hope that the realignment will also stimulate regions to be creative in trying new programs and sharing results of pilot programs between the regions.

EB: How will this affect members and the regional meetings?

TR: All SGIM members will continue to be affiliated with a region according to their primary location. They will be included in the GIMConnect community for that region so that they can communicate with other members in that region.

We encourage members, especially those early in their career, to run for a leadership position in their region. The regions are always looking for volunteers to serve in a variety of positions, whether it is as a regional officer or chairing a committee as part of each region's meeting planning team. With the recent appointment of Regional Diversity, Equity, and Inclusion (DEI) Chairs, the regions are also expanding opportunities to lead in the DEI space.

A regional leadership position is a great way to get more involved in the Society. Indeed, most of our national leaders previously served in a regional leadership position. Although we encourage all members to attend the regional meeting in their area, members are permitted to attend any regional meeting that interests them. We also encourage members to invite students, residents, and fellows to join us at a regional meeting. Oftentimes, a regional meeting is the best way to introduce trainees to SGIM because it is easier and less expensive for them to attend a meeting in their area.

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PRIMARY CARE: WE KNOW THE PROBLEM, SGIM NEEDS TO LEAD THE SOLUTION

William M. Tierney, MD

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The slow-motion train wreck that is primary care has been brewing for a couple of decades: medical students opting for higher-paid specialties than primary care whereas the primary care physician workforce is aging and retiring faster before they are being replaced. Stir in physicians' dissatisfaction with short visits and unrealistic productivity expectations and you end up with a specialty that, though fundamental to health care and people's health, is on life support. The COVID-19 pandemic accelerated all of this to where we are facing an existential crisis for primary care and general internal medicine.

It is not that primary care is not wanted or needed. All patients want "their doctor," someone they can go to for new problems and worries and who will care for *them* and their chronic maladies, mitigate their risk factors, and help them navigate our labyrinthine healthcare system. And yes, to hold their hands and ease their passing. What to do? Assuming dramatic increases in primary care physicians' salaries is not in the offing, we need new models of care that include not only physicians but also nurse practitioners, physicians, assistants, nurses and nurse educators, mental health counselors, social workers, and community health workers, each working at the top of their capabilities. Who will develop, test, revise, re-test, and deploy such models of care? Patients, clinicians, and health care managers all need to be engaged, led by SGIM and its members.

It is critical that SGIM does more than survive as an organization that supports the professional development of its members. It needs to grow to attract and support health services researchers and clinician leaders who will create and assess these new models of primary care; demonstrate their value to patients, clinicians, health care administrators, and payers; and implement them in their own primary care health systems.

I talk to medical students regularly, and they give me hope. Although they know our health system is unwell and physicians are stressed, they are working hard to become physicians because they know that they can make a difference to their patients and to the health systems

that care for them. *We need these people to join us in our efforts to recreate primary care!*

SGIM can and should attract young physicians to academic careers to revolutionize primary care. One way is to help them attend SGIM's annual meeting. Time and again, I hear of students who have attended our meetings and come away both awed and inspired by the work being done. We should feel obligated to encourage our students, residents, and fellows to attend our meetings and strongly consider careers in academic general internal medicine. And we should do what we can to lower the barriers to their engaging with us.

A significant barrier to trainees' engaging in SGIM and its meetings is financial: dues and meeting fees are not cheap. SGIM's annual meetings are well-attended, given its relatively small size, and there is a huge, broad panoply of offerings in each of the missions of primary care, teaching, and research. Meeting fees are substantial because the meeting is substantial. SGIM itself is a broad organization that supports 15 committees, 4 commissions, 72 interest groups, 6 work groups, and 7 regional meetings. Managing all of this requires a staff of 21 and substantial annual dues.

SGIM's dues and meeting fees are sufficient to "keep the lights on." But, especially for students, residents, and fellows, we can and should do more. And we are. Through generous donations to SGIM programs, such as Forging Our Future, SGIM has been able to pay 2022-23 membership dues for 75 first-year fellows, provide scholarships for 50 students and residents to attend the 2023 annual meeting, and support 110 one-on-one mentor pairs and 23 junior faculty in its Women in Medicine Commission's Career Advising Program. Donations to SGIM's Unified Leadership Training in Diversity Program (UNLTD) has allowed it to expand, increasing the number of junior faculty participating and enriching the program's content. SGIM has hired an innovative consulting group to help the Association of Chiefs and Leaders in GIM (ACLGIM) develop and implement novel approaches to recruit and retain trainees and young

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SHELTER FROM THE STORMS: A CALL TO ACTION FOR PATIENTS EXPERIENCING HOMELESSNESS

Valerie Gobao, MD; Emily Min, MD

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As the Earth's climate grows more inhospitable, so does the civic environment for some of our most vulnerable citizens. From Pittsburgh to Portland, many people experiencing homelessness suffered involuntarily displacement from temporary shelter this summer. At the same time, the demand for shelter, not to mention housing, is higher than ever. Between 2017 and 2022, homelessness increased by 6%.¹ To eliminate the visible evidence of homelessness, communities employ strategies such as encampment sweeps, where police or sanitation workers clear out belongings and dwellings. Such involuntary displacement policies are a mistake. They worsen health outcomes and increase mortality instead of addressing the underlying issues leading to homelessness.

As resident physicians, we witness the health impacts of housing insecurity every day. People experiencing homelessness are at higher risk for exacerbations of chronic medical conditions because they cannot store medications, have a higher susceptibility to acute illnesses, such as pneumonia, and are at higher risk for physical violence.² They are also more vulnerable to climate-related health issues related to air pollution, as well as cold and heat exposure. Indeed, heat kills more people worldwide than any other climate-related event.³

Involuntary displacement policies harm people experiencing homelessness. During a sweep, they may lose critical belongings, such as IDs, medications, sterile injection supplies, and naloxone.⁴ Displacement often disconnects this population from local support services, like street medicine teams,² and from their own communities, which detrimentally affects mental health. More than 30% of people experiencing homelessness have a substance use disorder and are at higher risk for infections from drug use and death from drug overdose—over a 10-year period, it is estimated that involuntary displacement leads to a 25% increase in all-cause mortality for individuals experiencing homelessness that also inject drugs.⁴ If these glaring health threats were not enough, these policies are also costly to local governments, diverting

funds from initiatives which could address root causes of homelessness such as high cost of living, and underfunded social safety net supports.^{4,5}

Proponents of involuntary sweeps argue that temporary encampments are unsafe, detrimental for public health, and disruptive to communities. We reject the implication that the lives of the people displaced matter less than the comfort of their housed neighbors. Others who support dissolution of encampments may extol the virtues of “Housing First” policies which seek to provide housing to persons experiencing homelessness as the first and most important step to improving health. Unfortunately, rapid access to housing is not always feasible due to high housing prices and limitations of municipal social safety net supports.^{4,5} A temporary shelter or an encampment can provide important risk mitigation for unhoused people by offering safety, protection from the elements, and community. The simple fact of having a community can be lifesaving in the event of overdose, assault, or illness.

We call upon our physician colleagues to advocate for people experiencing homelessness by standing against involuntary displacement policies and supporting evidence-based strategies to combat homelessness in our communities. On a civic level, we can use our expertise to oppose encampment sweeping and support legislation that increases funding for housing navigation and other social services. This can be accomplished by writing a letter to local government officials, participating in town halls or council meetings, and mobilizing the power of local physician organizations to work with local politicians to create such legislation. We can also make a stronger effort to vote in local and state elections and help register our colleagues and patients to do the same. Finally, we can leverage the power of our social media networks by raising awareness about this issue while engaging with local politicians and amplifying the voices of local activists and people experiencing homelessness.

On a clinical level, we can use harm-reduction measures to mitigate risks of comorbidities associated

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SPECULATIVE MEDICINE: ENVISIONING A LARGER REALITY FOR THE FUTURE OF MEDICINE

Gaetan Sgro, MD

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Imagine...

The new school sits between 40 acres of hilly farmland and the outskirts of an old mining town. There is an airy classroom building, several greenhouses, and a large community center that includes a restaurant and a gymnasium. The campus is built on earth scarred by draglines and scrapers, and the immediate surroundings have been replanted with solar panels and young pines.

The first-year students spend as much time tending crops and feeding chickens as studying biochemistry and pharmacology. The seniors are already staffing a network of small primary care clinics scattered throughout the valley. They spend less time in traditional medical settings than they do building relationships in classrooms, at local markets and basketball games. The school's truly novel curriculum—rooted in principles of preventative medicine, environmental and nutrition science, and community engagement—aims to foster a new generation of healers focused less on treating disease and more on helping individuals and communities thrive.

The preceding decade has been one of upheaval in American health care and society. The Russo-Chinese wars of the late 2020s opened the door to a conservative austerity government that repealed the Affordable Care Act, shuttered Medicaid, and converted Medicare to a voucher system accessible only to the wealthy. An ongoing backlash against elite institutions led to the end of federal funding for Graduate Medical Education and within a few years only a handful of traditional academic medical centers, clustered in large, coastal cities and supported by private endowments, survive. An already fragile and fragmented healthcare system fractures and care becomes inaccessible to hundreds of millions.

After years of struggling to care for patients in a region plagued by public and private divestment, increasing environmental stress, and the opioid crisis, a

loose collective of healers forms in the foothills of the Alleghenies. They garner funding from farming subsidies, state and local grants, and private philanthropy to establish the first Health Oriented Medical Education (HOME) program. It's barely enough to purchase building materials, but local tradespeople contribute free labor and within a few years, the educational, clinical, and agricultural programs will become self-sustaining.

Over the next decade, HOME centers will spring up in both rural and urban parts of the country. Health professions graduates—a historically nomadic tribe—

will put down roots and work alongside the people they serve to realize Wendell Berry's vision¹ that, "The community—in the fullest sense: a place and all its creatures—is

the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms."

If only this dream were a reality.

It could be.

Einstein said that "No worthy problem is ever solved within the plane of its original conception."² In the pages of *SGIM Forum* and many scientific and lay publications, concerned physicians have scoped the problems that plague our disorganized, unequal, and ineffective healthcare system. But the scale of our industry and the powerful interests that support it discourage bold thinkers from sketching a future state conceived on an entirely different plane. I wonder how much I've been restrained by Upton Sinclair's insight that it's difficult to get a person to imagine radical change when their career and salary depend on not imagining it. How can we set our imaginations free?

Speculative fiction refers broadly to literary genres that depart from reality, including science fiction and fantasy. The term also applies to futuristic narratives more

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"Send us your wildest imaginings, your unrealistic visions, your most embarrassing and impractical dreams."

LESSONS FROM A PROJECT-BASED MENTORSHIP INITIATIVE

Jennifer Wright, MD; Helene Starks, PhD, MPH; Lauren A. Beste, MD; Jared W. Klein, MD; Somnath Mookherjee, MD

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Mentorship is critical for career-satisfaction, faculty retention, scholarly productivity, and confidence in professional development skills; yet many academic physicians note a lack of mentorship.¹ Forming effective mentoring relationships can be challenging, especially in a large division of General Internal Medicine comprised of predominantly junior faculty. At the time this initiative was launched, formal mentorship practices for new and junior faculty entailed annual progress meetings with section heads, seminars on mentorship, and meetings with the director of the faculty development program for incoming faculty. Based on conversations with colleagues and division leaders, these measures seemed inadequate for fostering durable mentorship connections. In this article, we describe an innovative project-based mentorship model to bolster mentorship knowledge and increase mentorship connections across our division.

Our idea was to use a book-writing project to connect junior and senior faculty not only as co-authors of a book chapter but also as mentorship dyads. The book, entitled *Chalk Talks in Internal Medicine—Scripts for Clinical Teaching*², comprises teaching scripts for common clinical scenarios in internal medicine. The book editors started by creating a list of salient inpatient and outpatient clinical teaching topics and invited all faculty in our division to sign up for chapters of interest. We designated authors as *junior or senior* based on number of years on faculty, then paired junior (mentees, n=48) and senior (mentors, n=46) faculty based on mutual clinical teaching interests. We prioritized connecting co-authors who in our estimation would not have met otherwise given multiple campuses and settings in our large division. Two mentors wished to work with two mentees each and were therefore assigned two chapters.

Participants were given instructions on creating a teaching script on the clinical topic they selected. In addition, all participants were given copies of a one-page

Project-Based Mentorship Guide³ which provided guidance for mentor- and mentee-ship.^{4,5} Author dyads were encouraged to meet at least once to plan their chapter and use the opportunity to discuss career development as outlined in the guide. We sent e-mail reminders to follow the steps outlined in the guide and highlighted positive comments from participants engaged in mentorship.

The project launched in January 2017 and ended in March 2019 with the submission of the chapters to the publishers. We surveyed participants in October 2020 after publication of the book. We queried prior mentorship experience and impact of the project-based mentorship approach on the writing process, quality of the chapter, and enjoyment of the process. We asked participants to rate the overall benefit of the initiative for themselves and their partner using a 5-point “strongly disagree” to “strongly agree” Likert scale. We also asked whether they had remained engaged with their co-author around either career development, additional joint scholarship, writing letters of support, or networking, and invited other comments about the overall project.

We received 69 responses to the survey: 43/46 (93%) of mentors (MO) and 26/48 (54%) of mentees (ME) responded. Twenty-three dyads had responses from both members. We examined differences in the distributions of responses by group (mentor v. mentee) using chi square tests. For surveys with matched data from both co-authors, we repeated the analyses using only data from matched pairs to assess potential response bias given different response rates between the two groups.

All respondents reported that they had met at the start of the project and 75% of mentors and 94% of mentees reported that career advice was reviewed in the initial meeting. Only 13% of mentees reported any prior structured mentorship relationship.

Mentors and mentees generally agreed that the ap-

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IKIGAI: FINDING PURPOSE AND JOY IN MEDICINE

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As irrepressible storytellers, internists crave purpose. We spend an inordinate amount of time sketching the countless connections between the moments of our lives. That purpose drives the joy and engagement we bring to our careers.¹ Purpose brings life satisfaction and well-being. Unfortunately, our modern profession's reality has painted a sometimes-stark contrast to that idealism. Up to 63% of physicians report at least one symptom of burnout and only 30% are satisfied with their work-life integration.² No doubt, the causes and solutions for burnout are complex.³ We propose the concept of *Ikigai* as a piece of the solution—an approach to identify purpose and, in turn, joy in our careers.

Ikigai combines two Japanese concepts, *iki* (life) and *gai* (worth or value). It is loosely translated as the “reason for being” or *raison d'être*.⁴ *Ikigai* is a state of well-being that arises from devotion to activities that bring joy and meaning to life. Japanese culture places great emphasis on the mind-body connection. As such, *Ikigai* is considered one of the key ingredients to longevity and a healthy and happy life. While broadly applicable in all aspects of life, applying the concept to evaluate our careers and opportunities in medicine can reduce burnout and improve the longevity of our careers.

Ikigai exists at the intersection of four vital overlapping questions:

1. *What are you good at?* This may be known or innate. It may require self-exploration to investigate further, for example by tools such as *Strengthfinders 2.0*.⁵ Or it may be something you can cultivate with the appropriate time, support, and resources. You may ask: “What am I good at, and what can I be good at?”
2. *What do you love?* Think about the things that energize you and make you smile. It certainly doesn't have to be related to medicine.
3. *What does the world need?* The *world* can be defined differently—your patients, communities, division, department, institution, or, quite literally, the world itself. You live and work in a variety of different mi-

cro- and macro-environments. Sometimes you know where attention and efforts are needed; other times, you must assess and reflect more formally upon the gaps. This question is crucial in connecting your purpose beyond the individual self.

4. *What can you get paid for?* Getting “paid” can be defined differently—internal satisfaction, resource allocation, budgeting, time, or financially. Instead of thinking of being “paid” as solely financial, think about the ways in which you can be “compensated.”

To achieve *Ikigai*, finding where these areas overlap is crucial. These four questions are represented as circles overlapping in a Venn diagram, with *Ikigai* being the center—a point of equilibrium and resonance: *Ikigai*. Asking these questions identifies what provides meaning while balancing where and how others value you. Not everything you do for your career fits in every area (nor does it have to). To work towards achieving *Ikigai*, focus on the individual questions first, answering from your unique point of view. Some find it helpful to list skills, activities, or elements for each domain. Others focus on larger domains such as medical education or research. Include both clinical and non-clinical elements of your life (e.g., music, cooking, poetry, research, travel). After exploring these questions, evaluate how to harmonize your answers; find the area(s) of overlap and think creatively about incorporating them into your work. If you love music, explore whether you can develop a “Music in Medicine” elective for students or work with the hospital on integrating music into the wards to improve the patient experience. Think about what piece(s) might be missing from your ideal state, one that can provide a state of balance. Maybe you want to be a medical educator, have a passion for global health, or are suited for a C-suite role. Whatever the answer, understand its present state, and assess steps to combine these four pillars to bring satisfaction and purpose to what you do. However, know that those answers may change over

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I wrote about my vision of general internists' work and why it's important in my *Forum* column, "The '4Cs' of a Generalist's Care" in the October 2023 issue.² Listening to the discussion at the 2023 Hess Institute and knowing about the work ACLGIM is doing to address the three top recommendations from the Institute confirmed my own vision and helped me see the variations of that vision due to local patient populations and organizational structures.

Building relationships and learning from others. I have had many discussions about improving primary care practice and educating trainees in primary care settings over the past 18 months. These usually end at the barriers of finding resources to support change and physician payment. At the start of my president-elect year, I reached out to John Goodson, SGIM's expert on the Medicare Physician Fee Schedule (MPFS), knowing I had a lot to learn. He has been a wonderful teacher and advisor. This is a very short synopsis of what I have learned.

The MPFS is a complex system used by CMS to determine reimbursement rates for healthcare services provided by physicians and others who participate in the Medicare program. It is frequently used as a starting point by private insurers when setting rates. The foundation of the MPFS is the Resource-Based Relative Value Scale (RBRVS), a system that assigns relative values to various medical services based on the resources required to provide them. These values are divided into three components:

- Work RVUs (Relative Value Units) represent the time, skill, and effort required to provide a specific service. This is what almost all organizations use to determine physicians' salaries, as you likely know already.
- Practice expense RVUs cover the overhead costs associated with providing a service (e.g., rent,

equipment, staff salaries).

- Malpractice RVUs account for the cost of malpractice insurance associated with a service.

Historically, work RVUs have rewarded procedural care and undervalued cognitive care, the type of care provided by primary care physicians. We use the outpatient evaluation and management (E/M) service codes to bill for our cognitive care. The E/M service codes have not been well reimbursed; while at the same time, the cognitive work we do has expanded. Defining and setting the payment rates for work RVUs is a process that is not transparent, and it has been swayed by strong political pressure from organizations representing specialists who benefit from the procedural codes. The result of this longstanding imbalance in the RVU system and the expansion of the care generalists are expected to provide to our patients is well described by Goodson's article,³ the recent *Washington Post* opinion piece by Rosenthal,⁴ and Berenson's recent viewpoint article.⁵ I urge you to read these articles so you are informed of the issues driving the work SGIM's HPC is doing on our behalf and for the patients we serve.

During my president-elect year, I also reached out to my colleagues active in the Oregon American College of Physicians (ACP) state advocacy efforts. I asked if I could listen in on their planning meetings and participate in their Advocacy Day at our state capital. I wanted to learn how the Oregon ACP Chapter does this work and whether there might be opportunities to have SGIM regions collaborate in these efforts. I am an ACP member. The Oregon ACP Governor knew my goal was to learn how SGIM and ACP members in a state might do advocacy work together and welcomed my participation. Through this activity, I got to know our ACP Governor and an Oregon member of the ACP's Board of Regents. Both are general internists in Portland.

We found we shared the same concerns and desires to advocate to improve primary care. John Goodson provided us with information about the MPFS and ideas for advocacy since one of our Senators is Ron Wyden, Chair of the Senate Finance Committee. Senator Wyden cares deeply about Medicare and its solvency because of his position and earlier years working for the Gray Panthers, a grassroots advocacy network fighting ageism and supporting older people. Lisa Rubenstein—an Oregonian, former SGIM president, and health services researcher—joined our discussions. The four of us learned from each other. We shared research studies, ideas, and anecdotes; we knocked on legislators' doors in Oregon; and we used each other as sounding boards about our "asks." These relationships have been enriching for me, as well as motivating me to do more personal advocacy.

Supporting institutional, local, and state advocacy. Andrea Christopher, a SGIM member in Idaho, gave a rousing advocacy talk at the Northwest Regional meeting in 2023. Her advice was, "don't get mad, advocate!" I took this to heart as I thought about the 2024 SGIM Annual meeting and the theme, "Strengthening Relationships and Valuing Our Differences." This year, we started the meeting planning with an advocacy focus: decreasing the burden of firearm injury. Although this is the focus, the 2024 Annual Meeting committee is putting together a program that will help you develop your skills and strategies for your own advocacy work and to build and strengthen relationships to advance that work.

If you want to join the four of us in Oregon advocating for the Senate Finance Committee to support the CMS CY 2024 proposed rule, submit comments to your state senators, especially those of you who have senators on the Senate Finance Committee. Ask them to support CMS' efforts to evaluate the current

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method for developing the MPFS and consider other transparent, evidence-driven methods for doing this. Finally, I want to thank our HPC members, Francine Jetton, SGIM staff for the HPC, and Erika Miller, our lead policy consultant from CRD Associates, for their work on the MPFS and other policy issues pertinent to SGIM members. They have played the long game, and my hope is the relationships they have developed will move our efforts forward to make changes in the MPFS.

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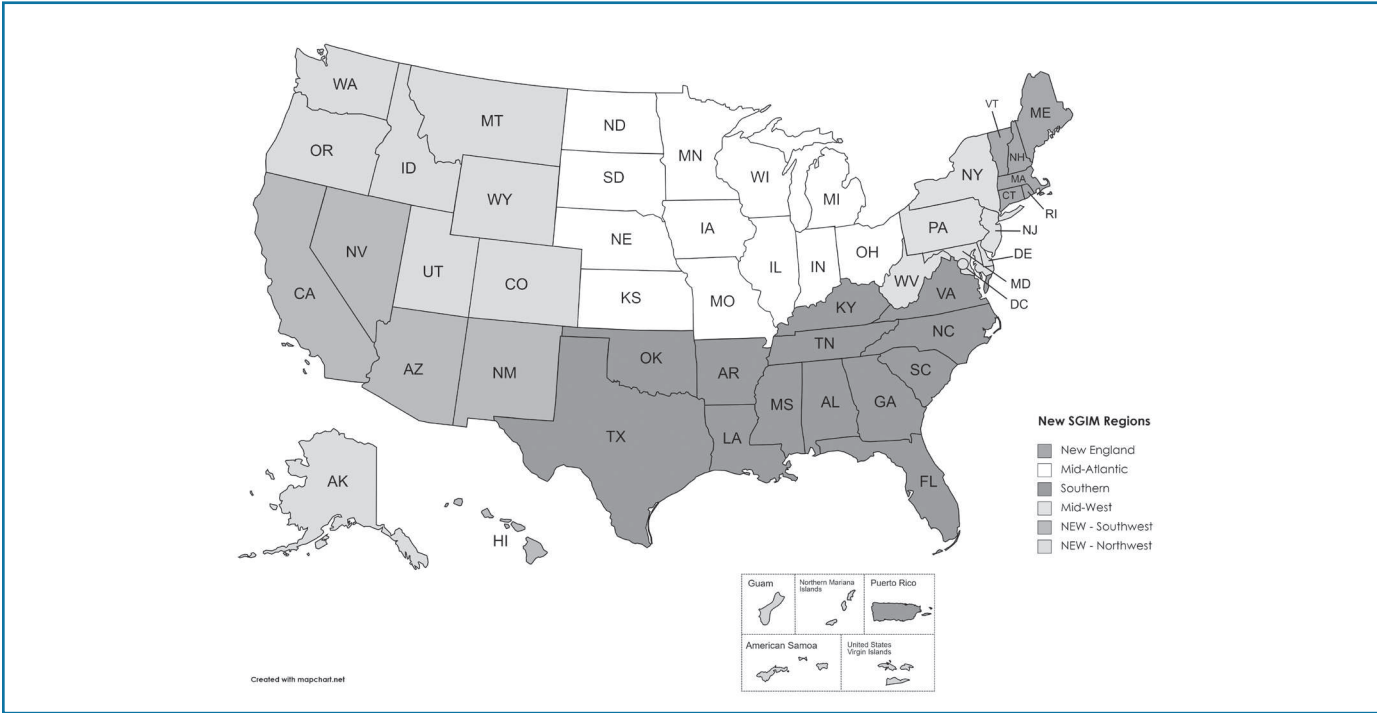
FROM THE SOCIETY (continued from page 4)

EB: How will this affect trainees?
TR: In our survey, members made it clear that ensuring a high level of trainee participation during the realignment was one of their top priorities. The BRL is exploring ways to reduce the cost of meeting registration for trainees, to better support those trainees who may now need to travel longer distances to attend their

regional meeting. Ultimately, we believe that the enhanced programming and networking that will accompany the realignment will be a net positive for trainees.
EB: What if members have additional questions?
TR: SGIM leadership, including the President, President-elect, CEO, and BRL Chair, will be attending each

regional meeting in this academic year to discuss the realignment. Members will have the opportunity to ask questions in both a public forum and one-on-one with SGIM leadership. Members may also reach out to the Regional Meetings Team regions <https://www.sгим.org/meetings/regional-meetings>.

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faculty are more willing to express the importance of meaning and satisfaction in their work and to eschew traditional metrics of success.⁵ In 2003, incoming junior faculty were paired with mentors with the implicit objective of focusing on achieving goals for promotion. The expected outcome of successful mentorship was publication, which was expected to lead to eventual promotion. Promotion was expected to result in job satisfaction. In 2023, the word *mentorship* connotes a much broader function; mentors may be asked for guidance on projects, reflection on the pursuit of job satisfaction, help to decide which opportunities to pursue, and advice on work/life balance.⁵

Therefore, it is not surprising that the contemporary understanding of mentorship is more expansive than a traditional dyadic relationship between a more experienced mentor and the protégé mentee. Twenty years ago, the authors already suspected that linking senior and junior faculty would be insufficient to meet the career needs of all junior faculty across academic tracks.³ Now, it is widely appreciated that effective mentorship must take many forms and include many variations including coaching, sponsoring, and advising—qualities we hoped would organically evolve when mentees worked with their professional mentors. Furthermore, there is greater awareness of the benefits of employing a variety of mentorship structures, including mentorship networks (or “committees”), peer mentors, and connectors to support varied career paths.

In 2023, women are *still* more likely to report ineffective mentoring compared to men.^{1,3} The authors of the 2003 report joined an increasing number of mid-career women faculty and women in leadership positions; yet, the progression of a generation of women faculty has not sealed the “leaky pipeline.” Women now represent nearly half of medical school graduates; however, only 21% of full professors and 18% of department

chairs are women.¹ Women who have risen through the ranks carry a significant “gender tax”—the expectation that they will be the primary source of mentorship for a growing number of junior women faculty. Addressing these gender differences in mentorship is crucial for improving equity in advancement and promotion.

Despite a steady increase in racial and ethnic minoritized populations in the United States, our Division does not reflect local or national diversity. At the time of their publication, the authors of the 2003 report were two of a handful of racial and ethnic minoritized faculty in our Division. Their mentorship assessment did not examine underrepresented in medicine (URiM) or minoritized junior clinician-educator perspectives. In our recent survey, only 6% of Division respondents self-identified as URiM and only 18% of faculty identified as minoritized, not underrepresented. Nearly all URiM faculty and more than half of minoritized, not underrepresented, faculty are full-time clinical faculty—the promotion track most lacking in mentorship. What has changed in 20 years? We now appreciate that intentional efforts to support mentorship and sponsorship specifically for minoritized faculty *and* across all identities are needed for our Division to represent and serve our entire community.

Based on these reflections, we propose four principles for future work in developing mentorship programs in Academic GIM:

- We must dispose of the notion that “mentorship” today should uphold the same process and outcomes of 20 years ago, or that these processes and outcomes should remain the most valued today.
- We must learn *how* to support this generation of academic generalists. Relying on traditional mentorship structures is inadequate. Mentors may need

to learn or re-learn how to mentor, coach, and sponsor through active skill development.

- We should focus on what outcomes faculty are trying to achieve and how to best achieve them instead of settling on “lack of mentorship” as the foil for all types of career dissatisfaction.
- We should examine whether the “scholarship” imperative that mentorship was meant to support 20 years ago is still relevant today and consider more expansive definitions of scholarly work. Will it make the world a better or worse place if academic generalists are more fulfilled, more impactful, more oriented to serving their communities ... but with fewer peer-reviewed publications?

The landscape of General Internal Medicine has changed greatly in the past 20 years. Mentorship and mentors must also evolve to support successful career development for the next generation of academic generalists.

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proach enhanced the writing process (MO=78%, ME=65%), the quality of the chapter (MO=70%, ME=61%) and their enjoyment of the process (MO=83%, ME=70%); results were similar for the 23 matched dyads. Most mentors and mentees reported personally benefiting from the experience. Interestingly, the groups differed with half as many mentees (31%) as mentors (65%) perceiving benefit for their paired colleague ($p=0.006$). Ten mentees (38%) and 20 mentors (47%) endorsed some form of ongoing engagement after the book project; examples included sharing occasional pleasantries on clinical service to a mentor recruiting their mentee to work in an educational role.

We identified three themes in the written comments:

1. mentorship worked best when the dyad had similar academic interests and clinical practices;
2. the project-based format was an effective faculty development tool to teach mentorship skills; and
3. mentors and mentees described challenges in evenly distributing the writing effort and keeping to deadlines.

Several lessons from this project can inform future efforts to foster mentorship. First, formal integration of mentorship guidance can have a positive and enduring effect on career development as long as 18 months after completion of a project. This approach should be considered as part of any comprehensive strategy of fostering mentorship in an academic group.

Secondly, we learned that assigning mentorship dyads is challenging, even in a project-based model. In this project, the book editors assigned authors to work together based on their understanding of the authors' content expertise, stated interest in specific chapters, and perception of whether the authors would have otherwise had a chance to work together. Several comments raised the possibility that this approach may have hindered the mentorship aspect of the project extending beyond the authorship work as the authors' career goals or research interests were not necessarily aligned. The matching process could have been improved by surveying faculty to learn more about their career focus or allowing mentees to select from a pool of potential mentors.

Lastly, effective mentorship while co-authoring a manuscript proved to be a complex process. Greater foundational teaching may be required than a concise one-page project-based mentorship guide. For example, mentees tended to believe that their mentors received fewer benefits from project-based mentorship than they did, suggesting the need to highlight what mentors receive back from mentoring relationships. Greater awareness of the mutual benefits of mentorship might enhance mentees' comfort with reaching out to mentors to initiate or perpetuate relationships. In addition, comments referencing imbalances in the distribution of work highlighted that not specifically articulating the ground rules of co-authorship can distract from positive mentoring experiences.

Overall, the project was useful for teaching mentorship skills to mentors and in enhancing the writing experience for both mentors and mentees. The use of a structured guide to promote mentorship and career development conversations paired with a clearly defined scholarly product resulted in benefits to both junior and senior faculty.

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relationships.”²⁴ One of the main reasons I volunteer to serve as a mentor is that mentoring forces me to self-reflect on my own career and how I handled situations in the past. Though offering advice to mentees revolves around the specifics for that mentee, it is shaped by the mentor’s past experiences and thoughts when guidance is offered.

In this issue of the *SGIM Forum*, Associate Editor Dr. Somnath Mookherjee and his co-authors offer two articles on mentoring. In the first article, Drs. Deshpande, Mookherjee, and team compare mentoring concepts in 2023 to a previous study on mentoring completed 20 years prior. They remind us that as much as things have changed, many opportunities remain to be tackled in the mentoring arena. In the second article, Drs. Wright, Mookherjee, and team describe how a novel paired mentoring concept around a specific project led to successes but also recognitions of how things can be done differently in the future. SGIM president Dr. Martha Gerrity highlights the efforts of the Health Policy Committee and her crusade to advocate for internal medicine. SGIM CEO Dr. Eric Bass and Board of Regional Leaders Chair Dr. Tom Radomski detail the

unfolding of a long-standing effort to realign regions within SGIM’s organizational structure. SGIM Philanthropy Committee Chair Dr. Bill Tierney reminds us that running an organization like SGIM requires financial commitments. Current SGIM financial requirements (annual membership renewals and annual meeting registrations) cover the basics of what SGIM offers as an organization. As a forward thinking and moving organization, it is the new and innovative efforts that make SGIM special, and the expansion of these programs can be supported with a donation on “Giving Tuesday.” Drs. Gobao and Min offer perspective on the detrimental impacts of certain policies and processes on the health and wellbeing of the unhoused. Associate Editor Dr. Gaetan Sgro envisions an idealized future state of health care to meet society’s most pressing needs utilizing a future fictionalized narrative article. Finally, Dr. Alvarez Concejo and co-authors help us find purpose and joy in what we do by defining *Ikigai*: devotion to activities that bring joy and meaning to one’s life.

As busy internists, we all have a need for mentoring. This need can be a brain to help us formulate our thoughts, an ear to listen to

our concerns, a mouth to provide wisdom and challenge us, a hand to support us when we feel unsteady or a foot to kick us into action when we need it most. But we must remember “the delicate balance of mentoring someone is not creating them in your own image, but giving them the opportunity to create themselves”¹. We all need mentors. We all need to be mentors. We all need SGIM.

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BREADTH: PART I (continued from page 7)

closely tethered to our present reality. In fact, many speculative fiction scenarios are not hard to imagine; it just takes a leap of faith—or a catastrophe—to realize those future states.

These narratives are often propelled by cataclysmic events or new technologies: a fertility crisis in *The Handmaid’s Tale*; a lethal pandemic in *Station Eleven*; a revolution in gene editing in *Klara and the Sun*. While recent data on Americans’ health outcomes³ may be less dramatic than a zombie apocalypse, it confirms that a more insidious disaster is already underway. So, what would you like to think comes next?

To confront immense challenges, Ursula K. Le Guin urged writers to become “realists of a larger reality.” In that spirit, I invite you to embrace (and to submit to *Forum*) your wildest imaginings for the future of healthcare; your unrealistic visions; your most embarrassing and impractical dreams. I know this community will take you seriously. We may even try to make the impossible happen.

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physicians into GIM. SGIM has also launched GIMLearn, a platform through which young GIM educators can store, share, and disseminate innovative approaches to teaching. It received 30 programs to its first call for submissions, 12 of which have been accepted already.

Most of the funds supporting these programs come from substantial donations from a small number of SGIM members: only 6% of SGIM's approximately 3,000 members were donors in 2022-23. Just imagine what an expanding "Spirit of Philanthropy" could do within SGIM! If each member donated \$25 or more annually, the resulting \$75,000+ would provide much greater sustained support for trainees and junior faculty, exposing them to the wonders of our field and the spirit and culture of SGIM, our specialty's academic home. More would join

us and be the vanguard of a new generation of health system innovators. SGIM members have always given freely of their time, talents, and treasures to trainees; we encourage each member to donate an amount they can afford to ensure the future of GIM.

As the end of the year draws near and Giving Tuesday looms, please consider adding SGIM to your philanthropy plans. This year SGIM's goal for Giving Tuesday is to cover the cost of at least 10 additional scholarships allowing students and residents to attend SGIM's 2024 annual meeting. You can help us reach our \$5,000 goal and ensure an additional 10 or more trainees are able to benefit from the career changing experience of attending SGIM's annual meeting by visiting the donation page on SGIM's website to make your gift today.¹

Primary care and caring for people in need is the most rewarding and satisfying career in medicine. But the care needs to be delivered by the right clinicians in the right venues at the right time for the right people for our health system to be both efficient and effective. I encourage all SGIM members to join in the Spirit of Philanthropy and make a modest donation annually to SGIM so it can attract the young academic physicians and help them create the new models of primary care we so desperately need.

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SIGN OF THE TIMES (continued from page 6)

with homelessness. When seeing patients in any setting, implement a universal screen for housing instability into your practice. If identified, it will be important to assess for the unique health burdens that come with homelessness or housing instability, including access to safe storage for medications, availability of air-conditioning or heating (and awareness of local cooling centers), and presence of a substance use disorder. Information on local resources can also be helpful to distribute to patients, share with other providers, and use on the clinics/wards. This includes local street medicine or mobile healthcare groups, safe syringe initiatives, and programs to screen and treat communicable diseases. Physicians should also be aware of available respite care facilities modeled after the Barbara McInnis House in Boston, which provides recovery medical care for people experiencing homelessness after acute medical illnesses, surgeries, or chemotherapy. If these

lifesaving resources are not present, then we should support establishing these services with local academic or community health centers.

Housing is a human right and governments incapable of housing everyone must at least allow for basic shelter. Shelter, no matter how imperfect, can be the difference between life or death for people experiencing homelessness.

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BREADTH: PART II (continued from page 9)

time, and careers can and should adapt and evolve to continue a fulfilling career that provides lasting joy. Importantly, finding your Ikigai isn't so much about the destination but about enjoying the journey and experience along the way to find who we are and what provides us meaning.

Doctors and leaders can use Ikigai to guide critical and periodic reflections on current state, growth, and career trajectories. There may not be a single Ikigai, but sometimes multiple things that fulfill your purpose. This process can allow us to be present and intentional in our search for meaning, guiding us through

inevitable ebbs and flows of work and of life. Seeking Ikigai could be the first step to reclaiming what we desire and deserve: medicine as a source of joy and purpose.

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