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SGIM Forum
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COMMISSION/COMMITTEE/INTEREST GROUP UPDATE

FORGING THE FUTURE OF SGIM THROUGH TRAINEE ENGAGEMENT

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The SGIM Membership Committee cultivates a healthy membership base by recruiting and retaining a diverse, inclusive, and active membership of academic general internal medicine (GIM) physicians, including educators, investigators, and clinicians. While the committee has focused primarily on faculty physician membership, there is a growing need to ensure that the pipeline to these faculty positions is healthy and robust. In April 2023, SGIM President Dr. Martha Gerrity noted in her inaugural president's column that general internal medicine faces many "wicked" problems in the upcoming years. Among them is the need to ensure increased support for our pipeline of academic general internists, particularly from underrepresented backgrounds. This problem should be addressed through targeted outreach, support, and career development at all career stages.[1]

> **"Solving the 'wicked' problem of the academic general medicine pipeline cannot be left to chance. It will require support and deliberate outreach to trainees to ensure a vibrant and thriving future community of academic generalists."**

If we look upstream at various stages of training that precede a faculty position in academic general internal medicine, the first group we see are the general internal medicine fellows, followed by internal medicine residents and medical students. Many general medicine fellows have already made the choice to pursue a career in academic GIM and thus are a particularly high-yield group to engage as they consider which organization best aligns with their values and will serve as their professional home. For this group, it is important to highlight the full scope of benefits available to SGIM members. By contrast, many internal medicine residents and medical students have yet to solidify their career choice. As such, they require a different form of outreach which should include opportunities to network and interact with the many facets of academic general medicine, such as those offered by attending the annual SGIM meeting.

Considering the needs of these distinct groups is vital as we seek to engage trainees and retain their interest throughout their training.[2] The SGIM Membership Committee offers trainee engagement programs to help facilitate this exposure and engagement with SGIM at an early stage in a trainee's career by providing financial support for annual meeting registration for students and residents and support for SGIM membership for fellows through donations from the Future Leaders of GIM fund.[3,4] These investments contribute meaningfully to the pipeline of future academic generalists and to the success of SGIM as a whole.

Program Description

National Young Scholars in General Internal Medicine (NYSGIM)

The NYSGIM program is an online scholarship application that provides financial support for medical students and internal medicine residents to attend the national

continued on page 12

CONTENTS

THE ROLLERCOASTER OF MEDICAL TRAINING

Michael Landry, MD, MSc, FACP,
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Medical training is a long and winding rollercoaster ride with arduous slow ascents, perilously sharp curves, gravity-defying loops that leave us temporarily upside down, and rapid descents which can be exhilarating to some, terrifying to others. Students, residents, and fellows (SRFs) often ride this rollercoaster daily. SRFs have a safety belt securing them in place (staff supervision) and often ride this rollercoaster with others (training program). After completing training, SGIM members face similar perils on this training rollercoaster due to lifelong learning requirements. As physicians, we all ride this same rollercoaster, but maybe in different cars or at different times.

Many physicians enter medicine with a goal of helping patients by curing illnesses or treating chronic diseases. While some physicians endorse the concept of wellness and health promotion, fewer physicians learn to care more about the patient than the disease. Riding the rollercoaster of formalized education while undergoing self-discovery takes a lot of emotion and energy from individual riders.

Physicians remember specific patients that influenced their SRF training. I remember the 600 gram 25-week preemie born to a crack cocaine addicted mother with no prenatal care that I successfully intubated during training. Upon my return to the NICU four months later, I was dismayed to see the same infant still there after suffering several healthcare setbacks. More heartbreaking was to hear that "mom" never visited or called to check on her son. I remember the 22-year-old college student brought into the trauma room at Charity Hospital after a motor vehicle accident while driving under the influence. He was nearly the same age as many of the students and residents as we labored to plug the holes, stop the bleeding, and get him to surgery. After 35 minutes of unsuccessful attempted life-saving heroics, I sat with the attending and upper-level resident as we informed his parents that he had died. I remember the 44-year-old female with end-stage cirrhosis secondary to Hepatitis C as my first patient as a third-year medical student. She had come to peace with her future and selected hospice care. I naively thought there was still something that I could do to change her course and impending death. My attending told me that as her doctor (in training), the most important thing I could do was obey her wishes, make her comfortable and be there for her and her family. This was not quite the message or first patient a

continued on page 13

THE "4 Cs" OF A GENERALIST'S CARE

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

"In advocating for changes to improve our pipeline of trainees and support general internists, I am struck by how often we need to explain what we do, how it differs from specialist care, and why this type of care is more important now because of the increasing complexity of our healthcare system."

Patient care is increasingly complex and health care delivery is increasingly fragmented.[1] Primary care and hospital-based general internists are the lynchpins in our healthcare system. They see the big picture, understand what matters most to patients, coordinate care across consultants, and communicate effectively with patients and their loved ones. In the hospital, this type of care occurs in a compressed timeframe of days and weeks; however, in the outpatient setting, it occurs over a longer timeframe, often extending many years.

As healthcare complexity increases, the pipeline of trainees entering general internal medicine, especially primary care general medicine, is shrinking;[2] and recruiting and retaining academic general internists to train future generations of physicians is increasingly difficult. In advocating for changes to improve our pipeline of trainees and support general internists, I am struck by how often we need to explain what we do, how it differs from specialist care, and why this type of care is more important now because of the increasing complexity of our healthcare system.

I keep returning to the "4 Cs" of primary care, first described by Barbara Starfield—a pediatrician, public health and policy leader, and vocal advocate for primary care throughout her career—to help me explain the unique characteristics of generalist care: first contact, continuity, comprehensive care, and coordinated care.[3] These characteristics are the foundation of quality health care and have long been associated with improved health outcomes for patients.[4]

1. *First contact* emphasizes the importance of a general internist as the physician who knows a patient well and is the first one called about a health concern, usually by a nurse in the inpatient setting and by the patient or a family member in the outpatient setting.

continued on page 11

Q & A WITH SGIM'S CEO AND THE CHAIR OF THE GENERAL INTERNAL MEDICINE (GIM) FELLOWS TASK FORCE

Eric B. Bass, MD, MPH; Nisa Maruthur, MD, MHS

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Maruthur (maruthur@jhmi.edu) is the Chair of SGIM's GIM Fellows Task Force and an assistant professor of medicine at the Johns Hopkins University School of Medicine.

EB: What have you been charged to address as the newly appointed Chair of the GIM Fellows Task Force?
NM: SGIM's President (Martha Gerrity, MD, MPH) asked me to lead a task force that is charged with developing plans to address the highest priority recommendation that emerged from the Research Committee's recent surveys of current and former GIM research fellows and fellowship directors. The recommendation calls for SGIM to develop a community around GIM research that spans career stages and supports a GIM research pipeline with activities at meetings and between meetings.

EB: What were the specific aims of the Research Committee's surveys of current and former GIM research fellows and fellowship program directors?
NM: In 2021, the Research Committee formed a GIM Research Fellows Survey Subcommittee that included Lauren Block, MD, MPH; Kristina Cordasco, MD, MPH; Deborah Gomez Kwolek, MD; Karin Nelson, MD, MSHS; Michael Paasche-Orlow, MD, MPH (co-chair); Kira Ryskina, MD, MSHP; Mara Schonberg, MD, MPH; Bimla Schwartz, MD; Himali Weerahandi, MD, MPH; Donna Windish, MD, MPH; Erika Baker (SGIM staff); and myself as co-chair. The subcommittee designed a pair of surveys to address growing concerns about the future of the academic GIM research workforce. The surveys were designed to answer four specific questions:

1) How can we improve the experience of research fellows in SGIM during their fellowship?
2) How are the career paths of research fellows similar or different from what they intended at the time of their research fellowship?
3) How can SGIM help its members maintain long-term investigator careers in academic GIM?
4) How can SGIM help research fellowship directors?

EB: What were the most important or surprising findings from the survey?
NM: We learned a lot about factors influencing the motivation to pursue a research fellowship and how people viewed the training and experience during their fellowships. We also learned about their career plans and outcomes after fellowship training. We were disturbed to learn that many people experienced discrimination during their fellowship training and many reported symptoms of burnout at a very early stage in their careers. We also heard from fellowship directors that they would be very interested in having more fellowship-related resources provided by SGIM.

EB: What did the Research Committee recommend based on the survey results?
NM: The committee included 10 recommendations in its report to SGIM's Council, including the one that Council identified as the top priority for the task force. The other nine recommendations were:

1) SGIM's expansion of resources to support clinician-investigators should include meeting-related activities such as support of fellows to attend meetings, networking opportunities during the meetings, and outreach to fellowship programs not currently active in SGIM;
2) SGIM should create a national strategic marketing plan for the GIM research pathway and research fellowships across career levels (i.e., medical students, residents, fellows, and faculty);
3) SGIM should conduct additional investigation into experiences of discrimination among its members at different levels of training and develop a strategy to address this;
4) SGIM should focus on assisting fellowship programs with recruitment of fellows, including those who are underrepresented in medicine;
5) SGIM should perform a closer evaluation of non-meeting SGIM resources to determine which resources should be improved or removed;
6) SGIM should consider how it can address burnout among its members;
7) SGIM should develop career development resources for fellowship program directors;
8) SGIM should consider hosting a website for fellowship program directors with helpful resources for fellows and program directors; and

continued on page 13

FIND YOUR JAM TEACHING IN THE CLINICAL SETTING

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Over the past 10 years, multiple clinical apps, online calculators, and decision-making tools on smart phones have become available for residents to use in clinical care. Despite having numerous technological resources for clinical work and decision making, the use of technology for teaching in resident education is variable and does not advance the use of evidence-based learning strategies at the bedside. In this column, we review how a whiteboard application, Google Jamboard, can positively impact the inpatient learning environment with an attention to adult learning theory.

Google Jamboard was released in 2017 as part of its office suite. It is a free virtual whiteboard that enables users to draw, add text and pictures, link to other Google products, and post sticky notes. In health professions education, Jamboard has been primarily used for undergraduate medical education as an adjunct to virtual anatomy classes.[1,2] It has also been used to post dental student reflections and to share "shout-outs" in a residency program.[3,4]

Reflection and spacing are known evidence-based learning strategies that can be difficult to operationalize on wards.[5] To promote reflection, we created a shared Jamboard link for all clinical learners on the team. Using the sticky note feature in Jamboard, resident learners were encouraged to post one learning point from rounds each day. These learning points or "sticky notes" could be a medical factoid, clinical pearls, or "soft" skills observed on teaching rounds. (The following link is an example of what a Jamboard looks like for our clinical learning teams: https://jamboard.google.com/d/1vZI-1WB7NI7cbF2gA_SXKrX_9S8lr8pl-Ei9NAf4TR_4/viewer.)

Medical students also posted notes indicating one learning point they learned for every patient they followed. We did not dictate the color of the sticky note, but educators could assign a color for each learner or topic. At different time points during the week, the attending led the team through a review of the pearls posted and expanded on concepts shared. To make the review session more fun, the team would have tea, coffee, or ice cream during the discussions and then share the Jamboard on social media. Social media reached a broader audience and encouraged asynchronous discussion about learning points. By utilizing these techniques, Jamboard becomes a fine tool for spacing of concepts as learners get to hear again about topics discussed and elaboration as the attending can lead group discussions to expand on teaching points described by learners.

Another use for Jamboard is to organize and share feedback. To do this, the attending creates a Jamboard for each learner and posts comments on skills, patient interaction, and documentation observed throughout the rotation. Next, the attending can either share the Jamboard with the learner to review or the attending can reference the Jamboard during verbal feedback. It is also possible for Jamboard to be used for educational handoffs around feedback if the attending had any concerns about certain areas of clinical performance with a learner.

Lastly, Jamboard can promote inclusivity as a way for all learners—regardless of training level and confidence—to share what they have learned. Additionally, the anonymous nature of Jamboard allows all learners to participate without fear of being singled out for a wrong comment or thought.

To obtain feedback on the impact of Jamboard on the learning environment, we anonymously surveyed learners and posted on Twitter for asynchronous feedback. One medical student replied, "Utilizing Jamboard made me more diligent about reflecting on specific patient encounters and looking for a learning experience from our encounter" and a resident responded, "The use of these technologies created an intentional space for reflection and synthesis of knowledge. It forced me to actively acknowledge my learning." An instructional consultant commented on Jamboard being an effective strategy for bite-sized learning and feedback. Multiple academic hospitalists were interested in Jamboard, and one tweeted, "Jamboard is much better for shareability and finding later" when compared to traditional sticky

continued on page 15

BEYOND BURNOUT: MORAL INJURY AS A MORE PRECISE DIAGNOSIS

Sheryl A. Cherian, M.S., M.D. Candidate, 2024

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Wintery morning after wintery morning, I shuffled through the chilly hallways of the county hospital and encountered the same scene: my patient, a 24-year-old woman, reclined in her bed, nearly buried in a mountain of dusty yet colorful stuffed animals brought in by her mother. I was a third-year medical student coming from the large academic center next door, but without the many resources available there.

My patient had a bizarre case of catatonia likely related to her advanced lupus cerebritis. This meant that she was mostly frozen in bed when I visited, except one special morning when I saw her slowly tap her phone screen to skip a YouTube ad. *How human, I thought.*

I had learned that lorazepam was first-line treatment for catatonia. However, IV lorazepam was in shortage, and we were running out of options because my patient could not safely swallow oral medications. Even after we managed to obtain and administer IV lorazepam, the patient remained frozen. Electroconvulsive therapy was the next best option, but unavailable at this county hospital, and my patient's insurance coverage created barriers to transferring her to my home institution next door.

Days passed, and I felt uneasy visiting my patient each morning. Before her lupus progressed, this patient was a young woman in her early 20s who went to work, had friends, and loved her mom—not so different than me. When I realized my lack of power to help this person whose life had been like mine, I felt dejected. Physically, I experienced increasing fatigue, and I found myself looking forward to this psychiatry rotation less and less. I was aware of the rising rates of physician burnout—from 38% in 2020 up to 63% at the end of 2021 according to a recent study cited by the American Medical Association.[1] Was I experiencing the phenomenon of "burnout" I had been warned about early in medical school, or was this something else?

Medical students are taught the importance of building a broad differential diagnosis because, "if you don't think about it, you won't diagnose it." With respect to the crisis of physician and medical trainee burnout in our country, our "diagnosis" of burnout is imprecise and therefore our "treatment plan" is inherently incomplete.

In a seminal opinion article published in 2018, Drs. Wendy Dean and Simon Talbot introduced another potential contributor to the syndrome of burnout: moral injury.[2] They posited that "burnout" operates on the individual level and implies a failure to be resilient. On the other hand, they argue, moral injury is a result of the smaller conflicts of interest that mission-driven physicians and trainees face in an increasingly profit-seeking business model of health care. One such conflict—my patient lying motionless in bed day after day when a reasonable treatment option existed a few hundred feet away—was transpiring before my eyes.

Medical students are constantly reminded to appreciate our patients' humanity. As a novice, I am equally struck by the humanness in myself, my residents, and my attendings. I remember the frustration expressed by my psychiatry attending at the lack of options for our catatonic patient. In his decades of work with underserved psychiatric patients, this was not the first time he faced tension between his clinical judgment plus moral intuition and the limitations of the system. He is a survivor of chronic moral injury.

To acknowledge and address moral injury, we must first acknowledge our humanity and examine the conflicts of interest we have at work. Like my patient, we as physicians sometimes find ourselves frozen in response to moral conundrums. In these moments, going on our walks, talking to our therapists, and having that occasional grounding coffee meeting with a colleague may not be enough. We need to examine the extent to which our systems are aligned with our core values, our purpose as physicians. And if you, like me, conclude that they are not, this is largely because they were not designed to be. As human beings who chose to enter a field with moral underpinnings, we are at risk of injury not only because of the number of hours we spend training and working, but also because we work within the boundaries of a system that does not share our values. The only option, then, is to leverage our voices as people who took a special vow to protect humanity in medicine, including our own.

In the case of our young woman with catatonia, we researched the evidence, created a presentation, and ultimately appealed to the humanity of an ECT provider at my home institution to get our patient transferred there. This led to inter-department conversations as well as even-

continued on page 15

REIMAGINING DIVERSITY, EQUITY, AND INCLUSION IN MEDICAL ACADEMIA

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Higher educational institutions have historically been bastions of knowledge. Controversies have recently engulfed some of these esteemed institutions regarding their history, including exclusivity and marginalization, which are often rooted in race/ethnicity, gender, generational wealth, legacy[1], and disability. Today, many institutions are striving to rewrite their narrative by increasing minority staffing, under the guise of broadening perspectives and fostering innovation. Despite these attempts, minority leaders are still vastly underrepresented. There exists enduring hesitation in appointing minorities to leadership positions or allowing them a voice in organizational decision making. Although strides have been made in this area, inequity remains. Bilingual people with English as a second language might be viewed as inept; in reality, they may be skilled, creative, and empathic. There will only be true progress when opinions of individuals who are "different" are sought and valued. These individuals might have an accent, might be unfamiliar with local linguistic phrases or euphemisms, or lack confidence, but they matter. Weighing the suggestions of these individuals less than others will invariably lead to biased policies.

It is often overlooked that diversity and inclusion originate in the pre-hiring process. Academic institutions and healthcare systems must ensure that bias is removed from their job descriptions. A candidate's religion, ethnicity, and gender can be inferred from his/her name; therefore, this should be redacted during all stages of the pre-hiring process. Candidate evaluation should be based on a standardized and unbiased rubric, rather than a "gut feeling" or selecting a compatible golf buddy. Some studies show that white-sounding names received almost 50% more interview invitations than African American-sounding names,[2] with similar results for male versus female. Women are often doubted subconsciously or behind closed doors based on inferred commitment or pregnancy,

Of equal importance is eliminating bias for faculty promotions. The median institution-specific promotion rates for White, Hispanic, and Black faculty, respectively, were 30.2%, 23.5%, and 18.8% ($P<.01$) from assistant to associate professor and 31.5%, 25.0%, and 16.7% ($P<.01$) from associate to full professor.[3] The promotion process should be open and transparent utilizing fair and standard practices such as a standardized rubric. Failure to do so can lead to feelings of distrust and discouragement, which erode employee morale and participation. This hurts equitable healthcare delivery and leads to worse healthcare outcomes for marginalized patients. Immigrants from low or middle-income countries may have less childhood exposure or formal training in communication styles and emotional and interpersonal skills. This often leads them to seek care from physicians who "look like" them or "talk like" them which further necessitates a diverse healthcare workforce.

Feedback and evaluation of academic healthcare providers and trainees are frequently subjective and therefore bias-prone, especially if the feedback mechanism lacks structure. Individuals typically rate faculty who are in their peer group higher than those that they perceive to be outside, referred to as *similarity bias*.[4] Racial minority faculty, particularly Blacks and Asians, receive more negative evaluations than White faculty in terms of overall quality, helpfulness, and clarity. A two-stage cluster analysis demonstrated that the "very best" instructors were likely to be White, whereas the "very worst" were more likely to be Black or Asian.[5] This is consistent with reinforced negative stereotypes of racial minorities and has implications for their tenure as faculty and other promotional opportunities.

Targeting subtle discrimination and materializing "true" diversity, equity, and inclusion in academic institutions requires further legislative reform, greater transparency in the areas of pre-hiring, hiring, evaluation, promotion, and equitable patient care. Organizations need to set goals, value complaints, avoid biased technology, and involve supervisors to evaluate efforts to improve their culture.

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continued on page 15

DOCTORS ARE ONLY HUMAN

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"Be human" is something I wrote down as my goal heading into my intern year of my internal medicine residency at Oregon Health and Science University. My goal at that time, and now, has been to break barriers in patient care and connect with patients in a therapeutic alliance to optimize their health. In less than a year as a resident physician, I have learned a profound amount of medicine, but perhaps more about myself and about patient care. What's more, I have learned a new context of being human that patients and physicians alike should keep at the forefront of their interactions with one another.

I have been humbled to work with the Veteran population in my training. Although not a stranger to this community, having active duty and retired military family members, I found myself learning more about what exactly it means to be human and the importance of building rapport. As we say in medicine, a patient's pathology does not "read the textbook" and, in that regard, no two patients can be treated alike or approached in the same way. I learned this lesson when working with a patient who was suffering from the long-term effects of PTSD and a traumatic brain injury. Struggling with chronic lower extremity pain, this patient frequently came to the clinic due to insistence that they had a deep venous thrombosis, despite extensive imaging ruling this pathology out. "If I do not have a blood clot, then what is this?" my patient asked, pointing clearly at superficial varicosities on the calf. Relaying information and reassuring this patient that neither anticoagulation nor vasodilators would solve their lower extremity pain was simply not the same as telling another patient similar information due to this patient's unique culmination of experiences. This patient did not understand the extent of my training, compassion, or well intention for their medical care. Perhaps I failed to understand the extent of their pain that was lost in a fixed, false belief. Increasingly frustrated, my patient ultimately asked for a new physician and while I am certain they do not have a blood clot, I often grieve over my failure to bridge that therapeutic alliance and reassure them otherwise.

The culmination of various patient experiences ultimately redefined my approach to patient care. To that end, my message is simple and succinct—as physicians, we are only human. We will unfortunately overlook data, fail to connect with patients, miss diagnoses, and commit errors, though the delineation is that *good* physicians will learn from these mistakes and allow them to inform their future practices, for better or worse. According to the National Academies of Sciences, Engineering and Medicine in a landmark report[1] from 2015, "Most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences." To that end, physicians are often held to a higher standard than the rest of the community due to our unparalleled training and because we deal every day with our most valuable asset: health. Despite this, adherence to physician recommendations continues to be a worldwide issue as well as often a multifactorial issue, according to the World Health Organization (WHO). Unfortunately, only 50% of patients are adherent to long-term therapies in developed countries, according to the WHO.[2] While physicians are expected to be superhuman and perform free of error, sometimes our recommendations, efforts, and sacrifice go without recognition.

The solution? I believe it lies in communication, transparency, and remaining fundamentally human. While I approached my intern year with the mindset to just be approachable and an advocate for patients I encounter, I found a new meaning and relief in those instances where I realize I am no different than some of my patients. In return, I hope that patients keep their physicians' humanism in mind when forming expectations as we fight to evolve as clinicians and earn the admiration that patients often give us. Although we may not always have the answers or operate in a realm free of error, we often shed tears and grieve the same situations our patients' families do. It is of the utmost importance to approach our work with humility and a meticulous approach to ensuring that patients know humanism is often at the foundation of our training. We must not operate in a routine devoid of emotion or be fearful of expressing these amidst immensely challenging cases. Teaching me how to perform a death exam on a patient in the middle of night during my second month of intern year, I watched as a senior resident shed a tear for a patient she had never even met before. This experience only reaffirmed my early intern year goal to "be human" and recurrently demonstrates to me the importance of

continued on page 15

SHARED DECISION-MAKING: BENEFITS AND CHALLENGES IN CLINICAL PRACTICE

Farzana Hoque, MD, MRCP (UK), FACP, FRCP

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A 68-year-old man with a history of recurrent GI bleeding and a high CHA2DS2-VASc score told me he does not want a stroke, so no matter how many times he gets admitted to the hospital for GI bleeding, he wants to continue his anticoagulant. On the same day, I had another patient who insisted on not continuing anticoagulation despite a high CHA2DS2-VASc score, as his close relative had bleeding while on an anticoagulant. I would never know their goals, and preferences without engagement in shared decision-making.

Shared Decision-Making (SDM) is an interactive, collaborative process where clinicians focus on the available best scientific evidence and patients' goals, preferences, and values to make healthcare decisions.[1,2] Clinicians assist patients to analyze potential risks, benefits, and outcomes to reach evidence-based and value-congruent medical decisions. In numerous clinical scenarios, multiple viable options can complicate medical and surgical decision-making. The traditional paternalistic approach, where the clinician unilaterally makes decisions and presents them to the patient, may limit patient involvement to mere consent without a detailed discussion and understanding of their preferences or adherence to recommendations.[1] Patients have the right to be well-informed and actively engaged in their care decisions, with a comprehensive understanding of potential risks, benefits, and alternatives. To enhance patient participation in healthcare decisions, SDM has been advocated since the early 1980s. The U.S. Preventive Services Task Force (USPSTF) and the Institute of Medicine endorse SDM for preventive health and treatment choices to improve healthcare quality in the United States. The concept of SDM emerged from the phrase "nothing about me, without me," during a 1998 seminar "Through the Patient's Eyes".[1] Recent research suggests that most patients prefer an active role in medical decision-making but perceive that physicians often make decisions contrary to their preferences.[2] SDM offers a structured bidirectional approach; clinicians enable patients to decide whether to accept certain services or treatments based on their preferences, circumstances, and core values by providing relevant evidence. For instance, patients may opt for different screening tests based on their perspectives and preferences regarding potential risks in screening recommendations where benefits and harm may exist. Similarly, in complex decisions such as anticoagulation for patients with atrial fibrillation and high CHA2DS2-VASc scores and bleeding risks, SDM facilitates understanding patient and surrogate preferences in weighing the risks of bleeding against the risk of thromboembolic stroke. The UK SDM tool, *BRAN questions*, promotes engagement in shared decision-making.[3]

1. What are the Benefits?
2. What are the Risks?
3. What are the Alternatives?
4. What if I do Nothing?

The BRAN tool's adaptability to various health decision settings, including treatment, investigations, and procedures, expands its potential to enhance patient safety.[3]

A study published in JAMA demonstrated that SDM is associated with higher patient satisfaction.[1,2,4] This increased satisfaction, in turn, correlates with improved treatment adherence.[4] Patients who were actively involved in SDM were also significantly less likely to resort to legal action, with an 80% reduction in lawsuits compared to those not engaged in shared decision-making.[1,2] Participants in the study rated their physicians more favorably and were less inclined to blame them for any adverse outcomes. These findings highlight the empowering nature of SDM for clinicians, allowing them to view patients as unique individuals which is crucial for safe and exceptional patient-centered care. It's important to acknowledge that treatment choices are seldom straightforward and often involve uncertainty. Clinical prediction scores, like the Pulmonary Embolism Severity Index (PESI), can provide valuable insights into patient outcomes and risk categories. However, these clinical tools should not replace clinical judgment and the importance of shared decision-making. For example, in cases where patients have a low risk of complications from pulmonary embolism, the American Society of Hematology

continued on page 14

BENEFITS, RISKS, AND REANIMATION

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When I was working on the inpatient wards and medicine consult service at Maastricht University Medical Center in The Netherlands, the day usually started with "running the list" during table rounds. Frequently, an attending physician would check with the house staff or medical student presenting for the middle-old (74-84 years old) and oldest-old (85+ years old) patients because the individual is hospitalized for a serious acute illness, "*their life expectancy is only another [X months or Y years].*" I noticed this comment recurred in situations when weighing the benefits or risks of medications, such as acenocoumarol (coumadin), statins, or certain antihypertensives. What is the expected added benefit of the medication for this patient versus the potential risks (e.g., of bleeding, falls)? What mental calculator and evidence basis is the foundation for these considerations? How accurately does this mental calculator predict the possible outcomes, including death?

Talking about life expectancy is a shifted perspective, compared to talking about code status. Life expectancy seems to take on a more holistic perspective of the patient's health status and considers the complexity of their medical and social circumstances—something we pride ourselves in being primely positioned to accomplish as general internal medicine physicians. When I was in residency training, I often encountered a different question for hospitalized patients: *what is the patient's code status?* Informed by best evidence in geriatrics care, a conversation around life expectancy as a way to drive medical or shared decision making was far less common.

Code status is still a vital piece of information for hospitalized patients during my work in a Dutch hospital. For almost every elderly patient admitted, especially those with multiple medical conditions—possibly with or without a dementia diagnosis or delirium—they always had their resuscitation status documented. I noticed a stark difference with the United States hospital system: If their code (or resuscitation) status could not be confirmed by the patient or a family member, Dutch physicians would indicate that a patient's status is "*NRNB (niet reanimatie niet beademing) op medische grond*." This translates most closely to "DNR/DNI on medical grounds." This is remarkable and worth additional consideration. The doctor asserts their medical judgment to indicate that a patient is not to be resuscitated and not to be intubated. Furthermore, this can be considered a standard practice. Of course, the ideal scenario is still to be able to confirm with the patient, a spouse, or next closest kin or surrogate decision-maker as soon as possible. But what this means is that if an unexpected demise of a patient occurs in the hospital, despite best efforts to diagnose and treat the patient, just short of resuscitation and intubation, this could be medically acceptable.

The Dutch health system and policies can be quite different compared to the U.S. health system. To name a few distinctions, there is a very strong gatekeeper system through general practitioners, a system for patient complaints and malpractice is also completely different and far less litigious, and of course, a long-established medical end-of-life or euthanasia policy.[1]

Nevertheless, the ability to be able to indicate resuscitation status "on medical grounds" still surprised my acculturated American medical senses. As a comparison, I remember from residency encountering a case of a 101-year-old woman with a hip fracture and delirium admitted to my inpatient hospital service. While I no longer remember the full case details, I recalled how she experienced a code before a family member could be contacted to verify code status and was resuscitated and intubated, as a default. I also remember that once a family member was reached, that family member still wanted their mother's chart to indicate "Full Code." There are numerous ethical questions raised in this situation, which I will not explore in this column, although additional debate is welcome from SGIM colleagues in future SGIM *Forum* publications. I expect that a comparable case encountered in a Dutch hospital might have had a different outcome, based on my limited experiences in the system.

Stepping back from the reductive "code status" conversation and returning to engaging in hospital-based decision making partially by life expectancy, I appreciate the different perspective that this mindset could help to frame some decisions that we face in routine patient care. Some decisions are straightforward. On the other hand, they can be complex—sometimes, it can be useful to step back and try a different approach. Accounting for life expectancy might be one potential additional consider-

continued on page 16

2. *Continuity* implies having long-term relationships with patients and getting to know the whole person. Continuity builds trust with patients and provides a longitudinal perspective of patients' health, medical conditions, and social context, which can inform decisions when new or difficult issues arise.
3. *Comprehensive care* means considering the full picture of a patient's health; providing a broad range of care including preventive, acute, and chronic care; and supporting a patient when there is uncertainty about a condition, or the condition is serious and untreatable.
4. *Coordination of care* provides patients with a game plan for their care and ensures they receive the right care at the right time, enhancing patient safety and quality. The general internist is the quarterback for the team of specialists and others involved in a patient's care and an advocate for patients to assure seamless and timely care in a fragmented health system. The work involved in care coordination and the importance of developing relationships with others involved in a patient's care is well described in the article, "Instant replay—a quarterback's view of care coordination," by Press.[5]

Specialists may assert they provide care coordination and the other Cs of generalist care, but they would be hard pressed to document that they provide the care described by Press.[5] More often, specialists will advise patients to talk to their generalist physician for comprehensive and coordinated care when patients raise issues perceived to be outside the scope of their specialty care (e.g., completing forms for family medical leave, addressing a flare of chronic back pain).

SGIM is working on several issues to improve support of academic general internists so we can continue to incorporate the 4 Cs into our practice and enhance our ability to attract and retain trainees. On the organization of healthcare front, SGIM is partnering with ACLGIM to work on three areas identified as high priority based on the 2023 Hess Institute report: enhance the focus on team-based care delivery, rebalance primary care compensation to align with the work at the institutional level, and improve learner experience in primary care and increase training time in this setting.

Some of the key issues identified during the Hess Institute can be traced to the discrepancy in physician payment between generalist physicians and those in procedure-based specialties. Our Health Policy Committee is taking on this broader policy challenge. The Centers for Medicare & Medicaid Service's (CMS) issued their proposed rules for the 2024 fiscal year affording us an opportunity for advocacy on payment reform. The CMS proposed rules include starting payment for a new evaluation and management (E/M) code, G2211, which was put on hold several years ago due to concerns raised by some specialty organizations. It would provide additional funds for care coordination and continuity, an important role that generalists play. The proposed rules also open an opportunity to evaluate the current process for setting the physician fee schedule that relies on the American Medical Association's Relative Value Scale Update Committee (RUC). CMS requests information that could lead to other methods for setting the value of E/M and other codes.

To address the needs of student, resident, and fellow SGIM members, this issue of the SGIM *Forum* kicks off a quarterly column dedicated to these members that will highlight resources for trainees, the challenges they face, and celebrate their successes. Second, based on the Research Committee's report on the state of general internal medicine (GIM) fellowships and fellows, the SGIM Council appointed a seven-member GIM Fellows Task Force to address the Committee's highest priority recommendations (see the CEO "Q&A" column in this issue). Finally, the Southern region is planning to have programming specifically for historically black colleges and universities (HBCUs) at their regional meeting again this year. SGIM's President-elect, Jada Bussey-Jones, will continue our personal outreach to medical students, residents, and residency program directors at HBCUs who attend the regional meeting.

I will keep you posted on our progress. The work you do is more important than ever and has an impact on health outcomes. Our job is to convince our health system leaders and policy makers.

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meeting. This important recruitment tool allows for early exposure to our organization and its mission at a point when trainees have not yet finalized their career plans or professional homes. Because many current SGIM members started by attending regional and national SGIM meetings during training, these programs represent a critical contribution to growing the pipeline of SGIM and academic general internal medicine. By attending the annual meeting, trainees can learn about the myriad ways to practice academic GIM, seek mentorship, and interact with like-minded colleagues. Additionally, many trainees have limited institutional support to attend academic meetings, so offering complimentary meeting registration is an important form of outreach to help overcome these barriers.

The SGIM Membership Committee and staff are integrally involved throughout the process, including the development and dissemination of promotional materials, peer review of applications, selection of National Young Scholars, and communication with applicants and awardees. Each year the committee receives applications and awards 50 NYSGIM scholarships. The applications are individually reviewed and rated by committee members based upon an applicant's interest in GIM and planned engagement at the annual meeting. In 2023, a record-breaking 189 applications were submitted, highlighting tremendous interest amongst trainees. Applications for NYSGIM have grown substantially in recent years, from 102 to 133 in 2018 and 2019 respectively to 171 in 2022 and 189 in 2023 with the return to in-person meetings after the pandemic. In the future, we hope to increase the program to meet this growing demand. The NYSGIM application opens in December coinciding with the annual meeting registration and closes in early March with notifications sent in late March.

Investing in GIM

Investing in GIM is an additional trainee engagement program that offers complimentary memberships to trainees in their first year of fellowship on an annual basis. Since the program's creation in 2012, 439 first-year fellows have entered the program with a membership retention rate of more than 85%. To be eligible, fellows must have completed internal medicine training and be actively enrolled in a full-time fellowship program. Although the original focus centered on general internal medicine fellowships, eligibility has expanded to reflect the various training backgrounds of current SGIM members, such as fellowships in addiction, hospital medicine, or safety and quality. Selected fellows are offered full member benefits, including career development tools, meetings, publications, and mentoring and networking opportunities. This provides tremendous value at a critical point in their career trajectory and is an important touch point as they consider their professional home. Investing in GIM can also serve as a chance to introduce fellows to the discounted Step program as they transition to full membership as faculty. Applications are open from October to December and are reviewed and processed by staff on a rolling basis. The Membership Committee reviews and contributes to the application process in advance of the program opening.

Future Directions

Solving the "wicked" problem of the academic general medicine pipeline will require the support and deliberate outreach to trainees to ensure a vibrant and thriving future community of academic generalists. These trainee engagement programs highlight one successful way to go about this. Each program has provided hundreds of students, residents, and fellows early exposure to SGIM, with many going on to not only become members but to meaningfully contribute as leaders within the organization.[4] This attention and outreach to trainees is particularly important when we consider that trainees are the most diverse subset of our Society's membership. As we move forward as a committee and organization, we hope to ensure inclusivity throughout the process by establishing a more robust pipeline between regional and national meetings for trainees and through a more holistic application review that also considers institutions and backgrounds of applicants. Doing so will help us answer the call to recruit and retain a diverse, inclusive, and active membership that will ensure a thriving Society of General Internal Medicine for years to come. Additional information on SGIM's trainee engagement programs including how to apply can be found at: https://www.sgim.org/career-center/trainee-engagement.[4]

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medical student expects transitioning from classroom to hospital.

These patient encounters were unexpected challenges in my training. There is no book training in the first two years of medical school to prepare you for these encounters. The support of colleagues and mentors at Tulane and SGIM was essential to my advancement in medicine. SRFs and early career faculty are an often-overlooked group within professional society membership. SGIM is different since SRFs are valued for their contributions: for example, they sit on SGIM Council, are Associate Editors for the *Forum*, and participate on the annual meeting planning committee with special emphasis on SRF programming.

In the September 2023 issue, I wrote "the SRF quarterly column will focus on scholarly articles by SRFs as well as articles for SRFs. The *Forum* envisions a future state where SRF trainees in Medicine view the *Forum* as the go-to source for articles such as preparing your CV, negotiating your first job, parenting in residency, work-life balance, etc."[1] With this October 2023 issue, the *Forum* presents the SRF quarterly column as a recurring initiative to meet their needs. We invite our SRF associate members to submit articles to the *Forum* that address their unique challenges. We also seek articles from SGIM members who work with SRFs to highlight lessons learned or local best practices. SRF members are the pipeline of SGIM as they will advance medical education, research, patient advocacy, and clinical care throughout their careers.

In this issue, we highlight articles by several trainees. Medical student Dr. Cherian discusses the humanistic side of medicine by discussing the frequency of burnout at the individual level and defines the awareness of moral injury as an underlying component in her descriptive case. We also see the humanistic side of medicine in Dr. Fenske's article as she describes her self-evolution during internship in understanding how communication, transparency, and humanism are essential in delivering excellent patient care. Drs. Williams and Kohli, Chair and Co-chair of the Membership Committee, discuss SGIM's investment in SRFs by spotlighting the "Investing in GIM" initiative for fellows and the National Young Scholar in GIM (NYSGIM) offering for residents and students. Drs. Allen and Jackson describe their use of innovation and technology to increase communication through JamBoard which allows reflection on daily experiences and sharing feedback or educational pearls. Dr. Ali reminds us to define, recognize, and advocate for "true diversity" because when all voices are expressed, we can have a healthcare system as heterogeneous as our communities and SGIM. Drs. Bass and Maruthur highlight the SGIM investment in establishing an SGIM Task Force to address future collaborative efforts between SGIM and fellowship training programs. Dr. Hoque describes the benefits and challenges of shared decision making in clinical practice while Dr. Leung describes her lifelong learning within the Dutch healthcare system with the focus on life expectancy instead of code status. Dr. Gerrity describes the value of generalist's care utilizing the 4 C model of first contact, continuity, comprehensive care, and coordination of care in an increasingly complex healthcare system. Finally, Dr. Ehrenberger pays tributes to trainees with her resident appreciation poem (applicable to all SRFs).

SGIM and the *Forum* are committed to the continued support and advancement of SRFs. Many SGIM members are involved in local undergraduate and graduate medical education while others are committed to less formal programs like mentoring or writing letters of recommendation. We all ride the rollercoaster together so remember that "The people closest to me determine my level of success or failure. The better they are, the better I am. And if I want to go to the highest level, I can do it only with the help of other people. We have to take each other higher."[2] Be sure to ride that rollercoaster with SGIM colleagues at your side.

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SGIM

9) SGIM should advocate to the Health Resources and Services Administration (HRSA) and other funders to gain more resources for research fellowships.

I should note that Council also asked the Research Committee to focus attention this coming year on expanding resources to support clinician-investigators, including meeting-related activities. In addition, Council confirmed that it expects the Health Policy Committee to give high priority to advocating for HRSA and other agencies to provide more support for fellowship training of general internists. I hope some of the other recommendations can be addressed in future years or in the course of the work that will be done by the GIM Fellows Task Force and the Research Committee.

SGIM

guidelines may recommend discharge with direct oral anticoagulation (DOAC). However, SDM remains essential in engaging patients and caregivers in discussions about the risks and benefits of anticoagulation, as well as their comfort level and willingness to be discharged on the same day. Informed clinical decisions require careful consideration of diagnostic testing, overcoming biases, and customizing evidence-based practices to suit individual patients' needs. Facilitating SDM has shown positive associations with improved quality of life and patient outcomes. A meta-analysis involving more than 4,000 patients revealed that SDM significantly reduces decisional conflict and increases patient knowledge.[5]

Shared Decision-Making (SDM) becomes particularly crucial for older adults with multimorbidity, as the best treatment for each disease may not be the most suitable option for the elderly patient as a whole. The elderly patient population is diverse, ranging from highly independent individuals to those with multiple chronic conditions requiring significant assistance with daily activities. In conversations involving elderly patients with multiple chronic conditions, their caregivers, and the medical team, the focus should be on preferred health outcomes to guide discussions and treatment choices, rather than addressing each medical condition in isolation. There are obstacles to SDM in clinical encounters with elderly patients. One significant challenge is undiagnosed cognitive impairment, which can hinder effective communication and decision-making. Additionally, disabling hearing impairment affects a substantial portion of elderly patients, potentially leading to misunderstandings, as hearing loss might be mistaken for cognitive impairment. The use of tools like the Mini-Cog, which can quickly assess cognitive impairment, can be valuable in such cases. Stereotypes about advanced age can also influence healthcare professionals, leading to unintentional paternalistic attitudes that hinder SDM in geriatric medicine.

Low health literacy is another common issue among older adults and can contribute to suboptimal SDM discussions, emphasizing the need for clear and patient-friendly communication during medical encounters. Furthermore, the lack of representation of geriatric patients in clinical trials, particularly those over 80 years old, poses challenges for healthcare professionals trying to apply evidence-based medicine to this specific population with multiple chronic conditions. The involvement of family members and caregivers in the care of older patients can both support and complicate SDM. While family members can provide valuable insights into the patient's values and priorities, they may also have their own perspectives that may not fully align with those of the patients. By acknowledging and addressing these various factors and challenges, healthcare providers can ensure that older patients receive the most appropriate and patient-centered care for their unique circumstances.

Time constraints are frequently identified as a significant barrier to implementing SDM in clinical practice. The limited duration of a typical 15-20-minute physician's office visit may not allow sufficient time to listen to patients, address their emotional concerns, and help them make well-informed decisions that align with their values and preferences. A recent study examining the mean time required for a primary care physician to provide guideline-recommended care estimated that they would need 26.7 hours per day, with substantial time allocated to preventive care, chronic disease management, acute care, and administrative tasks.[1] Clinicians can optimize clinical encounters by directly inquiring about the main reason for the visit. Sitting at the patient's level and avoiding a computer screen between the clinician and the patient can also contribute to a positive tone and improved communication during the visit. Quality and quantity of time are crucial in cultivating strong patient-clinician relationships, conducting patient-centered interviews, and promoting patient satisfaction. The patients could also be reluctant to engage in SDM due to concerns about feeling rushed during appointments or feeling uncomfortable asking too many questions.

In conclusion, SDM is a critical aspect of patient-centered care, where clinicians incorporate patients' needs, values, and goals into their treatment plans. SDM plays a pivotal role in enhancing patient satisfaction, and treatment adherence. By involving patients and caregivers in the decision-making process and considering their unique preferences and circumstances, clinicians can deliver more personalized and effective care, ultimately leading to better patient experiences and outcomes.

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continued on page 16

TECHNOLOGY UPDATE *(continued from page 5)*

notes. In our experience, using Jamboard to promote reflection and spaced learning has improved the educational experience for learners on the wards.

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SGIM

SIGN OF THE TIMES *(continued from page 6)*

tual administrative support, and our patient ultimately received the treatment she needed, though not without hurdles. Through this experience, I learned that first-line treatment for moral injury is advocacy, and that we are uniquely positioned to advocate *together* as physician-humans in diverse settings across this healthcare system.

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SGIM

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SGIM

PERSPECTIVE: PART II *(continued from page 8)*

connections in medicine or, as I have learned, our failures to connect. At the same time, I believe physicians may find light and hope in that very principle of just being human.

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BREADTH

RESIDENT APPRECIATION

Kristen Ann Ehrenberger, MD, PhD

Dr. Ehrenberger (ehrenbergerka@upmc.edu) is an assistant professor of medicine and pediatrics at the University of Pittsburgh School of Medicine in Pittsburgh, PA. This poem was written with the help of OpenAI's ChatGPT (24 February 2023).

In the halls of hospitals,
Where the sick and injured lie,
Are those who tirelessly work
To help them heal and thrive:

They are the medical residents,
Whose days are long and hard,
And whose patient dedication
ls unwavering and unmarred.

From early morning rounds
To a code just down the hall,
They're always on the go
To answer every nurse's call.

With stethoscopes and scrubs
And masks upon their face,
Diagnosing and treating
With expertise and grace.

Their work is never done
But their passion never fades,
For every life they touch
ls a chance to make a change.

So here's to the medical residents,
Whose hard work is truly inspiring;
May they never lack compassion
And forever be aspiring.

BEST PRACTICES *(continued from page 14)*

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SGIM

IMPROVING CARE *(continued from page 10)*

ation in the big picture of taking care of a patient across care settings and engaging in shared decision making.

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