

ANNUAL MEETING UPDATE

HIGHLIGHTS OF THE UPCOMING SGIM 2024 ANNUAL MEETING

Zirui Song, MD, PhD; Jenny Schmidt, MD

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On behalf of our colleagues on the SGIM 2024 Planning Committee and at SGIM, we are delighted to share a few exciting details about the Annual Meeting.

The SGIM 2024 Annual Meeting (#SGIM24) will take place in downtown Boston, Massachusetts, at the Sheraton Boston Hotel and Hynes Convention Center on May 15-18, 2024. Nested within the vibrant commercial area of Boylston Street, Newbury Street, and Copley Square, the meeting will provide attendees with an abundance of walking, shopping, and food options. The meeting will also renew our community's sense of energy as the Boston weather turns towards summer.

Building on the success of last year's meeting in Denver, Colorado, interest in this year's meeting is peaking, having surpassed several records for submissions. Our colleagues and trainees across the country submitted 835 Scientific Abstracts (most since the pandemic), and 966 Clinical Vignettes (the highest number in the last decade). There were more Innovations in Medical Education and Innovations in Health Care Delivery (more than 200 in both categories) submitted in 2024 than in nearly all prior years.

These record-high submissions signify that SGIM is growing, especially among younger members. These submissions also mean that our colleagues on the Planning Committee have worked hard to conduct peer reviews and adjudicate submissions for the meeting program. We are indebted to them for their time, diligence, and thoughtfulness in putting the substantive content into the Annual Meeting program. The flip side of more sub-

missions is more difficult decisions. Among the record 78 Special Symposia submitted, the meeting could only accommodate 10 (13% acceptance rate). Among the 350 Workshops submitted (the first time exceeding 300 submissions), there was capacity for only 90 (26% acceptance rate). Many excellent ideas were confronted by the lack of space—turning down these submissions was painful. On the other hand, it allowed the meeting committee the chance to offer a truly outstanding menu of learning opportunities in clinical, research, and other domains of generalist practice.

This collective effort on submissions was led by Drs. Rashmi Jasrasaria and Nick Cuneo for Special Symposia; Drs. Anne Smeraglio and Jessica Donato for Workshops; Drs. Michael Barnett, Lucinda Leung, and Eric Yudelevich for Scientific Abstracts; Drs. Dominique Cosco and Steve Fuest for Clinical Vignettes; Drs. Tamara Godfrey and Katie Sullivan for Clinical Updates; Drs. Tim Mercer and Sarah Stella for Innovations in Healthcare Delivery; Drs. Martin Fried and Chris Chiu for Innovations in Medical Education; and Drs. Ian Kronish and Valerie Press for Interest Groups. Drs. Ishani Ganguli and Pooja Lagisetty are leading the effort to recognize winners for the Hamolsky & Lipkin Awards.

We are also indebted to colleagues on the Planning Committee who are working to make the Annual Meeting meaningful and educational outside of the submitted content. Drs. Chana Sacks and Anders Chen are leading the inaugural integration of a national advocacy theme into the Annual Meeting: reducing the burden

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FROM THE EDITOR

THE MILLION VETERANS PROGRAM (MVP): ANOTHER WAY OUR VETERANS CONTINUE TO SERVE

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

One million is a large number. Did you know that a historic milestone was reached when the Department of Veterans Affairs enrolled the one millionth Veteran into the Million Veterans Program (MVP)?

MVP is the VA's largest research effort to date. The program was launched in 2011 under the oversight of the Office of Research and Development with the intent of understanding the unique interplay between genetics and the health conditions that affect Veterans. Some of these health conditions may be unique to Veterans based upon occupational or military exposures. MVP is open to enrolling all Veterans interested in participating. With more than 70 active VA sites recruiting and 10 former sites, a large medical database is being assembled through the enrollment of Veterans in MVP. Blood samples are collected and health screening questionnaires are completed before the data is stored anonymously.

The slogan for the MVP program is "MVP: Another Chance to Serve." On November 15, 2023, the Department of Veterans Affairs celebrated the enrollment of the one millionth Veteran and has continued to roll up with additional Veteran enrollment since then.

What are some "key facts about the Million Veterans Program?"¹

- It reflects the diversity of the Veteran population: More than 250,000 minority Veterans and 100,000 women Veterans have joined the program, and MVP includes more people of African ancestry than any research program in the world. This allows researchers to learn more about—and ultimately treat—populations that have historically been underrepresented in research.
- It's been used in the largest-ever genetic studies on anxiety, depression, blood pressure, heart disease, non-alcoholic liver disease, and more!¹ These studies

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SUPPORTING STATE AND LOCAL ADVOCACY

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

"#SGIM24 has a variety of symposia, updates, workshops, and interest groups where attendees can learn more about advocacy and develop skills that they can take back to their state and local institutions."



Many SGIM members are passionate about issues affecting the health of our patients, the well-being of healthcare professionals, and our ability to effectively practice in hospital and outpatient settings. SGIM members want to add advocacy to our role as general medicine physicians since we see the broad picture of health including the impact of social determinants of health. Some believe advocacy is an integral component of being a medical professional.¹ SGIM has offered the Leadership in Health Policy (LEAHP) program since 2017—it is a year-long mentored program for those who want to make advocacy a focus of their careers.² LEAHP provides knowledge, attitude, and skill development and primarily uses federal health policy and advocacy as its curricular focus.

As state and local governments pass laws that impact the health of our patients, the SGIM Council heard the call for more support for state and local advocacy, especially from those attending #SGIM22 and #SGIM23. Participation in state and local government and health system advocacy efforts can benefit healthcare professionals and the communities they serve. Involvement in advocacy allows physicians to connect with their state and local communities, as we educate our policy makers while providing data and stories about our patients and communities. Especially at the local level, policy makers are often surprised to hear directly from physicians. Over time, this engagement builds relationships and fosters trust and understanding among physicians, our patients, and policy makers.

In 2024, SGIM is developing plans to better support members in state and local advocacy, including activities

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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.

SUSTAINING SGIM'S FORGING OUR FUTURE PROGRAM AND GIVING THANKS TO CONTRIBUTORS IN 2023

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

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SGIM created the Forging Our Future Program in 2020 with the hope of establishing a culture of giving among members who appreciate how much SGIM has contributed to their career success and our shared mission.¹ That mission is more important than ever with many external threats to our vision of a just system of care in which all people can achieve optimal health.

In these challenging days, we are extremely grateful for the sustained support of the hundreds of members who have contributed to the Forging Our Future Program. In 2023, we received 387 gifts for a total of \$217,460 in donations, including a very generous gift of \$100,000 from the Hess Foundation. The total included \$7,980 for the Future Leaders of General Internal Medicine (GIM) Fund (to cover complimentary memberships for fellows and scholarships for medical students and residents attending the SGIM Annual Meeting), \$5,702 for the Unified Leadership Training in Diversity (UNLTD) Program, and \$36,270 to help launch the John Goodson Leadership in Health Policy Scholarship Program. The latter amount does not include additional pledges of more than \$15,000 for the scholarship program that is being established to recognize John Goodson's decades of extraordinary advocacy for the clinical practice of GIM.² Since the inception of the Forging Our Future Program in 2020, we have raised a cumulative total of \$787,111.

The generous support from the Hess Foundation has been particularly valuable in enabling us to expand the UNLTD Program and expand the scope of the annual Hess Institute. Beginning with the Hess Institute at the SGIM Annual Meeting in 2023, the leaders of our Association of Chiefs and Leaders in General Internal Medicine (ACLGIM) have invested in a sustained initiative for developing practical solutions to the crisis in recruitment and retention of general internists in academic medicine.³

We are very grateful to SGIM's Council for leading the way by achieving 100% participation in the Forging Our Future Program in 2023. We thank all members

of the Philanthropy Committee for participating in the program and for helping to reach out to other members. We also want to thank the past presidents of SGIM and ACLGIM for their continued strong support. To date, more than 85% of the past presidents have contributed.

The sustained contributions to Forging Our Future are enabling SGIM to expand and enrich career development programs for members while using dues and meeting fees to support core functions of SGIM including its committees, commissions, interest groups, and national and regional meetings. We greatly appreciate the support of all members who contributed to the program as well as those who made commitments to the Legacy Circle for bequests and planned giving, as listed in the following table (see SGIM's web site for the full list).⁴ While we are extremely grateful for the hundreds of members who donated in 2023, we want to further strengthen SGIM's culture of giving by reaching a goal of 15% overall membership participation in 2024. Even small donations of \$25-\$100 make an enormous difference. By strengthening the Forging Our Future Program, we enhance our ability to achieve the mission of cultivating innovative educators, researchers, and clinicians in academic GIM, leading the way to better health for everyone!

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LACTIC ACIDOSIS OF UNKNOWN ORIGIN: A DIAGNOSTIC DILEMMA

Monique Holod, BA; Kathryn A. Solka, PhD; Richard Abrams, MD; Michelle Sweet, MD

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A 31-year-old previously healthy female presented to the Emergency Department with two days of severe epigastric pain, nausea, rectal bleeding, and non-bloody emesis. She endorsed 50 pounds of unintentional weight loss over the past year that she attributed to decreased appetite and "picky eating." The patient reported social drinking and denied any drug use or smoking.

The initial evaluation of this patient should focus on narrowing a relatively broad differential diagnosis. Her symptoms could be explained by gastrointestinal causes such as peptic ulcer disease, gastritis, and malignancy, given the epigastric pain, rectal bleeding, and weight loss. Pancreatic and hepatobiliary causes, including pancreatitis, cholecystitis, and hepatitis, should also be considered especially, given her reported social drinking. Infectious etiologies including gastroenteritis and viral hepatitis are also possible diagnoses. Less likely diagnostic considerations may include metabolic and endocrine abnormalities such as hyperthyroidism, primary adrenal insufficiency, and uncontrolled diabetes, all of which could potentially explain her weight loss and decreased appetite. Occasionally, hematological conditions, such as anemia, or malignancies including leukemia or lymphoma, can also present with similar symptoms.

On arrival at the hospital, the patient was noted to be tachycardic but afebrile and otherwise hemodynamically stable. Her BMI was 26.1 kg/m². The physical exam was notable for epigastric abdominal tenderness without rebound or guarding. There was no organomegaly. Initial laboratory workup was significant for profound acidemia with a pH of 7.29, anion gap of 31 mmol/L, a lactic acid level of 13.7 mmol/L, and a bicarbonate level of 9 mmol/L. AST and total bilirubin were elevated to 55 U/L and 3.0 mg/dL, respectively. The remainder of the CMP was normal. CBC showed macrocytic anemia (Hemoglobin 9.8 g/dL, MCV 119.2 fL),

leukocytosis (WBC of 12.39 x 10³ μL) and an elevated platelet count (402,000 μL).

Normal lactate levels are under 2 mmol/L, levels between 2 mmol/L and 4 mmol/L are considered hyperlactatemia and levels at or above 4 mmol/L are regarded as severe. Lactic acidosis is also characterized by a pH of 7.35 or lower. Elevated lactate levels correlate with a higher mortality risk, even without organ failure or shock, can significantly impact patients with sepsis, and are associated with higher in-hospital 30-day mortality rates.¹ Lactic acidosis may impair cardiac function and reduce vascular responsiveness to vasopressors. However, lactic acidosis is considered an aggravating factor rather than a direct cause of mortality. It tends to act as a precipitator and exacerbate existing comorbidities, which impacts their progression and associated mortality risks without an established direct causal relationship with mortality.¹

The initial workup for her symptoms and the concurrent lactic acidosis was focused on evaluating for infectious sources or possible malignancy. On ultrasound, her gallbladder was distended with sludge without specific findings of acute cholecystitis. The surgical team recommended magnetic resonance cholangiopancreatography (MRCP) and intravenous (IV) antibiotics. The patient was admitted to the inpatient medical unit for further evaluation and treatment. Blood and urine cultures were without evidence of infection. An MRCP showed no cholecystitis or choledocholithiasis but was suggestive of hepatic steatosis. Esophagogastroduodenoscopy (EGD) and colonoscopy did not reveal any concerning source of bleeding, infection, or malignancy. Antibiotics were discontinued.

The differential diagnosis for lactic acidosis includes Type-A, Type-B, and Type-D etiologies.² Type-A lactic acidosis commonly results from tissue hypoperfusion and hypoxia and typically occurs in the setting

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of oxygen consumption-delivery mismatch; examples include septic shock and tissue hypoxia. Type-D lactic acidosis arises from the overproduction of D-lactic acid due to the proliferation of intestinal bacteria, typically observed in individuals with short bowel syndrome or other conditions leading to gastrointestinal malabsorption. Type-B lactic acidosis is less common and is related to the inability of mitochondria to process pyruvate and alternative metabolic pathways, resulting in lactic acid accumulation. Type-B processes may include thiamine deficiency, mitochondrial myopathies, diabetes, liver disease, malignancy, and certain medications.^{1,2}

Type-D lactic acidosis was excluded based on a lack of relevant history. Workup for conditions associated with hypoperfusion and hypoxia, including infection and malignancy, was also unrevealing. On admission to the hospital, the patient was noted to have significant macrocytic anemia, normal vitamin B12 levels, and undetectable folate levels. Subsequently, other vitamin and mineral levels were checked revealing that her copper, vitamin A, ceruloplasmin, and thiamine levels were low.

Supply of thiamine is entirely dependent on dietary intake as it is not made endogenously. Therefore, in poor oral consumption or excess excretion, thiamine stores can be depleted in as little as 18-20 days.³ Thiamine deficiency is known to be more common among patients with chronic alcohol use and is often associated with other nutritional deficiencies.⁴ The uptake of thiamine and other aspects of its utilization are influenced by alcohol, potentially in the development of thiamine deficiency in alcohol use disorders.⁵

Further discussion with the patient and her family revealed that the patient had minimized her alcohol use to the medical teams. The patient eventually admitted drinking an unspecified amount of beer

daily, coupled with a poor diet that primarily consisted of fried foods, if any food was consumed. The patient's significant alcohol use and minimal food intake corresponded to her laboratory evidence of nutritional deficiencies, including deficient levels of folate and thiamine.

Thiamine deficiency disorders can present with a broad range of clinical symptoms, often leading to delayed diagnosis. Thiamine deficiencies are classically associated with signs of neurologic toxicity, including encephalopathy, peripheral neuropathy, ataxia, and hearing loss. Thiamine-deficient patients can also present with musculoskeletal weakness, atrophy, and heart failure. Other manifestations may include transaminitis, acute abdominal pain, vomiting, and acidosis, as was seen in our patient. The administration of thiamine has been shown to improve the various symptoms quickly. Up to 20% of critically ill patients have evidence of thiamine deficiency; however, the disorder remains underdiagnosed.² Thiamine deficiency should be considered an etiology of lactic acidosis, even in patients without neurologic deficits or an overt history of alcohol use disorder.

The patient was placed on vitamin supplementation, including folate and thiamine. Her lactate levels began normalizing within one day of fluid replenishment and thiamine supplementation. The patient's abdominal pain and nausea improved with appropriate pain medication, nutritional supplementation, and fluid resuscitation. Her infectious workup remained negative throughout her hospitalization. The patient quickly improved with vitamin administration and was discharged in stable condition with close primary care follow-up and referral to a substance use specialist.

This case illustrates the intricate relationship between nutritional deficiencies and chronic alcohol use, emphasizing the importance of a thorough history and clinical as-

essment in identifying underlying causes of common presentations, including abdominal pain and nausea. Our patient's minimized disclosure of alcohol use and poor dietary intake highlighted the challenges that SGIM clinicians may face in obtaining accurate clinical information and the necessity for SGIM providers to maintain a high index of suspicion for nutritional deficiencies in patients both with and without a history of chronic alcohol use. Successful management and resolution of the patient's symptoms after nutritional supplementation emphasize the importance of early identification and intervention in cases of nutritional deficiencies.

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FALLS AMONG THE ELDERLY: A BRIEF REVIEW

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My previously independent 69-year-old grandmother, without prior medical issues, suffered a mechanical fall in her home, resulting in a diagnosis of a right hip fracture that required surgical intervention. Following this fall, she was extremely frightened about recurrent falls and avoided any ambulation. Her activity level gradually declined, leading to her confinement to bed until her death 20 years later. Despite being a very social person, she experienced social isolation after the fall. Due to the loss of independence, she increasingly depended on her family for assistance with all chores, eventually requiring the hiring of a full-time caregiver. This imposed a growing financial burden and social isolation on her family. This patient's experience underscores the significant impact that falls can have on an individual's mortality, morbidity, and their families.

Approximately a quarter of US residents aged 65 years or older report falling each year. These traumatic events often result in emergency department visits, decreased functionality in daily activities, and death.¹ Over the last decade and a half, the rate of deaths from falls in the elderly increased in the United States by an average of 3% per year.¹ Though falls in the elderly have been discussed in the literature, the issue remains pervasive in various settings and persists as one of the leading causes of death among older adults. Nearly 10,000 deaths in older Americans are associated with falls annually.² Falls contribute significantly to the financial costs associated with elder health care, with patients experiencing prolonged hospital stays and management of associated injuries. SGIM physicians must recognize the risk factors associated with these events and implement protective measures to minimize the incidence and consequences of falls, both inside and outside of the hospital.

Falls are more prevalent among elderly females than males, occurring at a rate five times higher.³ The rates of falls and deaths from falls tended to be higher in white adults compared to other racial or ethnic groups.¹ In general, etiologies of falls may be separated into intrinsic and extrinsic causes.³ Intrinsic causes are more common and include dizziness, vertigo, lower extremity weakness, syncope, and stroke. The most frequent extrinsic causes include slipping, uneven floor surfaces, external forces, and insufficient lighting.^{2,3} Reviewing medication history

is integral in risk assessment, as numerous medication classes including hypnotics, anxiolytics, antihypertensives, corticosteroids, nonsteroidal anti-inflammatories, and anticholinergics may increase the risk of falls.² The causes of falls are commonly multifactorial.

Only a fraction of falls can be linked to a single identifiable cause. A history of falls is the single most significant association with an increased incidence of falls.³ Elderly patients contend with multiple underlying health conditions, are prescribed a variety of medications, and often manifest symptoms that coincide with their pre-existing ailments. These elements of the patient's clinical profile should be evaluated in conjunction with the present history and the physical examination to delineate the etiology of falls.

As modern healthcare technology extends lifespans, the general population becomes older and the incidence of falls among elderly patients is on the rise. Prioritizing primary and secondary prevention remains paramount. The United States Preventative Services Task Force (USPSTF) 2023 recommendations included exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.⁴ For all adults aged 65 and older, the USPSTF recommended against vitamin D supplementation to prevent falls in 2018.⁴ The American Geriatrics Society recommends that all adults over 65 years old be screened annually for a history of falls or balance impairment.⁵ Comprehensive interventions encompass a spectrum of approaches, including targeted exercises—such as balance, strength, and gait training—adjustments to the home environment, and an evaluation of medications focusing on minimizing psychoactive drugs. To effectively diminish the risk of falls among the elderly, it is essential to meticulously consider other critical factors like foot problems, appropriate footwear, postural hypotension, vision impairments, and slippery surfaces. These interventions have demonstrated efficacy in reducing falls across various settings, spanning from community to hospital and nursing home environments.

In evaluating the appropriateness of these interventions for patients, SGIM clinicians should discuss the pros and cons with their patients through a shared deci-

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MEDICAL SCHOOL SUPPORT OF TRAINEES THROUGH FAMILY ILLNESS: A STUDENT'S PERSPECTIVE

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In the spring of my second year of medical school, my mom got sick. Due to her illness, she couldn't drive or cook, so I became the primary caregiver responsible for taking her to doctor's appointments, picking up medications, cooking, and cleaning. I had to do this while completing my preclinical coursework and studying for USMLE Step 1. As medical students take more gap years between undergraduate and professional school, the age at medical school matriculation of students and parents alike increases. Given this, how can we best support the needs of students taking care of sick parents? My school, and specifically my society dean (a faculty member who meets with medical students throughout their medical school career), went to great lengths to support me through this difficult time. Opportunities for medical schools to support students taking care of sick parents, along with adaptations for different curricular structures, will be proposed.

Being a Caregiver While Being a Medical Student

There is insufficient literature exploring medical student stressors, such as parental illness and caregiving responsibilities. A few reasons come to mind. First, family illness is a private matter and can be a sensitive topic. Second, many students may come from privileged backgrounds, and their families can hire help instead of having the student take on some caregiving responsibilities. Finally, many students fear that being a caregiver will be seen as a red flag by residency programs, since caring for ill parents may lead to fewer extracurricular activities or lower academic performance due to their added caregiver responsibilities.

There are no studies to date that have investigated caregiving responsibilities of medical students. However, there is literature that explores how caregiving responsibilities affect medical school faculty members. In a 2021 study published in *Human Resources and Health*, it was found that in a sample of 2,126 medical school faculty, 19 percent were taking care of a friend, a neighbor, or

a family member with chronic illness.¹ More than 90 percent of those who reported being a caregiver experienced caregiving-related mental or emotional strain.¹ It is important to note that similar strains are likely faced by medical students shouldering these responsibilities, especially while going through a rigorous medical education curriculum.

Due to the paucity of peer-reviewed literature exploring caregiving responsibilities of medical students, we investigated the gray literature, including popular news outlets and online medical student forums. Our research revealed that being a caregiver for family members is common among medical students. In a *Washington Post* article, one medical student described her experience taking care of her mother throughout high school, college, and medical school and highlighted "missed opportunities" and "surges of guilt" that have accompanied her experience.² Additionally, medical students described coping with illness and loss of close family members in more than 12 entries from the last 8 years alone on online medical student forums, such as *Reddit* and *Student Doctor Network*. Eight students asked for advice on navigating sick parents. A common question is how taking a leave of absence will be perceived by residency programs.

This shared experience affects many students and will shape the formation of their professional identity and how they provide care to patients. Supporting medical students through these moments will ensure a physician workforce that is resilient and able to relate with patients and their families through one of life's most difficult challenges.

How Medical Schools Can Support Students through Family Illness

As medical students get older, their parents and other loved ones will experience health setbacks. Providing meaningful support through these challenging times is

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MY LIFE, MY STORY: AN APPROACH TO WHAT MATTERS MOST

Nam-Ha Brown, MD; Elise Binder, MD, Med; Shivani K. Jindal, MD, MPH

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Background

One of the most vulnerable things a person can share is their life story. Life stories connect physicians to patients' hopes and values and invite the interprofessional team to learn more about how patients have experienced life events that have shaped who they are. *My Life, My Story (MLMS)* is a narrative medicine program developed at the Madison VA Medical Center in 2013.¹ The program allows the healthcare team to learn what Matters Most to patients and in turn, further support goal-concordant care. *MLMS* gives Veterans the opportunity to share their stories and have them recorded in a durable document in the Electronic Health Record (EHR). *MLMS* is present in 75 VA facilities with more than 8,000 stories completed. The program has gained momentum and garnered interest at non-VA facilities who have implemented *MLMS*.

First, a Veteran is interviewed by a trained volunteer or learner, then the draft of the transcript is shared with the Veteran prior to being transcribed into an *MLMS* note in the EHR. Stories are written in first person and in the Veteran's own words. Stories are recorded under the note title, "My Story" and can be easily accessed by all team members when viewing the Veteran's postings in the VA's EHR which is called *CPRS*. All experiences (big and small) shared with the healthcare team are honored.

This bidirectional relationship of interviewing, listening, sharing, and editing deepens connections between Veterans and care teams. These connections enhance patient care and health outcomes.³ Care teams have greater insight into experiences that have impacted a Veteran, and this knowledge informs care teams about what Matters Most to the Veteran (aligning with what Matters in the IHI Age-Friendly 4Ms framework).⁴ All stories are meaningful as they offer a glimpse into the lives of patients and provide information the healthcare team may not know or learn.

Our Journey at the Cincinnati VA

In January 2020, an interprofessional team at the Cincinnati VAMC, collaborated to bring *MLMS* to our

facility. Fifteen employees and volunteers participated in a one-day training on *MLMS* through the national Veterans Experience Office. We worked with our local health informatics specialist to create an *MLMS* consult and note template. Medical media printed brochures to promote the program. Our local Patient and Family Advisory Council and Veterans of Foreign Wars Department of Ohio Charities generously donated money to purchase audio recorders. *MLMS* was officially launched at the Cincinnati VA in January 2021.

Interviewers include volunteers through the Voluntary Services as well as trainees (medical students, residents, and fellows) during their geriatric medicine rotation. Volunteers recruited through Voluntary Services are offered a virtual two-day training created by the Madison VA Medical Center. Trainees on the geriatric medicine rotation receive truncated training, focusing on training guides developed at the Boston VA Medical Center. Interviewers connect with Veterans residing in the VA's Community Living Center (CLC, a skilled nursing facility connected to the main hospital), admitted to the hospital, or residing in the community via telephone. Interviewers obtain consent from the Veteran and conduct a 60–90-minute interview via a combination of scripted and open-ended questions. Stories are documented and condensed for length by the interviewer, shared with the veteran for additional editing, printed for the Veteran, and then completed as an *MLMS* note in the EHR.

In 2020, the Cincinnati VAMC received funding through the Innovation Network to bring Reno VA Medical Center's *Through Our Eyes—The Women Veterans' Experience* project to our VA—an *MLMS* display featuring women Veteran stories. The first display was featured at the "Operation Thank You" event in September 2022. The Cincinnati VAMC *MLMS* project has connected with a broader narrative medicine effort in our region as we partner with other individuals and institutions who are passionate about Narrative Medicine, Compassionate Arts and Healing.

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at #SGIM24. SGIM's Health Policy Committee (HPC) focuses on federal policy and advocacy for SGIM and our members. They are effective in helping us target our federal advocacy to have the greatest impact on academic general internal medicine (e.g., physician payment reform, funding of primary care training and health services research). SGIM leadership recognized that this left a gap at the state and local level and that SGIM can support members in their advocacy work in other ways.

The following are 6 ideas discussed at the Council retreat in December 2023:

1. Make SGIM position statements, other policy statements, and amicus briefs that SGIM is asked to support, easy for members to access. SGIM's new website, launched in February, will house these documents.
2. Encourage workshops at national and regional meetings to train members in advocacy and create networks for those interested in state and local advocacy work. These activities will be an essential component of #SGIM24. In addition, SGIM Council is working with the Board of Regional Leaders to determine how best to involve the regions and their meetings. The HPC has been looking at ways to offer workshops (e.g., a skill building workshop—Advocacy 101) at regional meetings and welcomes input on this from regional leaders.
3. Identify champions within regions who are passionate about advocacy and could serve as mentors to regional leaders. Advocacy is a mobilizing force that can happen between meetings and can engage trainees, showing them the value of SGIM as more than “just a meeting.”
4. Build a relationship with the American College of Physician (ACP) at the state level, starting in states where ACP has strong

advocacy activities, and coordinate with national ACP to share advocacy resources and training efforts. Many members have informal connections with ACP national and chapter leaders. Regional advocacy champions could connect with state (ACP) organizations and explore how best to collaborate on state level advocacy. At the same time, SGIM leadership will continue to work on ways to formalize this collaboration.³

5. Develop a position paper that can be used by members to advocate for their promotion and tenure committees (P&T) to include advocacy work as scholarship in the P&T process and encourage talks and workshops on documenting advocacy as scholarship for a curriculum vitae.^{4,5} This would be analogous to SGIM's position papers and workshops on education and quality improvement scholarship. Members need to report to and be recognized by their institutions for the work they do on behalf of their patients.
6. Assure that SGIM continues to assist members in their advocacy efforts, potentially adding a HPC subcommittee focused on advocacy education.

The SGIM Council will work to implement plans for the 6 strategies over the next several years. We will be looking to our committees, commissions, and members with advocacy skills to help us create and support these resources.

Local advocacy at SGIM Annual Meetings is more important than ever as a growing number of states have policies counter to our values. At #SGIM24, the advocacy focus will be on decreasing the burden of firearm injury. The chair for advocacy programming, Dr. Chana Sacks, has expertise in this area and is based at Harvard Medical School. A HPC member served as the co-chair for advocacy programming in 2024.

All future Annual Meetings committees will have a chair and HPC co-chair for advocacy to help guide meeting planning to support state and local advocacy. If you are interested in being involved, #SGIM25 is looking for a chair for advocacy (Contact SGIM President-Elect, Jada Bussey-Jones). Finally, LEAHP scholars have been asked to consider policy issues within their state as they develop workshops for national and/or regional meetings.

Our Annual Meeting, #SGIM24, has a variety of symposia, updates, workshops, and interest groups where attendees can learn more about advocacy and develop skills that they can take back and use for advocacy in their state and local institutions. Four special symposia will highlight activities and members doing work at the state and local level, including the following:

1. “Paths to Increased Funding for Primary Care Practice: Creating an Action Plan”
2. “Advocate for Health Policy in Your State—With Whom, to Whom, and How?”
3. “More than Just Talk: Advancing Health Equity through Policy Change” and
4. “Turning Despair into Action—Generalists as Advocates for Gender Affirming Care.”

These will introduce attendees to SGIM colleagues who are advocating for change, including their successes, setbacks, and strategies. Our goal is to provide attendees with knowledge and strategies for their own advocacy efforts.

In addition, several workshops will help attendees build their skills in advocacy, including:

1. “Is the Pen Mightier than the Stethoscope? How to Write Impactful Op-Eds”
2. “A Story in 2 Minutes or Less—How to Present Legislative Testimony” and

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of firearm injuries. Drs. Delaney Goulet and Milad Memari are making mentoring a core part of the meeting in coordination with Jillian Gann, SGIM Director of Leadership and Mentoring Programs, by creating new opportunities for senior members to connect with junior members during the meeting. Drs. Emily Mullen and Anthi Katsouli are supporting a larger slate of pre-courses this year: they include established offerings, such as the ACLGIM Hess Leadership Institute and the POCUS Pre-Course led by Drs. Rob Smola and Michael Wager, as well as the new US Deprescribing Research Network pre-course and GIM Fellows Symposium.

Programming for Students, Residents, and Fellows is organized by Drs. Sara Spinella and Matthew Metzinger. Special Programming, including the annual trivia night, is led by Drs. Allie Dakroub and Eduardo Mulanovich. The VA Special Series, led by Drs. Amanda Mixon and Amy Linsky, includes a new workshop by the VA on the approach to patients at risk of firearm injury. Indispensable for an SGIM Annual Meeting, Drs. Elisa Sottile and Brigid Dolan are leading the MOC component of the content; meanwhile, Drs. Chris Jackson and Desiree Burroughs-Ray are heading up the Evaluations component of the meeting. With a commitment toward future generations, Drs. Elizabeth Gillespie and Heather Whelan are leading the way in making the Annual Meeting's carbon footprint more sustainable.

Each session—whether focused on research, medical education, clinical practice, or innovation—is poised to deliver useful take-home learning points for attendees. Within a subset of these sessions, expert discussants will join presenters in putting the new data and findings into the context of the broader clinical evidence or field. The Special Symposia and Workshops will provide hands-on training and broader perspectives pertaining to key concerns of SGIM membership, including women's

health, primary care financing, and making a difference in state health policy.

In addition, a highlight of the Annual Meeting will be a trio of poignant, thought-provoking Plenary sessions. On Thursday, May 16, 2024, Dr. Rochelle Walensky, Director of the Centers for Disease Control and Prevention (2021-23) and Professor of Medicine at Harvard, will speak about advancing public health through building interdisciplinary bridges—supporting the SGIM 2024 meeting theme of relationship coordination. Protecting the population's health is a noble, necessary, and daunting calling. In leading the nation's response to the COVID-19 pandemic and through her decades of academic and clinical leadership in infectious disease, Dr. Walensky has lived this calling. Her plenary promises to instill insightful lessons for us all.

On Friday, May 17, 2024, Dr. Rachel Levine, the 17th Assistant Secretary for Health in the U.S. Department of Health and Human Services, will talk about the many challenges and opportunities facing medicine today. As leader of the U.S. Public Health Service Commissioned Corps and the former Secretary of Health and Surgeon General for Pennsylvania, Dr. Levine's exceptional expertise draws from clinical practice, academia, and policy. Her work strives to give every person in the country the opportunity for health and well-being, and her plenary will serve as a source of inspiration.

On Saturday, May 18, 2024, the unique plenary session centers on the Annual Meeting's advocacy theme—reducing the burden of firearm injuries. Designed by Dr. Chana Sacks, a leading expert on firearm injuries, this plenary brings together an interdisciplinary group of community leaders, survivors of firearm injury, media experts, and physicians to provide SGIM members a clinically high-yield approach to address and prevent firearm injuries. The burden of firearm injuries nationwide contin-

ues to grow, yet learning how to talk with or work with patients and families who experience this trauma is not a routine part of medical education. Saturday's plenary will provide the generalist community concrete, useful tools for day-to-day clinical practice, where clinicians increasingly face the need to find the words to initiate this work with affected patients and family members.

We are grateful to SGIM President Dr. Martha Gerrity for the privilege of helping to plan the Annual Meeting. It is an honor to work with such an amazing group of peers around the country. Members of the SGIM Council, including Drs. Brita Roy and Eric Bass, CEO of SGIM, have also supported us through this planning process. Other colleagues, including Dr. Michael Fischer, who leads the SGIM Health Policy Committee, have generously given their time and wise counsel on key themes of the meeting.

Finally, we are indebted, in more ways than we can express, to our colleagues on the SGIM staff—including Corrine Melissari, CMP, Loubna Bennaoui, Francine Jetton, MA, CAE, Erika Baker, Kay Ovington, CAE, Dawn Haglund, MA, CAE, and others—who make the meeting possible for all of us in the Society. Long before the holidays, when plans for the next Annual Meeting were distant for most, they had landed in Boston, walked through every room in the Annual Meeting venue, and ensured all the logistics of the meeting would run smoothly. This is unsung, often thankless work. They deserve our full gratitude!

The 2024 Annual Meeting aims to reflect the values, commitment, and vision of the SGIM community in ways that sustain our shared purpose through years to come. We hope that many of you will be able to make it. On behalf of the Planning Committee, we look forward to seeing you in Boston this Spring! #SGIM24

one way that medical schools can demonstrate genuine care for students and ensure their success. In my experience, curricular flexibility, close mentorship from my society dean, and strong peer support are three things that have been instrumental:

1. *Curricular flexibility.* A large component of my medical school's curriculum involves case-based learning in small groups. My school understood my situation and allowed me to participate virtually as needed for a brief period, with constant communication with my dean to ensure academic progress and personal well-being. While this setup would not have been sustainable over an extended period, it allowed me to coordinate doctor's appointments for my mom during the critical period. Evidence suggests that increased medical school attendance flexibility does not harm academic performance and is paradoxically associated with improved board exam passing rates.³ For schools with lecture-based curricula, this may be more easily accomplished with lecture recordings, but even for schools with case-based learning, it may be worthwhile to assess the need for temporary virtual attendance in special circumstances.
2. *Close personal relationships with faculty members.* Because my society dean had established a close relationship with me through regular meetings from the beginning of my first year of medical school, I was able to access academic and personal support immediately. During these meetings, we discussed academic and personal matters. A program at Vanderbilt University School of Medicine that implemented a similar structure of advisory colleges was associated with increased perceived advisor accessibility, as well as overall



Many students help take care of sick parents during medical school. Here's how medical schools can support their wellbeing.

- satisfaction with career counseling and wellness, compared to traditional mentorship models.⁴ Establishing a personal relationship with a faculty member through programs like advisory colleges or societies is an excellent way for schools to ensure that students have a point person to confide in about their life inside and outside academics.
3. *Peer support.* In my school's curriculum, our small group sessions usually begin with social check-in questions. This creates a sense of camaraderie and moral support. Studies examining more formal peer support programs at medical schools have demonstrated decreased burnout, stress, and anxiety.⁵ For schools that feature small groups heavily, having a short check-in at the beginning of each session may be helpful in building team rapport. At schools that are lecture-based, creating a weekly small group session may help students feel more connected and less isolated during their medical education.

These are just a few examples of curricular adaptations that would help support medical students who are taking on caregiving responsibilities of family members.

It is important that medical schools and their faculty remain mindful of the students' well-being who are going through family illness. As a community of clinician educators, mentors, and leaders in academic medicine who frequently interact with students, SGIM members can serve as their advocates. SGIM mentors can highlight the positivity of this special caregiver responsibility

during residency applications and interviews to turn the student's concerns into a positive experience. It is critical that we promote a support structure in medical training that will help the future generations of clinicians succeed.

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sion-making process while considering factors such as co-morbidities and a history of previous falls. SGIM clinicians need to emphasize the importance of maintaining regular exercise routines, making home modifications to enhance safety, and adopting careful medication management to lower the risk of falls among older individuals. Looking back on our patient, a previously healthy and independent 69-year-old woman, she may have avoided the burden of physical dependence, social isolation, and being bed-bound after her fall through education about fall prevention, ensuring a safe home environment, and early introduction of physical therapy. Her family also suffered from the financial burden due to the expenditure on a full-time

caregiver, along with social isolation. Falls can have a significant impact on our patients and their families, so vigilance and education about fall prevention among the elderly are paramount.

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BEST PRACTICES *(continued from page 10)*

Outcomes

The goal of *MLMS* is to provide a meaningful opportunity for Veterans to share their life stories with their care teams and help them better understand the Veterans they serve. Five years after *MLMS* was implemented at the Madison VA Medical Center, healthcare staff were recruited to complete a survey with closed and open-ended items. Descriptive statistics and thematic analysis were used to analyze the results and they found that 94% of staff indicated they had read *MLMS* notes and more than 86% agreed or strongly agreed that reading the notes was a good use of their time and improved their care of the Veteran.¹

The Boston VA Medical Center's *MLMS* program is integrated into trainees' education, enhancing patient-centered care. In 2019, 482 stories were compiled by trainees from 7 disciplines. The trainees spent about 2 hours assembling the stories and 84% felt that doing so was a good use of their time.²

Conclusion

The Cincinnati VAMC plans to

measure the impact of *MLMS* on Veterans, their care partners, and care teams by partnering with local academic institutions. We hope to increase our volunteer base, expand educational integration to trainees in other departments and create innovative ways to share and honor our Veterans' stories.

Your patients' stories are meaningful; knowing them can improve the care you deliver. Patient experiences often inform their healthcare choices and goals. By understanding your patients' life histories, you can deliver better goal-concordant care. We encourage you to hear your patients' stories as we hope it helps you to find increased fulfillment and purpose in your practice.

SGIM members who are interested in building or expanding *MLMS* at their facility may reach out to the authors of this article.

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have helped increase the understanding of genetic risk factors for these conditions, paving the way for future treatment and research.

- It helped lead to a breakthrough in understanding post-traumatic stress: A study of more than 165,000 MVP participants identified several genes related to reexperiencing traumatic memories,² the most distinctive symptom of PTSD. The study shed new light on the biology of PTSD.
- It's the world's largest database on nutrition: When Veterans enroll in MVP, they are asked to complete a lifestyle survey that gives VA important information about what foods they eat and at what quantities—which helps researchers make important discoveries for Veterans and all Americans.³

The size and scope of the MVP database will improve the health care of enrolled Veterans, future generations of Veterans and their families, and the general public.

Why is MVP important to SGIM and its members? Many SGIM members work at a VA facility as a clinician, administrator, educator, or investigator. Any VA employee can obtain access to VA data sources including MVP, Corporate Data Warehouse (CDW), VA Informatics and Computing Infrastructure (VINCI), etc. Researchers employed at the VA can access the MVP database. Academic researchers without a VA appointment can work to obtain a Without Compensation position (WOC) or paid position that will also allow access to the data sets. This database has significant implications. The size of the database at one million plus Veterans is significant. It will be comparable to large databases, such as Medicare, Healthcare Cost

and Utilization Project (HCUP), and Surveillance, Epidemiology and End Results (SEER). Because of the electronic medical record within the VA (CPRS), there will be a population-based component like the Framingham and Bogalusa Heart studies. There will be benefits derived that are specific to the Veteran population that may relate to their military careers. However, this dataset will undoubtedly provide insight into diagnosis and treatment of

“The size and scope of the MVP database will improve the health care of enrolled Veterans, future generations of Veterans and their families, and the general public.”

medical conditions applicable to the general population. SGIM members are encouraged to utilize this data to improve the care of those who have already sacrificed through their military service as well as patients that include our family, friends, and colleagues.

In this issue of *SGIM Forum*, we start with an article from our Annual Meeting Chair and Co-Chair, Drs. Song and Schmidt, who highlight the hard work of the Annual Meeting committee and many of the offerings that will be shared in Boston, #SGIM24. SGIM President Dr. Gerrity discusses the work that the Health Policy Committee does for national advocacy, while identifying the gap at state and regional levels. Dr. Gerrity then explains how SGIM and the Annual Program committee are working together to offer tools and expertise to SGIM members to address this gap within our local communities. Dr. Holod and colleagues use the new *SGIM Forum* format for morning reports to walk the reader through the clinical decision making in a case of lactic acidosis and explain why an accurate history is important with patient care. Two of our SGIM

trainees share their experiences with the assistance of SGIM mentors. Fourth-year medical student, Won Jong Chwa, BS, communicates his experience after the fall of a family member and educates SGIM members on fall awareness and prevention. In a similar article, third-year medical student, Tatini Mal-Sarkar, MPH, approaches the illness of a family member and the impact on trainee education and how medical schools can support trainees through this trying time. Dr. Brown and her co-authors describe an initiative at the Cincinnati VA hospital that documents the personal stories of Veterans called *My Life, My Story* as an opportunity to emphasize

what matters most to each Veteran in their care. Finally, SGIM CEO Dr. Bass and Philanthropy Chair Dr. Tierney thank the many contributors to SGIM fundraising efforts while describing the varied programs to which SGIM members contributed.

#SGIM24 is only months away. Take the time to make your scholarly work count twice by submitting your Annual Meeting presentations to the *SGIM Forum* team at SGIMForumEditor@gmail.com for consideration of future publication in *SGIM Forum*.

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PRESIDENT'S COLUMN (continued from page 11)

3. “Climbing the Hill—
Empowering Physicians to
Participate in Legislative
Advocacy.”

Special symposia will cover strategies, using real examples, and workshops will help build skills for SGIM members to be effective advocates for issues important to them. Please let us know if we have accomplished these goals by completing evaluations for these sessions.

By actively participating in state and local government and institutional advocacy efforts, SGIM members can have a positive impact on healthcare policies, patient outcomes, and the overall well-being of our communities. I am confident that symposia and workshop presenters and interest group organizers will help members get involved with advocacy efforts. Many times, good

ideas bubble up from our interest groups through our committees and commissions to the Council. This is a good example for how this happens. Keep your ideas coming. We look forward to seeing you at #SGIM24.

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