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SGIM Forum

Society of General Internal Medicine

ANNUAL MEETING UPDATE: PART I

# SGIM 2024 SPECIAL SYMPOSIA: STRENGTHENING RELATIONSHIPS AND VALUING OUR DIVERSITY

Rashmi Jasrasaria, MD; C. Nicholas Cuneo, MD, MPH

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As we gear up for the Annual Meeting in Boston, Massachusetts, this spring (#SGIM24), we hope you are excited to hear thought-provoking perspectives on innovative approaches to solving today's healthcare challenges. Reflecting on a complex healthcare landscape that evolves rapidly, the SGIM 2024's Special Symposia are a curated collection of 12 sessions led by expert panels designed to highlight this year's conference theme—General Internal Medicine: Strengthening Relationships and Valuing Our Diversity.

The Special Symposia bring together experts in clinical medicine, research, program implementation, community collaboration, advocacy, and education. These speakers will share high-level evidence and best practices with the goal of energizing, catalyzing, and inspiring SGIM members to continue and improve upon the meaningful contributions this community makes in promoting health. The sessions are spread throughout the two full days of the meeting (Thursday-Friday, May 16-17, 2024) covering a breadth of topics that demonstrate the strong tradition of cross-institutional collaboration and interdisciplinary relationships that defines our SGIM community.

As the chairs for submissions in this category this year, we had our work cut out for us, challenged with selecting a dozen symposia from a record number of excellent submissions. We prioritized proposals that demonstrated alignment with the conference theme, high levels of inter-institutional collaboration, interest to the audience, and engaging methods. We are excited by the collection of speakers and topics that will vividly illustrate this year's conference theme. We invite SGIM members to attend and engage with experts in their field as they showcase how generalists can elevate our impact on individual and population health by "strengthening relationships and valuing our diversity."

On "strengthening relationships," we will hear from two outstanding groups on Thursday, May 16, 2024. Drs. Jody H. Gittell[1] and Anthony Suchman[2]—two experts on relationship-driven healthcare organizations—will present on Relational Coordination, a field they have helped to define. Relational Coordination offers a framework for understanding and improving the quality of communication and relationships to achieve better outcomes in health care. Dr. Patrick Hemming—an expert in how we teach doctors to work together as teams with allied health professionals—and colleagues from several academic medical centers will present a toolkit on how to successfully implement and sustain Behavioral Health Integration (BHI), which intertwines mental health and substance use disorder treatment within primary care. They will cover the basics of BHI's two preeminent modes—the Collaborative Care Model[3] and Primary

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# OUR LEGACY: WHAT WE LEAVE BEHIND

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

"Every person has a legacy. You may not know what your impact is, and it may not be something that you can write on your tombstone, but every person has an impact on this world."[1]

I recently lost a beloved family member. I had come to know my father-in-law quite well over the past 25+ years. He had a zest for life and a love for people. He lived a full life passing on at 86 years old. Over these 25 years, I heard many stories from him, his siblings, and his children about his youth, upbringing, and adult life. These stories were recounted by a family of great storytellers during family gatherings. His family loved to reminisce, and these stories were told with detail and passion. The more popular stories repeated on occasion, but you could always count on at least a few new chronicles being laid out for all to share.

At his funeral, I had the pleasure of meeting some of those friends and family members I had heard about from the stories. Additional stories were shared, including new ones I had not heard before. I thought I knew a lot about this man: he was a deeply religious man who read his Bible every day, and, as the eldest, he always led the family in prayer at holiday gatherings. However, I was surprised to learn during his eulogy that as a young man, he had journeyed to the state penitentiary in Louisiana to start a bible study group. I was even more astonished to hear that this bible study continued under his leadership for many decades until a few years ago. We heard that several inmates went on to become members of the clergy once released from prison because of his group. This was just one of the stories that were shared by those who lived these stories with him. His eulogy made me realize that there was so much more to him that I did not know. However, I recognized that he made a difference in the world around him.

In the days after his funeral, I began to reflect on my life. I recounted a comment from an old friend in which they told me that there would come a day when you start to recognize your own mortality. Family and friends will pass on to a better life. You start to take stock of your life. If we think for a second, we can remember many great things we have accomplished. But many people, me included, think of all the things we have yet to complete. Maya Angelou once said "If you're going to live, leave a legacy. Make a mark on the world that can't be erased."[2]

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# LOOKING FORWARD BY LOOKING BACK

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

*"I am confident that the accomplishments from this past year will move SGIM forward in cultivating 'the next generation of educators, researchers, and clinicians in academic general internal medicine.'"*

This is my final column as SGIM president, and it has been quite a year. This realization prompted me to reflect on our future by reviewing the past year and asking the question, "How well is SGIM supporting the needs and interests of our members?" I am confident that the accomplishments from this past year will move SGIM forward in cultivating "the next generation of educators, researchers, and clinicians in academic general internal medicine."[1] I want to highlight the resources invested and accomplishments achieved that make me confident.

Our most important resources are our talented hard-working staff[2] who support SGIM members, our committees and commissions, and the many volunteer members serving on these committees and commissions as well as the SGIM Council. I had the opportunity to meet and work alongside many staff and to learn about their impressive skill sets and backgrounds. I also want to acknowledge this past year has been a difficult year for our organization with the loss of Leslie Dunne, SGIM's long-term Director of Finance and Administration, who died from complications related to cancer. This loss weighed heavily on SGIM leadership and staff. As a past SGIM treasurer who worked closely with Leslie, I feel this loss and miss her cheerful "can do" attitude and willingness to help with any task that was needed. I am impressed by our staff who have filled gaps, as we search for a new Finance Director, and by SGIM leaders who understood the challenges staff faced and added their support.

The Council made changes in our meeting structure to ensure we dedicate sufficient time to generative discussions that look to the future and consider innovative ideas

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

# Q & A WITH SGIM'S CEO AND PAST PRESIDENT MARTIN SHAPIRO ON THE PRESENT ILLNESS OF OUR HEALTHCARE SYSTEM

Martin F. Shapiro, MD, PhD, MPH; Eric B. Bass, MD, MPH

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SGIM has had many fabulous leaders since it was founded in 1978 as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM) with Dr. Robert Lawrence as the first President. I am thankful that so many of SGIM's past presidents remain engaged in the life of the organization. The past presidents are an incredibly valuable resource with their amazing diversity of leadership experiences and their historical perspectives on the challenges we face in pursuit of our vision for a just system of care in which all people can achieve optimal health. When I learned that one of our past presidents had written a book about our ailing healthcare system, I decided to ask him about it—*The Present Illness: American Health Care and Its Afflictions*.[1]

### EB: Why did you feel it was necessary to write a book about the afflictions of the American healthcare system?

MS: Many of us who entered academic general internal medicine (GIM) in the early 1980s considered ourselves to be change agents. I studied disparities and hoped that evidence would lead to a system that was efficient, effective, and just; it did not. To investigate why the United States is such an outlier in these respects, I drew upon history, sociology, health services research, and my own experiences. The problems go well beyond the usual targets of reform. All the actors in health care—physicians, medical schools and their faculty, health systems, other corporations, investors, scientists, governments, employers and employee groups, and also patients and the public—obstruct meaningful change.

### EB: What are the three most important problems standing in the way of effective healthcare reform?

MS: Three major problems interact to stymy reform: commodification of care by all the groups of actors; their "consciousness" (values, expectations, unmet needs, attitudes, and personal limitations); and toxic relationships and communication among them.

### EB: How does the "financialization of health"[2] complicate efforts to achieve meaningful healthcare reform?

MS: Financialization is a particularly reprehensible, but completely predictable, manifestation of what I describe as commodification of health care and health. Other problematic manifestations of commodification are the pursuit of market share of "covered lives" by teaching hospitals, and the distorted fee schedule that empowers proceduralists to "run the till." Efforts to achieve meaningful reform are also complicated by selecting medical students based on grades and test scores rather than on evidence of a capacity for compassion and empathy, ability to communicate effectively, and commitment to societal well-being that exceeds interest in high incomes. The failure to reinforce such values in training is no less problematic. The National Institutes of Health (NIH) doesn't invest nearly enough in improving population health, while scientists and their employers pursue patents. Much of the public wants their share of the goods (procedures, beds in the intensive care unit for relatives unlikely to benefit) whatever the consequences for the health of others, often abetted by doctors and health systems that fail to set limits. The notion of the common good, a founding precept of America, is blithely ignored.

### EB: What gives you hope that comprehensive reform can be achieved?

MS: Piecemeal reform efforts will continue to be undermined by those who believe they have something to gain from the status quo. We need combination therapy, addressing commodification, consciousness, and communication in all the actors in health care and in society as a whole to create a system that is humane, effective, and

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# YOUR FIRST SGIM: A PRIMER FOR STUDENTS, RESIDENTS, AND FELLOWS ATTENDING THE SGIM 2024 ANNUAL MEETING

Sara Spinella, MD, MS; Matthew Metzinger, MD

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On behalf of the SGIM 2024 Annual Meeting planning committee, we are thrilled to welcome the many students, residents, and fellows who will attend our Annual Meeting: Strengthening Relationships and Valuing Our Diversity, May 15-18, 2024, Boston, Massachusetts (#SGIM24).

While attending a national meeting can be overwhelming at first, we planned this meeting with the needs of students, residents, and fellows in mind. The meeting's theme is centered on finding strength in the diverse experiences of the members in our Society, especially our trainee members; we are focused on building relationships between peer and near-peer members as well as between senior and junior members. This meeting provides myriad opportunities for trainees to expand their clinical, leadership, research, and advocacy skills and positions them to launch a meaningful and fulfilling career in general internal medicine.

We want to highlight a few of the exciting opportunities for the student, resident, and fellow community. First, we have a new pre-course specifically for general internal medicine fellows. This is the first fellow-directed pre-course since the pandemic and provides a unique opportunity to network with our national community of general internal medicine fellows. The pre-course will allow fellows to receive feedback on scholarship and provides training on transitioning to junior faculty roles, job applications, and engaging with the scholarly community. The pre-course takes place on Wednesday, May 15, 2024, 11:00 AM-5:30 PM, and requires a separate $25 registration fee.[1]

Our Society is committed to mentorship, and some of the most meaningful experiences at our meeting are the formal and informal interactions with others in our field. Our one-on-one mentoring program matches trainees and early career faculty with an experienced mentor with shared interests. This year, for the first time, we are also offering mentorship for residents specifically curious about pursuing general internal medicine fellowships. Mentees should come prepared with goals for the mentoring relationship and meet with their mentors at least once during the meeting. Our one-on-one mentoring program operates on a first-come, first-serve basis and mentees must sign up no later than Friday, May 3, 2024.[2]

Outside of the one-on-one mentoring program, our meeting includes several formal mentoring panels. On May 17, 2024, 11:30 AM-12:30 PM, we will have a career planning session for students, residents, and fellows highlighting the diversity of rewarding and impactful career paths within general internal medicine. This session will intentionally facilitate peer and near-peer mentoring with a brief structured networking period. Additional mentoring panels of relevance to trainees include parenting in medicine roundtables and career panels for clinician educators and clinician investigators. A career fair is also scheduled for May 15, 2024, 5:30-7:00 PM.

First-time attendees have many opportunities to interact and organize with other SGIM members who share similar passions and interests during breakfast and lunch interest group sessions. Interest groups are formed independently by our members and may focus on clinical interests, advocacy goals, or building communities for ourselves within medicine (such as the General Internal Medicine Fellowship, Women in Academic Medicine, or the Minorities in Medicine groups). Interest group sessions tend to be small and interactive, offering more opportunities for forming relationships around a common goal. Feel free to bring breakfast or lunch with you to these sessions!

Poster sessions are another key offering of this meeting for students, residents, and fellows. The poster ses-

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# DEMENTIA CARE AWARE: A CALIFORNIA STATEWIDE EFFORT TO SUPPORT PRIMARY CARE TEAMS

Anna Chodos, MD, MPH; Clara Park, MPA; Josette Rivera, MD

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Alzheimer's disease and related dementias (ADRD) are underdiagnosed in primary care, especially among populations facing health disparities and structural racism.[1, 2] Failing to identify ADRD can lead to more rapid cognitive decline, accelerated mortality, increased hospitalizations, and higher health care costs.[3] Conversely, the benefits of early detection are increasingly recognized, as clinicians can address modifiable risk factors that slow further decline, improve quality of life, and avoid medical and social crises that lead to higher acute healthcare use.[3] And within the last year, a new class of medication has been approved to slow the progression of dementia in people with Alzheimer's disease, but is only indicated when the dementia has been diagnosed in the earliest stages.[4, 5]

Earlier detection, however, presents practical challenges with an unprepared workforce: seventy percent of primary care providers lack confidence in screening for cognitive impairment and desire more education.[2]

To address the problem of underdiagnosis in its diverse population, California Senate Bill (SB) 48 expanded Medi-Cal (California's Medicaid program) benefits to include an annual cognitive screen for patients 65 and older with Medi-Cal only (a similar benefit already exists in Medicare). To implement SB 48, the California Department of Health Care Services created Dementia Care Aware (DCA), a state-wide initiative to support primary care in earlier detection, and awarded the University of California, San Francisco (UCSF) the coordinating role. The key components of the program were the development of a screening approach for ADRD called the cognitive health assessment (CHA), associated trainings, and implementation resources for primary care practices. CHA is a screening approach because it incorporates several validated tools to identify the core criteria for dementia, functional and cognitive decline. To achieve these goals, UCSF created a state-wide collaborative consisting of several University of California campuses- Irvine, Los Angeles (including the Harbor-University of California, Los Angeles medical campus), San Diego, and College of the Law—and the University of Southern California/Rancho Los Amigos, the Alzheimer's Association, and local Alzheimer's organizations in California including Alzheimer's Los Angeles, Alzheimer's Orange County, and Alzheimer's San Diego.

The CHA was developed by a Clinical Advisory Board of experts in dementia and primary care and consists of three parts. The components of the CHA are as follows: 1) a brief patient history about cognitive symptoms, 2) tool(s) to assess for cognitive and functional decline with the patient and/or an informant, and 3) documentation of the patient's care partner status and information. These assist in detecting if someone may have dementia and how best to support them. Tools for cognition and function were chosen that are free, brief, available in multiple languages, validated in primary care, and relevant to the broadest numbers of patients. Also, we included asking if there is a care partner and recording their contact information in this screening approach because it is central to the care of someone with cognitive and functional decline.

Dementia Care Aware developed online courses on topics relevant to the CHA and implementation: how to conduct the CHA for both primary care providers and interprofessional team members; conducting the CHA via telehealth; adapting the CHA (e.g. for those with limited English proficiency, serious mental illness, experiencing homelessness, etc.); next steps after a positive screen; connecting with care partners; and advance care planning. Additional training includes live monthly webinars, in-person trainings, podcasts, and ECHO case conferences.

Finally, the program developed practice change and implementation resources. One example is a warmline, a live clinical consultation line for primary care clinicians

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to connect with DCA experts during business hours to review expert guidance on clinical issues. The program also provided intensive coaching resources for clinical practices interested in becoming dementia capable. These consultants are available through the UCLA Alzheimer's and Dementia Care Program and the Alzheimer's Association's Health Systems Implementation team.

The program collects data from the online curriculum on participant demographics, quality of trainings, and self-reported measures, including change in confidence and intended practice changes. From July 2022 to January 2024, 2,656 participants from 46 of 58 California counties completed the core training on the CHA. Participants who completed a continuing education survey for the online training rated the overall average quality 4.5/5 (n=383). Of these same participants, 90% were "somewhat" or "very" confident in their ability to make practice changes; 66% intended to "increase frequency of conducting, scoring, and interpreting a cognitive screening tool" and 58% intended to "start a brain health plan with their patients after conducting a cognitive health assessment."

The time has come to improve our care for people living with dementia, and this starts with earlier detection to maximize the time we have to support our patients with this condition. Dementia Care Aware in California is an initiative showing how a state may take on improving dementia care and embrace primary care-wide education and support. SGIM members can work to expand this and similar programs with additional incentives and resources to ensure that primary care is prepared and equipped to detect and address dementia for the pivotal years ahead of us.

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SGIM



to improve our ability as a volunteer governing board to keep SGIM moving forward. We now organize our agendas to begin with generative topics to ensure there is adequate time for discussion (e.g., articulating the goals and guidance for regional and national meetings). These are followed by strategic governance issues (e.g., plans for supporting members in state and local advocacy efforts) then operational and fiscal issues. Council increased engagement with SGIM past presidents by having two opportunities for them to meet with and advise current leaders by video conference, in addition to the past presidents' breakfast at the Annual Meeting. Our past presidents desire meaningful engagement with SGIM and have a wealth of experience and ideas to share with us.

SGIM staff and leaders completed several long-term projects that will be key to making SGIM's resources more accessible to members and others. The first project is SGIM's new website. After several years of careful planning and input from members about what would be most useful, we launched the new website in February.[3] Julie Machulsky, Director of Technology Services, led this effort. Please thank Julie and the web team for their hard work and let them know if you have questions or feedback about the website and its resources.

I hope you take time to explore all that the website and its new resources. For example, the website hosts SGIM's learning platform, GIMLearn. GIMLearn provides members with opportunities for learning and disseminating their work. The content is listed as courses, under professional and career development on the website.[3] It is the culmination of the work of the Editorial Advisory Board, currently led by Council member, Marshall Fleurant, MD, and Dawn Haglund, MA, CAE, SGIM's Director of Education. The Board developed content standards and an ongoing peer review process to ensure high quality content. The next Call for Submissions will be this fall.

SGIM continues to work on strengthening our regions. The

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# YALE'S DIABETES CLINIC: A NOVEL INTERPROFESSIONAL CHRONIC CARE MODEL TO ENHANCE AMBULATORY TRAINING IN RESIDENCY

Janani Raveendran, MD, MEd; Green Chung, MD; Tamara Malm, PharmD, MPH, BCPS; Stephen J. Huot, MD, PhD; Tracy L. Rabin, MD, SM

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Academic primary care practices face many challenges when striving to implement recommended chronic disease management strategies. As graduating internal medicine residents have reported unpreparedness in managing chronic conditions,[1] there is opportunity to improve the abilities and confidence of future primary care providers by incorporating innovative chronic care models into ambulatory education.

Experts in graduate medical education have long called for new teaching models that achieve a better balance between outpatient and inpatient training and develop resident proficiency and assurance in interprofessional chronic care.[1] However, there is a paucity of literature examining how team-based approaches to diabetes care affect resident educational outcomes.[2, 3]

Recognizing this need for additional resident training to meet the complex needs of its patient population, the Yale Primary Care Internal Medicine Residency Program (YPC) established a novel interprofessional Diabetes Clinic within its outpatient practice in 2004. The clinic is staffed by generalist attendings with expertise in diabetes management, dedicated junior preceptors (chief residents and/or General Internal Medicine Medical Education fellows), rotating postgraduate years (PGY) 1–3 residents, a pharmacist, and a nutritionist. A social worker is also available for consultation.

The primary educational goal of the clinic is to train residents to provide enhanced care for patients with diabetes. Patients are typically referred with a hemoglobin A1c (HbA1c) of 8% or higher, despite having worked with their primary care physicians to achieve a target HbA1c as recommended by the American Diabetes Association (ADA). The following elements are critical to meeting this educational objective:

1. *Foundational knowledge building.* Residents rotating in the clinic receive an e-mail each week with the abridged version of the most recent *ADA Standards of Medical Care in Diabetes*,[4] as well as an annually updated checklist of comprehensive diabetes care components based on these standards. In addition, the residency program's ambulatory curriculum consists of 45-minute pre-clinic teaching sessions, including six sessions on diabetes care yearly. Four diabetes-related topics ("ADA Standards of Care,"[4] "Insulin," "Non-Insulin Medications," "Using Diabetes Equipment") repeat annually, and two topics (e.g., "Diabetes and Weight Management/ Bariatric Surgery" and "Diabetes Distress") change every year. All residents on ambulatory rotations also participate in the Yale Office-Based Medicine Curriculum.[5] This regularly updated evidence-based syllabus, including at least two diabetes-related topics, uses a case-based approach to supplement outpatient clinical practice teaching.

2. *Structural and hands-on resources.* The electronic medical record (EMR) consists of a unique note template that prompts residents to address items on the above-referenced checklist. It also contains dedicated order screens with quick links to commonly used diabetes medications and equipment (e.g., glucometers, test strips, and lancets) to facilitate correct ordering processes. The clinic additionally maintains a supply of demonstration equipment, including insulin pens and needle tips, syringes and vials, and glucagon-like peptide 1 receptor agonist pens, which the precepting team trains residents to use to counsel patients.

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Further, given that many patients struggle to afford prescriptions and health insurance co-payments, preceptors teach residents to incorporate cost-reduction strategies, such as the Connecticut Medicaid Preferred Drug List and the federal 340B Drug Pricing Program.

3. *Practical application within an interprofessional team*. The clinic is held 1 half-day per week, and residents are scheduled to rotate in it at least eight times during ambulatory blocks throughout their 3-year training. After taking an initial history from patients, residents present their cases to and consult with the interprofessional precepting team. Following the group discussions, residents are accompanied by their supervising attending and other team members as appropriate based on treatment plans (e.g., pharmacist reviews the correct administration of insulin or pill box utilization). In instances where the pharmacist or nutritionist engage in targeted self-management training and counseling with patients, residents are expected to partake in, and learn from, those discussions.

Together, these didactics, resources, and interprofessional experiences teach residents a dedicated primary care-based approach to diabetes management.

We examined the impact of participation in this innovative interprofessional Diabetes Clinic on resident preparedness for comprehensive diabetes care and identified the educational strengths and areas of improvement of this team-based model.

Eligible participants for our study included 49 PGY-1–3 residents during the 2019-20 academic year, who completed at least one Diabetes Clinic session. In August 2020, we recruited residents via an e-mail containing a link to an online consent and post-intervention survey. The survey contained two demographic questions, 15 questions that used a 5-point Likert scale from "decreased" to "increased" assessing for changes in resident comfort with and attitudes toward important parts of diabetes management, and two free-response questions seeking feedback on the interprofessional clinic model. Likert scale data were analyzed as percentages, and key themes were identified from the open-ended responses.

At least 27/49 (55%) residents responded to 13 Likert scale questions; 28/49 (57%) responded to all 15 questions. Importantly, residents reported greater comfort across separate outpatient-specific diabetes care skills (64.3%–92.9%). The largest percentage of residents reported feeling more comfortable counseling patients on target glycemic ranges (92.9%). They also noted that participation in the clinic resulted in a "much better grasp of pharmacological options" and "expanding [their] knowledge base regarding insulin management (89.3%) as well as [use of] oral hypoglycemic agents" and other non-insulin medications (85.7%) in the outpatient setting.

Additionally, residents reported improvements in five of six areas related to attitudes toward diabetes care (85.2%-92.9%). In evaluating the interprofessional structure, 88.9% of residents conveyed a better understanding of the value of various team members' roles. Residents specifically noted appreciating the "hands-on experience to apply practical diabetes knowledge in a longitudinal, team-based, and patient-focused context," as well as learning "how crucial [their] pharmacy and nutrition colleagues are in helping [to] manage diabetes." Notably, they requested "more interactions with pharmac[ists] and dietitians… perhaps dedicated shadowing time" to learn to a greater extent about counseling on starting new medications and lifestyle modifications with a focus on nutrition, respectively.

It is important that SGIM educators find new ways to emphasize and enhance ambulatory training in residency. Though our study's population was limited to YPC residents during the 2019-20 academic year, we believe this curricular innovation is nonetheless generalizable to other academic outpatient practices today.

SGIM educators may find it easier to incorporate this clinic model into dedicated ambulatory blocks. The didactic components can be embedded within existing ambulatory curricula, and the electronic features within each EMR system. Physician preceptors may count clinic sessions toward their required clinical duties. Additional resources that could be needed include the hands-on teaching materials, which can be obtained free from pharmaceutical companies, and the availability of the non-physician team members, which may vary depending on financial situations.

Moreover, by implementing this clinic model, SGIM educators may see a positive impact on resident educational outcomes, including improved aptitude and assurance in chronic care and increased interest in interprofessional collaboration. These benefits could extend to the practice of future primary care physicians as well as patient outcomes.

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# LESSONS LEARNED FROM DR. LUCI LEYKUM

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

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Dr. Luci Leykum's riveting article, "Lessons from the Front Line of Fighting Gender Inequity,"[1] details her personal experiences with challenging the gender pay gap in academic medicine. Her story inspired members of the Women and Medicine Commission (WAMC) to think about specific strategies we can promote to reduce gender inequity. This article shares highlights and reflections from our conversation with Dr. Leykum and proposes practical steps individual physicians, academic institutions, and professional societies, including SGIM, can take to address systemic gender inequity in medicine.

## Individual Physicians: Relationships Are Necessary for Cultural Change

Dr. Leykum recommends addressing gender inequity through the lens of personal relationships. She notes that, as internists, we are skilled at developing connections with our patients to provide optimal care. Similarly, we need to apply these same skills to the workplace to ensure that trusting and respectful relationships with co-workers become the norm. Constructive dialogue about gender inequity can only occur if colleagues work to create an environment that "positively resonates with everyone." Individuals need to be comfortable addressing inequity when they witness it. For example, if an individual hears something that sounds unprofessional or disrespectful, they should feel empowered to speak up and say, "what did you mean?" or "this is what I heard, is that what you meant?" This calls attention to unprofessional behavior in a non-threatening way and ensures accountability. Dr. Leykum notes that, as physicians, we are constant learners and always looking for ways to improve. Discussions about unprofessional comments should be considered as "coming from a place of improvement" that will benefit everyone.

## Academic Institutions: Feedback Is Critical for Organizational Growth

Academic organizations play a critical role in addressing gender inequity. The institutional leadership needs to be open to feedback and provide mechanisms for faculty to voice their opinions in a psychologically safe way. Specifically, organizations should provide electronic portals or other online mechanisms for faculty to share their concerns anonymously. Additionally, institutions should ensure that the adjudication of faculty concerns is performed by a group that is separate and distinct from the academic leadership. Academic institutions should welcome feedback and consider it essential for fostering a high-performing organization. Importantly, faculty should feel comfortable proposing solutions to existing problems without fear of retaliation.

## Professional Societies: Empowering Physicians

In 2018, the *Annals of Internal Medicine* published a position statement, "Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians"[2] that provides eight specific recommendations to improve gender equity, such as ensuring the regular and transparent assessments of physician compensation and consistent exposure to implicit bias training. Similarly, Dr. Karen Freund issued a call to action for members of the Society of General Internal Medicine to address gender inequity in leadership by encouraging and funding "national processes that are evidence-based to promote diversity in our leadership."[3] Internists should feel empowered by these recommendations to take specific actions at their own institutions to improve gender equity. Professional societies can also contribute to advancing gender equity by leveraging their wide membership to connect individuals who have had similar experiences while amplifying the voices of their constituents and providing access to resources that de-mystify legal processes and procedures.

## Next Steps

In her book *Closing the Gender Pay Gap in Medicine*,[4] Dr. Amy Gottlieb, a former WAMC chairperson, outlines the causes of gender pay inequity and suggests strategies for closing the gap. The WAMC spotlighted

*continued on page 13*

Board of Regional Leaders (BRL) is working on strategies to connect our regional and national SGIM structures to support our regions and their innovative spirit. Strengthening our regions would improve the pipeline of new members and leaders by extending our outreach and engagement of faculty and trainees who may not attend national meetings. I attended four of the seven regional meetings and was impressed by the different areas of emphasis at these meetings, from climate change to artificial intelligence. I also found the same enthusiasm and networking that occurs at the national meeting.

This past year, the BRL, under the leadership of Tom Radomski, MD, recommended to Council that we realign our regions, starting in May 2024. This will decrease the number of regions from seven to six and balance the needs and numbers of members in the states west of the Mississippi river. The rationale and decision making for the realignment are described in the November 2023 SGIM *Forum*.[4] Please attend your regional meetings and talk with the trainees. They are committed to our values (e.g., dismantling structural racism and oppression; diversity, equity, and inclusion; and population and social determinants of health). Encourage them to get involved with their regions and national SGIM.

Some other accomplishments from this past year relate to our ability to support the development of our early career members. Under the guidance of Liz Davey, MBA, SGIM Development Officer, and with your generosity, our Forging Our Future philanthropy program continues to grow with 388 gifts made in 2023 amounting to $217,460 in revenue. These funds will support the Investing in GIM Membership program that will award 65 complimentary memberships to first-year GIM fellows and the National Young Scholars in GIM scholarship that will provide 60 medical students and residents with the opportunity to attend #SGIM24. We also launched the John Goodson Leadership in Health Policy Program (LEAHP) Scholarship. This is a new fund-raising initiative honoring the career-long advocacy work of John Goodson on behalf of SGIM and all who do primary care. This scholarship will enable SGIM to support the projects of LEAHP scholars who advocate for supporting the practice of general internal medicine.

Finally, #SGIM24 is shaping up to be an exciting meeting, from the three Plenary Sessions to the 72 Interest Groups.[5] I am proud of the hard work of the Annual Meeting Program Committee under the leadership of Zirui Song, MD, and Jenny Schmidt, MD, and with the support of Corrine Melissari, CMP, Annual Meeting Manager, and Loubna Bennaoui, Meetings and Events Associate. They had the difficult task of balancing innovation and tradition and guiding the work of 19 subcommittees as they selected among the increased number of submissions, 448 workshops/updates/interest groups and 2,236 abstracts/vignettes/innovations.

We are trying some new things this year. In line with the meeting theme, "Strengthening Relationships and Valuing Our Diversity," there are sessions that will cover theories and build skills in relational coordination that can be applied in any of the settings where we work. For the first time, we had an advocacy focus for the Annual Meeting, "Decreasing the Burden of Firearm Injury," with sessions that will increase knowledge and build skills to use in our clinical work. The meeting also includes several strategy and skill building sessions on advocacy for those who want to make state and local advocacy a focus of their work. The new SGIM website has additional resources listed under advocacy and policy, including SGIM's policy papers and endorsement letters.

I am struck by how quickly the year has passed and how busy it's been for SGIM. We continue to make progress towards our vision—"a just system of care in which all people can achieve optimal health."[1] I want to thank all of you, and especially SGIM CEO, Eric Bass, MD, and Kay Ovington, CAE, Deputy CEO, for your support during this year. As I prepare to pass the gavel at #SGIM24 to President-Elect Jada Bussey-Jones and succeed Leroi Hicks as Past President, I want to thank them for their partnership. I know that SGIM will continue to thrive and innovate under Dr. Bussey-Jones' leadership. I will close the same way I started by reflecting on the purpose of our gathering at #SGIM24 and ask you to do the same, to explore the deeper why of gathering. I am looking forward to our time together and encourage you to get involved in SGIM's committees, commissions, and work groups.

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Care Behavioral Health[4]—exemplifying one arena in which relationship strengthening across health care can translate directly into better results for patients.

There are several systemic barriers to such cooperative models of care delivery related to the structure and financing of health care. To better understand these forces and how to navigate them, on Thursday, May 16, 2024, Dr. Toby Terwilliger—an expert in physician advocacy—and colleagues will guide us through the recent corporatization of health care within the United States, its consequences, and ways internists and physician organizations can push back and advocate to preserve the pro-equity intentions of Medicare and Medicaid. In doing so, they will cover the trend towards Medicare Advantage plans, the expanding role of private equity firms and insurance companies, and the adoption of corporate practices in health care. Within this dynamic and increasingly revenue-driven landscape, Dr. Russell Phillips—Director of the Harvard Medical School Center for Primary Care—will moderate a critical discussion of ways to increase funding for primary care the following day (Friday, May 17, 2024). Through recent and pending changes in Medicaid and the RVU system, along with innovative models of reimbursement, Dr. Phillips will outline a path forward for mainstream primary care practices under threat in the face of recent competitors, such as virtual-first primary care. Also on Friday, May 17, 2024, Dr. John Mafi, Chair of the SGIM Research Committee, will moderate a debate on the role of artificial intelligence—such as large language models (LLMs)—in disrupting primary care practice and potentially spreading medical misinformation.

With an increased emphasis on generating revenue and greater dependency on technology, we risk leaving behind some of our patients. To address the second part of our conference theme, "valuing our diversity," we have an all-star line-up of speakers touching on innovative approaches for reaching diverse and vulnerable populations with an eye toward health equity. On Thursday, May 16, 2024, Dr. Hollis Day—Chief of Geriatrics at Boston Medical Center—and colleagues will present the sometimes-hidden inequities associated with dementia, more prevalent and diagnosed later among older adults identifying as Black, Hispanic, or indigenous. To address this gap, the presenters will share an evidence-based toolkit for improving dementia screening, communicating the diagnosis, and increasing access to treatment. On Friday, May 17, 2024, we will then explore two comparative systems-based approaches to addressing health inequities across state lines. Dr. Shari Bolen—an expert in health policy research and population health—and colleagues will present on four statewide initiatives to improve cardiovascular outcomes and equity funded by the Agency for Healthcare Research and Quality (AHRQ). Later, Dr. Jane Abernethy—an expert in healthcare delivery for the undocumented population—and colleagues will present health system-level innovations in caring for immigrants across two states (Maryland and Massachusetts) with contrasting policies regarding insurance eligibility based on immigration status.

Beyond considering how to innovate within different policy realities, we will also address the issue of advocacy and policy change head-on through hearing from four inspiring groups. On Thursday, May 16, 2024, Dr. Elena Byhoff—an expert on the impacts of the social determinants of health—and colleagues will share examples of how general internists have been able to influence policy to address upstream factors in care delivery and promote health equity in partnership with key stakeholders. That same day, Dr. Mark Schwartz—former chair of the SGIM Health Policy Committee—and colleagues will provide an overview on strategies to engage state government officials in advocacy efforts to impact state-level health policy. Then, on Friday, May 17, 2024, Dr. Rahul Vanjani—an expert on integrating social care into the clinical environment—and colleagues will focus on how to cultivate health equity at the provider, practice, and community levels through harnessing our power as "street-level bureaucrats," integrating social medicine in direct care. Later, Dr. Jennifer Siegel—Medical Director of the Massachusetts General Hospital Transgender Health Program—and colleagues will dive into the specific case of gender-affirming care, which has come under increasing public scrutiny in today's contentious political environment, compelling generalists to become advocates at multiple levels in defense of their patients' rights. Through this example, the presenters will deliver a toolkit for effective advocacy at clinical, institutional, and national levels.

Overall, this year's special symposia offer something for every general internist: inspiring presentations, engaging debates, and practical tips; tools to use at the bedside and in the classroom, state house/town hall, boardroom, and research roundtable; and a chance to reflect upon our community's successes and opportunities for growth and expansion. Collectively, our experts demonstrate that by "strengthening relationships and valuing our diversity," we can continue to improve health and advance equity. If you are looking to explore the power and potential of this year's conference theme, look no further!

We look forward to seeing you in Boston at #SGIM24!

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just. Success is far from assured, but taking this on is mandatory.

**EB: What is the best way for SGIM members to advocate for reform?**

MS: I present an agenda of concrete actions to address the many factors contributing to the system's failings. SGIM members should:

- challenge their medical schools to change the process of student selection
- radically revise curricula to nurture doctors who care about their patients and their need
- call out teaching hospitals for antisocial business plans whilst in pursuit of surplus
- share stories that convey the complexity and value of primary care
- focus research on addressing these really big questions, even if funding is scarce
- advocate for a fee schedule that does not prioritize procedures over caring
- insist on providing everyone the same insurance, since separate is never equal; and
- demand substantial change in the NIH's budget priorities toward assuring that benefits of science reach all populations.

Some of these problems can be addressed locally; others require policy change. SGIM's Health Policy Committee and the American College of Physicians[3] are potential vehicles. Still others require broader changes in society, for which we should struggle, as Rudolph Virchow eloquently wrote.[4]

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Dr. Gottlieb's work in the *Forum*,[5] and selected her as the Distinguished Professor of Women and Medicine in 2021.

In addition to highlighting new research in gender equity, the WAMC will continue to advance sponsorship of women faculty through workshops, symposia, and the Career Advising Program (CAP). We encourage and welcome SGIM members to join the WAMC and pursue this mission.

The Women in Medicine Commission would like to thank Dr. Leykum for her insights.

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sions shine a light on our members' groundbreaking educational, translational, research, quality improvement, and diagnostic work. Trainees often present their own scholarship in these sessions and meet others with similar academic pursuits by perusing the poster hall. Our senior members relish the chance to talk with early career clinicians about their work.

We strongly encourage our students, residents, and fellows to attend our plenary sessions that occur after breakfast May 16, 17, and 18, 2024. Plenaries will include Dr. Rochelle Walensky's perspectives on advancing public health, Dr. Rachel Levine's perspective as the Assistant Secretary for Health on the challenges and opportunities facing our field, and a special session on caring for victims of firearm injury led by experts Dr. Robbie Goldstein, Dr. Eric Gordon, Chaplain Clementina Chéry, and Dr. Chana Sacks. Our morning sessions also highlight some of the most inspirational work being presented by our members at this meeting. There is no competing programming during these sessions so that all members of our Society can have a shared learning experience as a community.

After the plenary sessions, attendees choose between a variety of clinical updates, workshops, poster sessions, oral presentations, and special symposia based on their own goals for the meeting. In clinical updates, content experts provide a curated review of practice-changing new evidence within a specific subfield of general medicine, ranging from primary care to geriatric medicine to perioperative care. Oral presentations and clinical vignette sessions allow for more in-depth discussions of our members' current research or diagnostic dilemmas. In our special symposia, experts present a topic of special interest to our members. This year, for example, the popular *The Clinical Problem Solvers* will record a live episode of their podcast on anti-racism in medicine 8:00-9:00 AM on Saturday, May 18, 2024, as one of our symposia.

Are you a student, resident or fellow attending #SGIM24? Start planning today with this overview of what to expect at the Annual Meeting!

SGIM24 (#SGIM24) will also offer a variety of workshops aimed at improving clinical, research, leadership, educational, advocacy, and career development skills. Workshops blend didactics with small group activities and thrive with the perspectives of a diverse set of participants, including students, residents, and fellows. The Student/Resident/Fellow subcommittee is curating a list of workshops and other programming that may be particularly applicable to our community, and this will be posted on SGIM social media outlets closer to the meeting—so be on the lookout! This year, for example, we highlight workshops on physician employment contracts, effective teaching strategies for large group lectures, scientific and scholarly writing for beginning researchers, setting boundaries without guilt, and so many more.

Finally, outside of the formal educational and mentoring program at our meeting, we are also pleased to offer Trivia Night once again on Friday, May 17, 2024, 6:00-8:00 PM. During this popular evening event, teams compete on medical and pop-culture knowledge for bragging rights and prizes.

As the Chair and Co-Chair for students, residents, and fellows on the SGIM24 planning committee, we are incredibly excited to welcome this contingent of our Society's membership to Boston this spring. We are confident this will be a meaningful, inspiring, and fun meeting filled with mentorship, learning, and growth. In the meantime, be sure to download the SGIM24 Online Planner[3] to learn more about the meeting's many sessions and to plan your days. We look forward to seeing you at #SGIM24!

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What *is* a legacy? Legacy can have many definitions depending upon the source, but my summation is that your legacy is something that you are passing on to the next generation. Your legacy is not what you think you have accomplished, but rather the impact that you have had on others and the world around you. Your true legacy will not be revealed until you are gone, and people realize the impact you made.

You may be wondering why this personal reflection is my SGIM *Forum* editorial for this month. As physicians, SGIM members are privileged to be in a unique group that can make a difference in the world around us. We are surrounded by experts in the fields of clinical medicine, education, health policy, research, and leadership. These members have accomplished great things and achieved great recognition. They are making a difference and can help us make a difference.

But we should all desire to advance past achievements, accolades, and success. "Achievement comes to someone when he is able to do great things for himself. Success comes when he empowers followers to do great things with him. Significance comes when he develops leaders to do great things for him. But a legacy is created only when a person puts his organization into the position to do great things without him."[3]

My reflection during this time helped me remember a quote by author Pam Farrel: "Each day we choose to live the legacy we want to leave."[4] We are creating our legacy every day when we interact with people and impact their lives. These interactions are what will be remembered. Did we treat people kindly? Did we help our patients by showing empathy? Did we do our best to teach the next generation of students, residents, and fellows to be the best versions of themself? Did we make the world a better place? "Carve your name on hearts, not tombstones. A legacy is etched into the minds of others and the stories they share about you."[5] We will all leave a legacy for those that follow. You still have a chance to define your legacy.

In seeing his legacy through the stories of his life, I realized my father-in-law was an amazing man who left the world better than he found it. I hope that one day, someone will say the same about me and my life.

***What do YOU want your legacy to be?***

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BREADTH

# WHAT I DID NOT EXPECT TO LEARN FROM RESIDENCY

Emma Fenske, DO

*Dr. Fenske (fenske@ohsu.edu) is a second-year resident physician in Internal Medicine at Oregon Health and Science University in Portland, Oregon.*

*In the pursuit of becoming a healer,*
*I discovered it was as much about me.*
*Unraveling the intricacies of health's dance,*
*I found my own threshold, my breaking point.*

*Through nights of questioning, I pondered,*
*Why this sacrifice, this debt we amass?*
*To join a fraction, a mere percentile –*
*The rare breed known as a doctor.*

*My intern's dialogue disrupted these thoughts,*
*"They are coding our patient in Kohler"*
*The chairs clattered into the wall,*
*A vivid mark, a constant reminder.*

*Chaos awaited as I stepped into the scene,*
*Announcing my role, hoping for few queries.*
*Eagerly scanning the sign-out sheet,*
*Seeking clues to explain the situation at hand.*

*Cancer. PRES*. Stable. Discharging tomorrow.*
*A nurse's query echoed, "Family updated?"*
*Chilled hands, I dialed the numbers,*
*An after-hours call, an unwelcome intrusion.*

*Her voice, unsuspectingly cheery,*
*Though I disrupted it with the grim reality,*
*Not the first time I muttered the words but*
*Perhaps the hardest time*

*"So you are telling me he is dead?" she asked,*
*As I could feel her world shifting.*
*The weight of affirmation stole my breath.*
*In solemn honesty, I replied, "Yes."*

*Residency's lessons transcend the expected,*
*Beyond medical acumen and clinical finesse.*
*It's about losing a piece of oneself,*
*Yet emerging a better doctor, a richer soul.*

*PRES (Posterior Reversible Encephalopathy Syndrome)

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