VOL. 47 ■ NUMBER 10 ■ OCT 24

SGIM FORUM

Society of General Internal Medicine

TECHNOLOGY UPDATE

MEDICAL JARGON IS EVERYWHERE: CAN AI HELP US CHANGE?

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"*Hypertension—what is that?*" my patient asked. I was a third-year medical student seeing her in clinic and she was scheduled for a regular return visit for hypertension. I quickly replied, "*Your high blood pressure.*" She appeared flustered and said, "*High blood pressure—oh I have that. I take pills for high blood pressure. Why didn't you just say that?*"

During the first years of medical school, students are taught a completely new language. Students begin to incorporate this new language into their regular speech that increases over time as their medical career progresses. Medical terminology, sometimes called *medical jargon*, is essential for communicating clearly and effectively in the medical world. But once physicians learn this language, they struggle translating this medical jargon back to words easier for patients to understand. Articles dating back decades demonstrate that poor health literacy impacts patient outcomes.[1] Physicians overuse medical jargon when communicating with patients and often overestimate patient understanding.[2]

While there has been ample research on the use of medical terminology and the impact medical jargon has on patient care, the focus has been on educating medical students and physicians on correcting their terminology. However, recently the use of technology in decreasing medical jargon has been investigated. It is well known that many patients utilize the internet to search for their symptoms or conditions. Most search engine algorithms prioritize known healthcare system patient education resources as top search results, but there is often confusing, incomplete, or inaccurate information online. While in some instances this can be helpful for patients trying to interpret the medical jargon used, this can lead to confusion and stress when information is incompletely or incorrectly understood.

Patient's health literacy varies significantly and in busy clinical settings, it may be difficult for physicians to assess and respond to patients and their level of education appropriately. What if artificial intelligence (AI) could help us explain information best to our patient's understanding by creating a more individualized patient response? While not used regularly in clinical care, physicians are increasingly seeing the impact and the integration of AI. One area where AI could benefit clinicians is in answering patient portal messages with easy-to-understand terms. While easy access to communicate with a clinician is advantageous for many reasons, answering portal messages takes significant time for clinicians, taking time away from other components of patient care. An AI service could help by either drafting or converting a previously drafted message to contain less medical jargon for patients. How this will truly impact patient care in the future is still to be determined.

Another opportunity where AI could be useful is providing patients with an appropriate interpretation of their clinical notes. Many patients access and read their clinical notes through an online system. It is often easier, and even essential, for physicians to use medical terminology in their notes. However, many times when patients read their notes, medical terms are misunderstood and lead to mistrust or confusion between pa-

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VIOLENCE AGAINST HEALTHCARE WORKERS: WE NEED LEGISLATION TO PROTECT US

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

Another month. Another editorial!
Another topic. Another opportunity!

As Editor in Chief of the SGIM Forum, I have the pleasure of writing the monthly "From the Editor" column. It is challenging to find topics germane and interesting to the SGIM Forum readership. Some months, I have my column topic selected weeks before my deadline. Other months, I struggle to find just the right one to cover. This month was a struggle until an August 14, 2024, article caught my attention. It can be difficult to write about "current events" in the Forum due to our extended lead time prior to publication, however this article remains a longstanding concern in health care—violence against healthcare workers.

On August 9, 2024, the body of a 31-year-old Indian medical student was discovered at the state-run R.G. Kar Medical College and Hospital in eastern Kolkata, India. The medical student was presumed to have retreated to a seminar room for a nap during her assigned 36-hour shift. She was brutally raped and murdered in this seminar room. Her death led the Indian Medical Association to declare a countrywide strike called "Reclaim the Night" which included medical professionals, the general public, and a large contingency of women protesters. The protest led to a cessation of all non-emergent health care for 24 hours. A central premise of their protest revolved around the presumed safety of a healthcare establishment and the protection of healthcare workers performing their healthcare duties.* As SGIM members, we should recognize that our trainees and colleagues may have trained in and been exposed to significantly different training environments and cultural norms.

Violence against healthcare workers is not new. However, this violence seems to be increasing in severity and frequency. According to the World Health Organization, "between 8-38% of healthcare workers suffer physical violence at some point in their careers. Many more are threatened or exposed to verbal aggression. Most violence is perpetrated by patients and visitors."[1] In 2021, during the COVID-19 pandemic, the

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A NEW PODCAST LEADING UP TO SGIM'S 50TH ANNIVERSARY: CELEBRATING SGIM'S LEGACY AND VISION

Jada Bussey-Jones, MD, FACP, President, SGIM

"The Presidential Podcast will not only be just a podcast but also will be a tribute to the rich history and dynamic future of SGIM. Each episode will spotlight a former President who will share their unique experiences, challenges, and achievements during their tenure."

Time flies when you're deeply connected to something that matters. Although my journey in the Society of General Internal Medicine (SGIM) spans nearly a quarter of century, it seems that it started yesterday. In SGIM, I found a professional home where I felt truly recognized in ways I hadn't before, such as validating the barriers I faced in academic medicine as a faculty with intersecting identities, acknowledging my insecurities as a first-generation college graduate, and supporting my interest in the relatively new concept of health equity.

My experience with SGIM is not unique. The organization has been central to the careers of countless academic general internists for nearly half a century. In 1978, the Society launched as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM). The founders envisioned a forum for professionals dedicated to medical education and research and, ever since, the organization has remained at the forefront of medicine. We have grown significantly since that first meeting welcomed 178 attendees and members. After a surge in membership and annual meeting attendance, SREPCIM rebranded as the Society for General Internal Medicine and became an independent entity in 1987-88. SGIM membership now exceeds 3,300 and our Annual Meeting attracts more than 2,000 general internists who gather to share their work, connect with peers, and receive that same validation and support that bolstered me years ago.

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Q & A WITH SGIM'S CEO AND ACLGIM'S PRESIDENT ABOUT LEADERSHIP CHALLENGES

Eric B. Bass, MD, MPH; Cynthia Chuang, MD, MSc

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A unique feature of SGIM's history is how it embraced the challenges faced by leaders in academic general internal medicine (GIM) by launching the Association of Chiefs of General Internal Medicine (ACGIM) in 2000.[1] The Association later became known as the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) when "L" was added to the name to recognize the importance of including leaders other than division chiefs. ACLGIM has grown to be an association of about 200 leaders working within SGIM's organizational structure. I decided to ask Dr. Cynthia Chuang, ACLGIM's 24th President, about the leadership challenges that her team is addressing this year.

> **"These existential issues require sustained engagement of ACLGIM members who hold many different leadership positions within their home institutions."**

EB: Why did you volunteer to serve as ACLGIM's President?

CC: I attended the ACLGIM Winter Summit for the first time in 2016, right before I started my stint as division chief. I learned how to be a better leader and advocate for GIM through that experience as well as every Winter Summit and Hess Institute since. Although I completed my division chief role in 2023, I was not ready to step away from what ACLGIM offers, and on the contrary, I wanted to be part of growing ACLGIM so it could serve others the way it did for me.

EB: What are the most important leadership challenges that ACLGIM should address?

CC: A major challenge facing academic GIM leaders stems from the worsening problems in recruitment and retention of academic generalists. GIM division chiefs find it increasingly difficult to retain faculty and even more difficult to recruit new faculty to fulfill the critically important role of GIM physicians in the academic mission. The situation is dire because GIM division chiefs and other leaders are simultaneously feeling enormous pressure to meet clinical productivity targets with a workforce at high risk for burnout.

EB: Why are you excited about the recent work of ACLGIM's Hess Institute?

CC: In 2023, ACLGIM's leadership decided to focus the attention of that year's Hess Institute on developing a strategy to address the existential problems with recruitment and retention of academic generalists. Led by Dr. Mark Earnest, we engaged a consulting group to prepare for and facilitate a day-long meeting of the Hess Institute that May. After lively discussions with more than 100 attendees, we identified three major priorities and formed a work group to tackle each priority: 1) enhance the focus on team-based delivery of care; 2) rebalance primary care compensation to align with the work; and 3) increase learner exposure to and training time in high-functioning primary care settings. Unlike past meetings of the Hess Institute that were single day events, we committed to work on these priorities throughout the next year, and dedicated time to the work groups at the ACLGIM Summit in December 2023 and the Hess Institute in May 2024. The groups are continuing their work. Due to the complexity and scope of the underlying problems, these existential issues require sustained engagement of ACLGIM members who hold many different leadership positions within their institutions. ACLGIM is uniquely positioned to convene such efforts.

EB: Why should division chiefs take advantage of ACLGIM's Site Visit Program?[2]

CC: The ACLGIM Site Visit Program gives GIM division chiefs an opportunity to receive objective feedback from a select team of experienced SGIM leaders on how

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HAVING A SEAT AT THE TABLE: 2024 HESS INSTITUTE RECAP

Jane Liebschutz, MD, MPH, FACP; Eric H. Green, MD, MSc, FACP

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The Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) 2024 Hess Institute, "Having a Seat at the Table: Finding Your Leadership Voice," provided attendees with the skills and mental framework to successfully advocate to the "C-suite" and other leaders for programs and projects that support the values of academic general internal medicine. The record-breaking group of 120 attendees included 17 incoming ACLGIM LEAD fellows and three Unified Leadership Training for Diversity (UNLTD) fellows.

The successful day started with an interactive morning session led by Dr. David Longworth, a retired CEO of Lahey Clinic Medical Center and long-time academic physician leader, and Mr. Ted Fleming, a teacher and consultant with a long career as a talent developer, strategic planner, and ultimately a human resources executive within CVS and Aetna. Without prior association before planning for the Hess Institute, they delivered a seamless 2.5-hour workshop offering attendees insight and skills practice on "Making the Case to the C-Suite." They emphasized that healthcare executives care not only about return on financial investment but also about investing in values and the mission. The seminar was structured around the following three guiding principles to structure a "story" for delivery to health executive leaders:

1. **Offer Solutions, Not Ideas.** This includes taking practices in other industries and adapting them to health care.
2. **Communicate in Business Language.** Executives typically consider three "buckets" for ideas: money (increasing revenue or decreasing costs); market (increasing market share or decreasing time to market); and exposure (increased retention of employees, clients, and/or partners or decreased risk).
3. **Build Powerful Coalitions.** Structure arguments as compelling stories that are supported by data and supported by coalitions from all levels of the organization.

Through a series of individual exercises, pair sharing, and table sharing, participants gained the skills to present a "pitch" (their idea to the C-suite) in 90 seconds that incorporated values along one of the following five dimensions:

1. **Operational Excellence** (e.g., financial, quality, productivity, patient experience),
2. **Service Excellence** (e.g., communication, courtesy, knowledge),
3. **Care Delivery Model** (e.g., innovation, integration, reliability),
4. **Resource Management** (e.g., culture, human capital, compensation), or
5. **Stewardship and Strategy** (e.g., education, governance).

In front of the whole audience, table representatives delivered succinct and meaningful pitches that told a story, connected with the leader, and made the leader desire more information. The body language of the workshop participants showed the level of engagement with heads leaned into the tables, few people were distracted on their phones, and the buzz of quiet and respectful discussion filled the room.

Following the opening session, Hess Institute participants heard updates from the three workgroups that formed in response to the work done during the 2023 ACLGIM Hess Institute: Enhance Focus on Team Based Delivery of Care, Rebalance Primary Care Compensation to Align with Work, and Increase Learner Exposure to and Training Time in High-Functioning Primary Care Settings.1 Each group made significant progress since last year. For example, the Increase Learner Exposure to and Training Time in High-Functioning Primary Care Settings group is proposing new Accreditation Council for Graduate Medical Education (ACGME) recommendations to prioritize high-functioning primary care experiences and continuity for internal medicine residents.

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VOTING AS A SOCIAL DETERMINANT: THE CLINICIAN'S ROLE

Stephen Gurley, MD, MPH; Laura Pax, MD; Phillip Anjum, MD; Tracey L. Henry, MD, MPH, MS

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Introduction

As physicians, our duty to promote health extends beyond the clinic into our communities. Voting, a key act of civic engagement, is increasingly recognized as a social determinant of health. This column explores the link between voting and health outcomes, the barriers to voting faced by our patients, and the strategies implemented in the Grady Memorial Health System to promote voter registration and civic engagement.

Discussion

More than just a civic duty, voting has a profound impact on public health. Non-voting individuals have significantly worse health outcomes, including higher prevalence of substance use disorders and obesity, as well as poorer self-reported health.[1,2] Conversely, establishing voting habits in young adulthood is linked to better mental health later in life.[2] Individuals with chronic diseases are less likely to vote and engage civically.[2] Multiple social determinants of health also correlate with lower voter turnout, including racial, gender, sexual minority status, and lower socioeconomic status.[3] The act of voting itself is a form of empowerment, giving individuals the ability to determine their leaders and inform policies that govern their communities.

This relationship to voting extends beyond the individual. Communities with low rates of voting have been found to have significantly worse health outcomes, including life expectancy compared to those with high rates of voting.[2] When communities vote, they have a stronger voice in decisions that affect their health services, local environments, and social policies. Recognizing this, the American Medical Association (AMA) acknowledged voting as a social determinant of health in 2022 and noted that gerrymandering limits healthcare access and contributes to poor health outcomes.[4]

Despite the clear benefits of voting, numerous barriers prevent individuals from exercising this right:

- **Structural barriers to voting,** including restrictive voting laws, gerrymandering, and lack of access to polling stations.
- **Social barriers to voting,** including discrimination, socioeconomic disparities, and language barriers.
- **Personal barriers,** involving lack of information, apathy, or health issues that make it difficult for individuals to vote.

To mitigate some of these barriers, we formed a team of healthcare providers focused on voting and civic engagement at Grady Memorial Health System, a large urban, safety-net hospital and health system in Atlanta, Georgia. Our initiatives included an inpatient voter access consult service, voter registration prior to primary care appointments, and a registration tool for residents and faculty. These efforts aim to ensure equitable civic participation for our marginalized and structurally disadvantaged patients. We have three focus areas—an Inpatient Voter Access Consult Service; an Outpatient Voter Registration effort; and a distribution system for ID-badge lanyards from the organization Vot-ER to promote patient voter registration:

- **Inpatient Voter Access Consult Service:** This initiative focuses on hospitalized patients who may otherwise miss the opportunity to vote. Our team visits these inpatients at the bedside, assesses their ability to vote, helps them register, and assists in creating a detailed plan to vote on election. For those hospitalized on election day, we ensure access to emergency absentee ballots.
- **Outpatient Voter Registration:** Before primary care appointments, our team registers patients to vote in public hospital spaces. We include voting information in after-visit summaries to ensure patients leave with the necessary resources to vote.
- **Vot-ER Lanyards and Badges:** Residents and other clinicians wear lanyards and badges with QR codes linked to a voter registration dashboard provided by Vot-ER. Vot-ER is a nonpartisan, nonprofit organization working to integrate civic engagement into healthcare systems across the country and successfully reached a significant swath of young and racially diverse voters during the 2020 election cycle.[5] The

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IN PURSUIT OF EQUITABLE CARE: THE 2024 SGIM ANNUAL MEETING FROM THE STUDENT PERSPECTIVE

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Being a physician should be synonymous with caring for every patient equitably, with an understanding that pathology is inclusive of both physical and social determinants of health. Starting with medical school, medical institutions try to teach this holistic approach to health care—but not without pushback that attempts to reduce diversity, equity, and inclusion (DEI). As SGIM members, we can be proud that the 2024 SGIM Annual Meeting was a testament to the importance of DEI. This year's meeting featured a "who's who" addressing the most important health and social issues in the United States and around the world. From a medical student's perspective, this felt like a proof-of-concept of what we learn in school. Too often, concepts are taught in the classroom but not practiced in the real world—that discrepancy was not evident at this year's meeting. Healthcare professionals across the breadth of the medical hierarchy came together to present research, discuss important topics, and create goals about how to improve the state of medical care, especially for those who are underserved and marginalized.

The 2024 SGIM Annual Meeting was a testament to the importance of health care equity and social justice. Read more about this year's meeting from a medical student's perspective.

Substance Use Disorders

In medical school, we often discuss the challenges of treating patients with substance use disorders. The most recent data from the U.S. Department of Health and Human Services reports that there were 9.2 million people with opioid use disorder and 29.5 million people with alcohol use disorder in 2020.[1] Of those with any substance use disorder, 94% did not receive any treatment.[1] Pharmacological treatment is just the tip of the iceberg for many of these patients. Follow-up care and referrals are where these patients receive some of the most powerful support. Substance use is inextricably tied to stress, employment, housing, food security, and mental health—so the proper care of these patients must include follow-ups with resources that can help with these issues. This year's meeting did not neglect this topic as there was an entire session with clinical vignettes of patients with substance use disorders.

Mental Health

Mental health by itself also continues to be a serious healthcare crisis in the United States, with about 25% of adults reporting a mental health disorder in 2022.[1] White patients were more likely to receive treatment than Black, Hispanic/Latino, and Asian patients.[1] As medical students, we learn that mental health care should be within the scope of practice of generalists, so it put a smile on my face to attend multiple sessions related to mental health, such as "Taking the Worry out of Screening, Diagnosis, and Management of Anxiety Disorders in Your Practice."

Carceral Health Care

In pursuit of equitable medical care, some medical schools have created curricula or included clinical rotations that center around incarcerated patients—this topic featured heavily in this year's meeting. In 2021, about seven million people spent time in a U.S. jail and about one million spent time in a U.S. prison.[2] Because of the prevalence of disease in carceral settings (e.g., COVID-19, tuberculosis, hepatitis B), jails and prisons *could* serve as important centers of infection control; but, too often, incarcerated patients have been hung out to dry, and as a result, carceral settings are hubs of infection mortality.

Incarcerated patients are present not only in carceral settings but also non-carceral hospitals, with shackles around their wrists and law enforcement studying their every move. How can we ensure that their rights are not infringed upon? What do the impact of shackles and constant supervision have on their privacy and medical

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ASK AN ETHICIST: CAN A PATIENT REFUSE CARE WHEN THEY LACK CAPACITY?

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For "Ask an Ethicist," members of the SGIM Ethics Committee respond to real ethics cases and questions submitted by SGIM members. Responses are created with input from the Committee but do not necessarily reflect the views of the Committee or SGIM.

Scenario

Mr. Cook* was admitted to the hospital with hyponatremia after a fall and consequent elbow wound that was repaired by orthopedic surgery at the time of admission. During his stay, he declined to take his prescribed antibiotics or use the provided splint regularly, and the wound dehisced. Despite several bedside attempts to wash out and close the wound as well as changing his antibiotics to IV from oral, the wound was not healing. Orthopedic surgery recommended a washout and repair of the elbow wound in the operating room, but Mr. Cook declined surgery.

Mr. Cook was evaluated by psychiatry who determined that, though his capacity had improved with correction of the hyponatremia, he still lacked capacity to refuse or consent to the surgical procedure. Additionally, given his underlying condition and prior history of mental health concerns, they did not expect his capacity would improve much with further treatment.

After the team was unable to reach any family, his close friend, Pastor Greg* was asked to serve as Mr. Cook's surrogate decision-maker. Ethics was consulted to help navigate the patient's treatment plan.

Analysis

It is generally accepted that patients with capacity can refuse medical intervention, even when it is considered lifesaving. In a patient who lacks capacity, but is refusing care, the authors use an algorithm.[1]

As outlined in that article, priority should be given to restoring capacity when feasible before a medical decision needs to be made. When medical decisions are too urgent to wait for the patient to regain capacity, the primary team must consider what is the standard of care and what would it require to reach that standard of care in this patient who is refusing (while lacking capacity). Clinicians are well versed in reviewing the risks and benefits of given procedures as usually performed, but the balance in Mr. Cook's case asks if the benefits outweigh the risks of going through with the intervention over a patient's voiced objection. Risks in that case may include consequences of mechanical or chemical restraints,[2] deepened mistrust of providers, staff moral distress or physical injury, violation of a patient's independence, and physical integrity.

If the benefits outweigh the risks of forcing the treatment, it may be ethically permissible (and in some cases ethically imperative) to proceed with treatment. Surrogate decision-makers should be counseled on the risks and benefits of forcing any treatments in addition to the general risks and benefits of the treatment. As always, it is important to ensure the surrogate decision-maker approximates the patient's values and judgments to the greatest extent possible.[3]

In this case specifically, the team considered what treating the patient in the operating room with a washout and repair over his voiced objection would entail. Despite the potential need for sedation before transportation to the operating room, the limb- and potentially life-saving benefits of this intervention seemed to outweigh the risk. The team discussed these risks and benefits of treatment over objection with the patient's surrogate, who, knowing the patient's values and preferences, believed that the patient would want to have this surgery done if he had capacity. Mr. Cook was taken back to surgery without incident and discharged in good condition several days later.

Cases like Mr. Cook are not infrequent and remind SGIM members of the importance of assessing capac-

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GENDER-AFFIRMING HEALTHCARE BAN: A TRAINEE PERSPECTIVE

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Introduction

Gender-affirming care, as defined by the World Health Organization, is a range of social, psychological, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with their gender assigned at birth.[1] Like recent laws banning abortion,[2] it has been hypothesized that banning gender-affirming care may influence medical students' decisions concerning future residency locations.[3] Although data assessing these predictions are preliminary,[3] our survey sought medical students' qualitative and quantitative perceptions of the recently passed legislation in Tennessee. Using an IRB approved survey, medical students at the University of Tennessee were anonymously polled regarding the gender-affirming healthcare ban for minors and the impact on student's geographic preferences for residency training. Data analysis revealed that half of the students polled agreed that this legislation would impact their preference for remaining in Tennessee for future training. Percentages increased when analyzing future Internal Medicine applicants specifically. Tennessee already experiences a shortage of healthcare professionals[4] and new legislation banning gender-affirming care may further exacerbate this shortage. This article raises awareness about the potential impacts of Senate Bill 1 including the predicted exacerbation on physician shortages in Tennessee and other states with similar legislation.

Discussion

In the United States, there is a pervasive shortage of healthcare providers in multiple disciplines, including physicians. These shortages exist nationwide but are especially felt by individuals living in low-income communities and rural counties in Tennessee. As of July 2024, nearly 2.4 million Tennesseans live in a Health Professional Shortage Area (HPSA), as designated by the Health Resources and Services Administration.[4]

Recent laws passed in Tennessee regarding gender-affirming care have the potential to exacerbate this pre-existing shortage. Senate Bill 1 bans gender-affirming care for minors including any surgical procedures or the dispensing of any medication to treat gender dysphoria. Under this bill, legal action may be pursued against the healthcare provider who administered such treatment, as well as the minor's parent who consented to treatment. Additionally, this bill increases the statute of limitations to 30 years from the date the minor reaches 18 years of age for lawsuits against healthcare providers.[5] The recent law criminalizing physicians for providing gender-affirming health care for minors is hypothesized to lead medical students to seek residency training opportunities out-of-state. This would lead to a worsening healthcare shortage in the state of Tennessee, one that Tennessee residents cannot afford.

To investigate the impact this law might have on the medical residency workforce in Tennessee, an IRB-approved anonymous survey was constructed using Google Forms. Students from the University of Tennessee Health Science Center were asked to respond using a 5-point Likert scale (answers ranged from strongly agreed, agreed, disagreed, strongly disagreed or unsure) to the following questions: "If I continue my training in Tennessee, these laws will impact the quality of my education and training" and "The Senate Bill 1 laws may impact my location preferences for residency training." Students were provided an optional free text box to include any further comments.

Overall, 48.7% of students answered "strongly agree" or "agree" that continuing to train in Tennessee will impact the quality of their training and education, due to Senate Bill 1. Furthermore, 52.6% of medical students responded "strongly agree" or "agree" that Senate Bill 1 will impact their location preferences for residency training. Of those respondents that indicated an interest in Internal Medicine, 70.8% agreed or strongly agreed that the quality of their training would be impacted by Senate Bill 1 or that Senate Bill 1 would impact their residency location preferences.

Representative quotes from medical students who stated that the new laws will impact their decisions for residency training include:

"On the first day of medical school, I raised my right hand and took an oath to "do no harm." As students, we already make sacrifices for our future patients, and I am prepared to make many more sacrifices throughout

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As SGIM's 50th anniversary approaches, I sought a better understanding of and connection with SGIM and its history. I proposed a President's Podcast initiative to demonstrate SGIM's journey and impact to staff leaders, including Eric Bass, MD, MPH (Chief Executive Officer), Kay Ovington, CAE (Deputy Chief Executive Officer), and Francine Jetton, MA, CAE (Senior Director of Communications and Publications). After securing their support and engaging in discussions with SGIM Council and past Presidents, I am excited to announce the launch of a new podcast series, the *President's Podcast*. As President, I am thrilled to host this podcast series that will feature interviews with past Presidents as a forum to offer a deep dive into the evolution of SGIM and the broader landscape of academic general internal medicine.

A Journey through Time

The *President's Podcast* will not only be a podcast but also a tribute to the rich history and dynamic future of SGIM. Each episode will spotlight a former President who will share the unique experiences, challenges, and achievements during their tenure. The podcast will cover a spectrum of topics, from the foundational days of the organization to the important moments that defined its growth. Listeners will have exclusive access to stories that shaped the organization and its role in the advancement of internal medicine. These conversations will offer valuable lessons and insights for current members as well as those unfamiliar with SGIM.

A Tribute to Leadership and Innovation

The *President's Podcast* will highlight the leadership qualities that have led our organization to prominence. Listeners will have the opportunity to engage with the stories of distinguished leaders who have shaped the organization's legacy. Our past presidents not only have steered this organization but also been national leaders across academia, health care, research, education, and policy. This podcast will provide an opportunity to explore their unique professional and leadership journeys within SGIM and beyond. The audience will better understand the challenges they faced and the support systems that guided them to success. Selfishly, I'm also excited to discover more about them on a personal level—what are their interests outside of their medical careers and what truly brings them joy.

Looking to the Future

While celebrating our past, the *President's Podcast* will also cast a forward-looking gaze. This is just one aspect of SGIM's 50th-anniversary preparations, which will be celebrated during the 2027 Annual Meeting and continue throughout the 2027-28 year. SGIM Council has approved funding and is commissioning a work group to develop and implement plans for SGIM's 50th-anniversary milestone. One critical objective of the work group will be to develop plans for communicating the history and accomplishments of SGIM during its first 50 years along with the vision for future years. This will include articles highlighting the organization's history and future opportunities with submissions to SGIM Forum and the *Journal of General Internal Medicine (JGIM)*. The *President's Podcast* will supplement and enrich these publications through living histories and storytelling from our leaders. In addition to Presidents, this 50th-anniversary work group will explore options to feature the accomplishments of many SGIM members, including Glaser awardees.

As we build to this important milestone, the podcast offers an ideal outlet to reflect and address the future direction of our organization and the field at large. Each episode will delve into discussions about emerging trends, ongoing challenges, and innovative solutions in academic general internal medicine. This podcast will provide listeners with a comprehensive view of SGIM plans to continue its mission and adapt to the changing healthcare landscape. By convening past and present leadership, I hope to foster a dialogue that connects the wisdom of experience with future possibilities.

Join Us on This Journey

I invite all members, and anyone interested in health policy, leadership, and academic internal medicine, to tune in to the *President's Podcast*. The first episode will feature Past President and Current CEO Dr. Eric Bass. Eric was SGIM President in 2013 and has been SGIM's CEO since 2017. He is a professor of medicine at Johns Hopkins where he serves as co-director of the Evidence-based Practice Center, Vice Chair for Faculty Development and Promotions in the Department of Medicine, director of the medical school's course on Foundations of Public Health, and co-director of the school's Scholarly Concentration in Public Health Research. He led John Hopkins' General Internal Medicine Fellowship for 15 years and served as editor of *JGIM*. His extensive experience within our organization and in leadership roles broadly makes him the ideal person to launch our podcast series.

For more details on the podcast schedule and how to listen, please visit our website and follow us on social media.[1] In addition to our website, the podcast will also be available on several podcast platforms, including *Apple Podcasts, Spotify,* and *Pandora*. Let's take this exciting journey together, reflecting on our legacy and envisioning the future!

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Indian Medical Association reported that 75% of the country's doctors had faced some sort of violence with 68% of the violence coming from the patient's attenders/escorts.[2]

Healthcare workers in the United States face similar threats. Recurrent stories in the news and on the internet highlight often deadly outcomes for U.S. healthcare workers. These stories neglect the less severe, but often daily physical and verbal abuse incidents that occur at the bedside in hospitals, emergency rooms and outpatient clinics. In 2018, 73% of all nonfatal workplace violence-related injuries involved healthcare workers.[3] The problem continues to worsen and increased in frequency during COVID-19 in the United States as well. The Bureau of Labor Statistics reports that the rate of injuries from violent attacks against medical professionals grew by 63% from 2011 to 2018, and hospital safety directors say that aggression against staff escalated as the COVID-19 pandemic intensified in 2020."[3]

What is being done to combat this issue? The Institute for Healthcare Improvement's (IHI) "Safer Together: A National Action Plan to Advance Patient Safety" addresses workforce safety as three points in its 17-point National Action Plan: "1. Implement a systems approach to workforce safety; 2. Assume accountability for physical and psychological safety and a healthy work environment that fosters the joy of the health care workforce; and 3. Develop, resource, and execute on priority programs that equitably foster workforce safety."[4] These big picture plans often become cumbersome and difficult to establish due to their complexity and resource needs. This delay in implementation of timely corrective action plans can lead to frustration among front line staff still faced with the ongoing threats of violence.

More tangible efforts are also being enacted at healthcare facilities and hospitals around the country. Electronic patient record flags document patients with violent tendencies. Restriction in access points to patient care areas can limit entry to the public. Hospital police are now wearing body cameras in some hospitals to better record events as they unfold. Behavioral response teams and staff training have focused on de-escalation of patient behavior.

Even with all these protections being enacted, more safeguards are needed for healthcare workers. Federal legislation protecting healthcare workers is one option that has not been enacted to date. Congressman Joe Courtney was elected to represent the Second Congressional District of Connecticut in 2006. He introduced legislation in 2021 and again in 2023—H.R. 2663: Workplace Violence Prevention for Health Care and Social Service Workers Act.[5] This bill was introduced into Congress on April 18, 2023, with a mandate "to direct the Secretary of Labor to issue an occupational safety and health standard that requires covered employers within the health care and social service industries to develop and implement a comprehensive workplace violence prevention plan, and for other purposes."[5] In the House of Representatives, this bill has a reported 172 co-sponsors but only a 4% chance of passing. It is currently pending before the House Education and the Workforce Committee, House Energy and Commerce Committee and the House Ways and Means Committees. This same bill was also introduced to the Senate with 37 co-sponsors but only a 1% chance of passing. Currently it is pending before the Senate Health, Education, Labor and Pension Committee.

These bills in the House and Senate are a great opportunity to protect the dedicated healthcare workers against this surge in healthcare related violence. It is discouraging to see that these bills are given less than 5% passage to enacted legislation.

SGIM is an organization of highly passionate physicians. We advocate for causes that we believe in. What can be more important than our safety and the safety of our colleagues. We must advocate for protection and change laws within the United States, which can serve as models for legislation in other countries like India.

*(*I am not an expert on Indian culture and societal norms so I would not presume to be educated enough to discuss these nuances in this column. As the Forum Editor, I welcome a SGIM member's article that discusses this perspective.)*

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ACLGIM/LEADERSHIP (continued from page 5)

The other two groups (Enhance Focus on Team Based Delivery of Care and Rebalance Primary Care Compensation to Align with Work) are planning a survey to identify how academic GIM practices across the United States approach design of practice structures, asynchronous work, patient panels, primary care provider compensation, and primary care teams. The attendees spent a working lunch with one of the three workgroups to provide feedback and suggestions for next steps.

The afternoon was highlighted by three skill-building workshops to complement the morning focus on "Finding Your Leadership Voice." During "Think Like a Shark," Dr. Longworth and Mr. Fleming along with Past Presidents of SGIM Drs. Gene Rich, Steven Wartman, Bill Tierney, and Eileen Reynolds gave two willing participants feedback on proposals for projects they were developing at their home institutions. Drs. Chavon Onumah, Jocelyn Carter, and Susana Morales empowered learners to harness the diversity on their existing teams in a seminar entitled "Creating Mission-driven Teams: Embracing Belonging and Maximizing Success." Finally, Drs. Mark Earnest and Rita Lee delivered a high-yield seminar packed with practical skills in their workshop "Delivering Persuasive Messages," highlighting the importance of framing the problem, vision, solution, and action using data and terminology relevant to your audience.

The Hess Institute attendees will have plenty to consider and practice as they return to their institutions and continue to advocate for the future of academic General Internal Medicine. For those who missed Hess 2024 as well as those who want to build on the momentum of the excellent work presented by ACLGIM leadership, the upcoming ACLGIM Winter Summit, to be held in Scottsdale, Arizona, December 8-10, 2024, will continue with three days of opportunities for skill building, networking with other GIM leaders, and advancement of initiatives to strengthen academic GIM. In addition, this year will feature an orientation for new chiefs and emerging leaders, a program offered every two years at the Winter Summit. We hope to see everyone at the 2024 Winter Summit and the 2025 Hess Institute as we continue to support current and future leaders in Internal Medicine.

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COMMISSION/COMMITTEE/INTEREST GROUP UPDATE (continued from page 8)

ity, diligently seeking surrogate decision-makers, and intentionally weighing the risks and benefits of treatment over objection. While autonomy and the right to refuse care are bedrocks of medical ethics, SGIM clinicians must have the courage to proceed with treatment in cases where incapacitated patients would unfairly be denied standard of care treatment.

*(*Names have been changed.)*

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PERSPECTIVE: PART II (continued from page 9)

my life for the best interest of my patients. I never fathomed that those sacrifices may include my future license, future practice, and future freedom for providing crucial holistic health care that indeed does the least harm."

"Staying in Tennessee or going to a state with similar bans in place for residency will stifle my ability to provide my absolute best care for my future patients … [and] I have been sincerely considering completing my residency training elsewhere. I want to train somewhere that will give me all the tools to help patients reach their short- and long-term health goals and desired outcomes."

"The only reasons I may stay in Tennessee to practice is out of service to patients and a fear of contributing to healthcare deserts. More and more lately, I imagine any time that I might practice as a physician here as a mission or deployment, that is, whatever time

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tools provided through Vot-ER resources facilitate conversations about voting and provide an easy way for patients to register.

We also proactively engage clinicians and trainees to increase community voter turnout. Building on previous resident organizer efforts, we introduced a survey-based tool to help healthcare providers check patient's registration status and aid with registration if needed, and to assist in creating voting plans. Additionally, we engage residents and other medical trainees via didactic lectures focusing on voting as a social determinant of health and emphasizing the importance of active provider participation in elections. These sessions empower residents to discuss voting with patients and encourage participation in our registration efforts. Finally, we work with residency leadership to identify and arrange times where residents can ensure they have protected time to vote.

Conclusion

By actively working to reduce barriers to voting for our patients and colleagues, we support their civic engagement and contribute to public health, fostering healthier communities and a more equitable society. Voting is a powerful tool for improving health outcomes and, as clinicians, SGIM members have a unique opportunity to promote it. Through our efforts, we aim to ensure that all individuals, regardless of their background or circumstances, can participate in the democratic process and have their voices heard. By fostering a culture of civic participation, SGIM members can ultimately drive meaningful change in both health care and society.

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to address the challenges they are facing in their local environment. The site visitors offer a fresh perspective that helps to generate new ideas or solutions that might otherwise never be considered. Both new and experienced division chiefs have greatly benefited from the Site Visit Program, and it is an opportunity for ACLGIM to empower and equip division leaders to amplify GIM impact locally.

EB: What else is ACLGIM doing to address leadership challenges in academic GIM?

CC: ACLGIM provides great networking opportunities to members through its active discussion forum on GIM Connect and its annual Summit that brings members together to foster collaboration. We continue to run the LEAD Program for junior and mid-career faculty who want to strengthen their leadership skills.[3] We also have expanded the Unified Leadership Training for Diversity (UNLTD) Program with the intention of diversifying leadership in academic medical centers.[4]

Learn more about ACLGIM and its upcoming meetings at: www.sgim.org/sgim-community/aclgim.[5]

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tients and their physicians. A recent example is a patient who read that her chemotherapy is "palliative" and thought that this meant that their physician thought they were at the end of life; however, her physician meant that the goal of chemotherapy was to decrease the burden of cancer and not for definitive cure. A helpful AI tool could give patients a version of their clinical notes that interprets the medical terminology to a more understandable language for the patient.

While the potential uses for AI to decrease medical jargon are plentiful, there are considerations about the real-life application of this technology. First, many AI chatbots are trained on open sources from the internet and not specifically from healthcare sources.[3] If the input for these clinical tools is poor, then the output would similarly be expected to be poor. Additionally, if there is inaccurate or confusing information provided by AI causing adverse events, who is liable? Currently, with AI integration still in its infancy, the liability of using these tools is still uncertain.[4] If physicians start to depend on AI to decrease medical jargon, is the burden of ensuring accuracy of these tools on the individual physician, the hospital system or on the developer? If ensuring accuracy falls on the individual physician, this may become just another added technological burden and liability for physicians.

Another concern is the impact on the patient and physician relationship. The bond between patients and physicians is important, and this relationship can be especially important in certain situations such as delivering bad news. If AI is integrated to interpret medical jargon, would it function as an interfering third party? Could overreliance on AI lead to less personalized care? For example, this could be especially harmful when responding to a message requiring a heightened level of compassion and humanism from the physician. Though recent studies have shown that AI can generate appropriately empathetic responses, more studies are needed to ensure that is the case in all instances.[5]

We are entering an era in which AI will be impactful in multiple areas of our lives, and the field of medicine will be no exception. It is reasonable to expect that most SGIM members have already started to see the incorporation of AI in their practices. Advances in technology, specifically AI, may be able to aid clinicians in communicating appropriately and with less medical jargon. With the exciting prospect that AI can be used to enhance patient care, we must be careful that the incorporation does not lead to additional burdens for individual internists or impact our relationship with patients. As part of SGIM's mission to advocate for high-quality patient care and increase equity, the goal of decreasing medical jargon is in line with current advocacy goals. However, research on AI and its impact on patient care is in the early stages, and we should continue to advocate for advances in technology that enhance, and not detract, from our ability to care for our patients.

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I spend practicing in Tennessee will be a temporary assignment to serve the greater good at personal risk to myself and my family. My outlook on the legal landscape for physicians in Tennessee is bleak since the trend seems to be more and more restrictions and interference by the state."

"Providing gender-affirming care to patients is important to foster the patient-physician relationship. If patients don't feel comfortable with their physician, they may feel less comfortable making regular appointments and getting the preventative medical treatment needed for health maintenance. It will be important that during my physician training, I learn to interact and treat all patients, and this bill greatly impacts what training programs can teach providers."

Responses from current medical students in the state of Tennessee highlight the imminent possibility of

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care? It was refreshing to see that interest groups and scheduled teaching sessions at the SGIM Annual Meeting addressed these important questions.

Reproductive Health, Women's Health, & LGBTQIA+ Health

Ever important—and ever under attack in the United States—are the reproductive rights of pregnant individuals. A recent cross-sectional study showed that barriers to reproductive health have increased between 2017 and 2021, especially for marginalized groups.[3] Pap smears, birth control, barrier contraception, and abortion rights are difficult to receive for too many people in the United States, and this issue affects quality of life and, for some patients, increases mortality. In discussing this issue, it is mentioned too infrequently that barriers to reproductive health disproportionately affect Black and LGBTQIA+ individuals. The 2024 Annual Meeting did not neglect the intersectionality of reproductive health care, with a session entitled, "Pursuing Reproductive Justice with LGBTQIA+ Individuals."

Refugee and Migrant Health

As a medical student, doing clinical rotations in various parts of the country offers opportunities to interact with refugees and immigrants. But how often do we dedicate our time and effort to understanding the unique struggle that these patients face in the United States and around the world? According to the World Health Organization, about one in every eight people in the world is a migrant, including about 80 million who have been forcibly displaced.[4] These patients often suffer more food insecurity, housing insecurity, and unemployment than the general population, which impacts their physical and mental health. Patients who have been displaced due to war and bombings often suffer additional adverse effects from radiation and harsh chemicals. For example, a study in *The Lancet* reported that parental exposure to white phosphorus in Gaza led to significant increases in birth defects.[5] As such, I will always appreciate sessions, such as "Innovations in Caring for Immigrants with Vulnerable Immigration Status," that teach us how to be empathetic in our care for these populations and advocate for healthcare justice.

> **"Physical health is social health and social health is physical health."**

What Does This Mean for SGIM Members?

As evidenced by the earlier statistics, the gaps in equitable care for many marginalized groups of patients are massive. How can we use what we learned at this meeting to take a step forward? An important start would be to weave social justice and social determinants of health into medical education at every level of the medical hierarchy. Unsurprisingly, the SGIM conference featured a session entitled "How to Develop a Social Justice Curriculum at Your Institution," an interest group on how to teach social determinants of health, and an episode on anti-racism in medicine run by the Clinical Problem Solvers.

As a student attending my first SGIM Annual meeting, I was fortunate to have had opportunities to learn about substance use, mental health, carceral health care, reproductive health, and refugee/migrant health, and I feel excited to know that SGIM clearly demonstrates compassion and care for marginalized people. It is important for all healthcare staff, especially students, to be exposed to the many ways in which equitable care is lacking—and how we might remedy that. Therefore, perhaps the most important takeaway from the 2024 SGIM Annual Meeting is that equity must be centered in health care. Physical health is social health, and social health is physical health. As SGIM members, we should be proud of this year's program and should continue to be in pursuit of healthcare equity and holistic medical care in our day-to-day practice.

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worsening healthcare shortages in response to restrictive laws, including those that restrict the ability to practice gender-affirming health care for minors. This could potentially lead to a worsening physician shortage as medical students, resident physicians, and fellows seek out of state training programs and attending physicians move practices to avoid persecution for performing gender-affirming care.

Conclusion

Like the decline seen in OB-GYN residency applications in states with abortion bans,[2] our survey results highlight the possibility of declining residency applications in states with gender-affirming healthcare bans, particularly among students interested in Internal Medicine. Similar data collected in the Midwest supports the conclusion that legislation, such as Senate Bill 1, may impact residency location preferences, not just for trainees in Tennessee but also for students in other states with similar legislation.[3] Multiple states are at risk of losing passionate, competent, and compassionate future providers who will positively impact the lives of their patients. Not only will transgender and gender diverse individuals be at risk of losing quality health care but also cisgender individuals will lose access to preventative health care and health maintenance.

Limitations of our data include a sample size of 78. By stratifying the sample by year of medical school, future studies may evaluate how trainee opinions are impacted as the trainee nears residency or fellowship selection. Additionally, once students in Tennessee have made their choices about residency, it would be beneficial to assess whether Senate Bill 1 was a factor.

As these gender-affirming healthcare bans have only emerged recently, the full impact on residency applications and overall provider shortages is yet to be determined. In the meantime, to promote the retention of medical students and residents in states with gender-affirming healthcare bans, undergraduate medical education and Internal Medicine residency programs should consider strengthening their curriculum to include more robust education in gender-affirming care and actively recruit diverse individuals to their programs, including those who identify as part of the LGBTQIA+ community. If medical students and residents continue to learn about the significant healthcare disparities that transgender individuals encounter, these trainees can continue to advocate for more comprehensive and inclusive health care in these states with restrictive healthcare laws.

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The ISSN for SGIM Forum is: Print-ISSN 1940-2899 and eISSN 1940-2902.