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THE HYBRID GENERAL INTERNIST: A NOVEL SOLUTION TO DECLINING INTEREST IN PRIMARY CARE

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Introduction

Primary care is experiencing a critical provider shortage.[1] During the past decade, there has been a 50% decline in internal medicine graduates entering primary care, opting instead for hospitalist careers or fellowship training.[2] Contributing factors include the increasing workload associated with ambulatory patient care tasks, pay discrepancy, and shortage of outpatient support staff.[3] Concurrently, the demand for primary care providers (PCPs) has increased due to population growth, aging, and insurance expansion.[4] This crisis calls for innovative solutions to recruit and retain PCPs. This article describes one such solution—a novel hybrid general internist job model that shows promise in addressing many factors that drive physicians away from careers in primary care.

In the typical PCP role, the physician works exclusively at an outpatient clinic five days a week caring for their patient panel. They may see an average of 100 patients and devote 10-15 hours per week on documentation and additional time to in-basket management.[5] General internists who practice in a "traditional" manner simultaneously balance outpatient and inpatient responsibilities. They are often on-call for direct care of their clinic patients when they require hospitalization, perhaps resulting in a physician transitioning between hospital and clinic duties multiple times a day. Both models have become increasingly stressful to sustain and contributed to a lack of trainees choosing primary care careers. As a result, physicians may choose hospital medicine and forego primary care altogether but at the expense of losing continuity of care and regular work schedules.

The University of Nebraska Medical Center/Nebraska Medicine (UNMC/NM) has faced similar challenges in our primary care workforce. These challenges, however, have been buffered by our ability to hire PCPs into a unique hybrid general internist role. This career path has grown in popularity due to a broad scope of practice, schedule diversity, and desirable work-life integration—resulting in high job satisfaction rates for hybrid physicians. Here, we share key characteristics of the hybrid role and experiences, challenges, and lessons learned thus far in implementation. We see this model as a potential solution for other health systems facing PCP shortages.

Nebraska's Hybrid Model of General Internal Medicine

The hybrid role was initiated in 2016 at UNMC/NM as a creative solution to mitigate our primary care shortage. In this model, two partnered hybrid physicians split one full-time hospitalist and one full-time primary care posi-

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CLIMBING LADDERS OR SWINGING ON MONKEY BARS: DIFFERENT OPTIONS FOR CAREER ADVANCEMENT

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

I wanted to be a professor of medicine. I needed to be chief of staff. I envisioned myself being a Veterans Integrated Service Network (VISN) Chief Medical Officer (CMO) within the Department of Veterans Affairs (VA). Since I had highly successful career mentors in these positions, these were logical measures of my personal success as I climbed the ladder of academic medicine.

Fresh out of Internal Medicine-Pediatrics residency in 2002, I stepped onto the lowest rung of my personal career ladder as assistant professor of internal medicine and pediatrics at my alma mater, Tulane University School of Medicine. I was excited to start a career in academic medicine by dividing my time between the Department of Veterans Affairs and activities in the Charity and Tulane Hospital systems.

In 2005, my ascent on the career ladder was interrupted by Hurricane Katrina. I decided to remain in New Orleans and considered myself lucky from a career standpoint as I was fluent in three local dialects: "Tulane," "VA," and a native speaker of "New Orleans." Many remaining faculty spoke one of them but did not understand the other two dialects. Newcomers often had to learn these languages over time. Faculty on the higher rungs of the institutional ladders left New Orleans to climb ladders at other institutions. I was afforded new opportunities on the ladder as these departures opened institutional rungs. I could collaborate, build bridges across systems, and do things others were less able to do because of my understanding of the different languages and cultures at each institution. I learned to take advantage of these opportunities.

As healthcare systems were rebuilt in New Orleans, there were crossroads for me to consider to continue up the academic ladder. I advanced to associate professor and continued with successful endeavors through Tulane. I began to shift my career ladder to the New Orleans VA

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FROM IDEAS TO ACTION: ADVANCING ADVOCACY AND ACTION AT THE 2025 ANNUAL MEETING (#SGIM25)

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

"I am looking forward to a well-attended, informative, and inspiring meeting that will motivate us to take action—whether on an individual, institutional, community, or legislative level."

The defining moment of the Society of General Internal Medicine (SGIM) presidential term is the Annual Meeting. It is the culmination of presidential year activities during which the organization, its priorities, values, and members are featured. The decision to hold our 2025 Annual Meeting (#SGIM25) in Hollywood, Florida, was made five years ago. As I stepped into the role of SGIM president-elect, the question of whether and how to proceed with the meeting remained uncertain. Following recent reproductive and anti-LGBTQIA+ legislation enacted in Florida, many SGIM members voiced concerns about hosting the Annual Meeting in a state whose policies seemed to conflict with SGIM's commitment to a just healthcare system where all individuals can achieve optimal health.

As I joined Council as president-elect, we charged an important Site Selection Workgroup, chaired by Brita Roy, MD, MPH, to help SGIM navigate the challenging decision of whether to hold our Annual Meeting in Florida. A previous article outlined the key questions this task force was asked to address, including: "What does our Society do when legislation passed in specific states is at odds with the views of many members about a 'just system of care'? How can we support our members and their patients in these states? Should SGIM contribute to the economy of locations where physicians are restricted from providing what they consider to be evidence-based care? How do we decide where to host our annual meet-

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Q & A ON THE AMERICAN HEART ASSOCIATION'S SCIENTIFIC STATEMENT ON THE ROLE OF PRIMARY CARE IN ACHIEVING LIFE'S ESSENTIAL 8

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In 2022, the AHA issued a presidential advisory that aimed to improve cardiovascular health by focusing on eight health behaviors and factors identified as *Life's Essential 8*.[1] On November 13, 2024, the AHA released a scientific statement on the role of primary care in achieving Life's Essential 8.[2] Since the Chair and Vice Chair of the AHA's Primary Care Science Committee that prepared the statement are SGIM members, I asked them to share what they learned while developing the new scientific statement.

EB: What exactly are Life's Essential 8?

MS: The AHA identified four health behaviors (diet, physical activity, nicotine exposure, and sleep) and four health factors (body mass index, blood lipid level, blood glucose level, and blood pressure) that can be modified to achieve optimal cardiovascular health.[1]

EB: Why did the AHA decide to focus on the role of primary care in achieving Life's Essential 8?

MS: Only 20% of Americans have optimal cardiovascular health, and the prevalence of optimal cardiovascular health varies a lot by socioeconomic status, race, and ethnicity.[2] AHA leaders recognized that primary care clinicians are positioned to play a central role in addressing this huge gap in care. We have both the opportunity and expertise to screen, counsel, and treat throughout an individual's life span. Much of Life's Essential 8 happens in primary care rather than sub-specialty settings. Therefore, the AHA assembled a committee with appropriate representation of primary care physicians and nurses, and we were charged with developing a roadmap of sorts to detail how primary care clinicians can support patients in implementing Life's Essential 8.

EB: What does the AHA's statement say about the role and functions of primary care in achieving Life's Essential 8?

JS: The Primary Care Science Committee followed the World Health Organization's definition of primary care as supporting "first-contact, accessible, continuous, comprehensive, and coordinated person-focused care."[2] The Committee used the social ecological model to define how the core functions of primary care can influence behaviors at the intrapersonal/individual, interpersonal, organizational, community, and policy levels. For example, at the interpersonal level, primary care clinicians can screen for cardiovascular risk factors and offer counseling to promote healthier behaviors. At the policy level, primary care organizations like SGIM can advocate for policies and payment models that support primary care clinicians in addressing health behaviors.

EB: How strong is the evidence on how primary care can be leveraged to promote Life's Essential 8?

JS: The Primary Care Science Committee found substantial evidence supporting the role of primary care clinicians in addressing the eight essential health behaviors/factors. The Committee's statement summarizes the evidence, including studies on the effectiveness of adherence to dietary patterns that support optimal cardiovascular health, including the Mediterranean and Dietary Approaches to Stop Hypertension diets, studies of behavioral and pharmacological interventions to address cardiovascular risk factors, and studies of lifestyle interventions to reduce disparities in cardiovascular risk factors.[2] All randomized controlled trials that were highlighted were conducted in primary care settings or used

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WHY IS FEEDBACK DIFFERENT? A CASE FOR DIRECT OBSERVATION OF VERBAL FEEDBACK

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The conductor steps to the podium. Gesturing with both hands he starts the piece, leading the ensemble through a rehearsal of Arnold Schoenberg's *Variations for Orchestra*.[1] At times, the conductor offers feedback to the instrumentalists. Several steps behind the conductor, Pierre Boulez, an expert conductor and pivotal figure of classical music, observes intently. At an opportune moment, Boulez speaks to the conductor in front of the audience of orchestral musicians: *"What is your intention when you go to this variation?"* They speak in full view of the orchestra, with Boulez guiding the conductor to identify that the character of the composition's opening was conveyed unclearly. He asks, *"How can you improve?"* With guidance, the conductor develops a method to communicate feedback to the orchestra more explicitly. Boulez and his mentee engage in a process culturally accepted in music but strange and unexplored in competency-based medical education (CBME): direct observation of feedback by a third party with coaching aimed at improving feedback delivery.

> **"Why should the skill of feedback be treated differently than all other skills which rely on direct observation to avoid injecting conjecture into feedback quality?"**

In music and medicine, feedback is a valuable tool that depends upon the observation of skills by a third party. Effective verbal feedback delivered by attending physicians to residents is a key component of CBME. Graduate medical educators treat this practice as a learnable skill: contemporary feedback models emphasize a bidirectional alliance between resident and attending and rely on an iterative cycle of reflection, observation, feedback, and practice change. Yet, most approaches to improvement of verbal feedback delivery rely on abstracted didactic sessions where educators simulate or reflect on their feedback practices in relation to a best practice model. Why should the skill of providing feedback be treated differently than other skills, which rely on direct observation to avoid injecting conjecture into feedback quality?

The quality of verbal feedback between attending and resident is difficult to ascertain given that both parties are subject to bias and inattention to objective quality measures. Importantly, such measures exist: numerous review articles summarize consensus best practice features of feedback in CBME, while Halman et al. published validity evidence for a tool created to measure attending feedback quality by an observer.[2] It is established that self-assessment without external validation across a range of professions is inaccurate. These inaccuracies are likely multifactorial, relating to intrinsic definitions of competence and self-serving protective biases. The limitations of self-assessment are one of the reasons why learner observation is a necessary component of CBME. We would never expect a second-year medical student to leap from pathophysiologic didactics to independent medical practice. Yet our current model for faculty delivery of feedback mirrors this ludicrous scenario with feedback skills being employed without external validation.

Fields outside of medicine provide proof of concept of formalized feedback observation: teacher observations in general education are commonplace and based upon widely used frameworks, most of which intentionally measure feedback quality. Sports coaching research has led to numerous case studies of feedback delivery and observation of successful athletic coaches have defined the attributes of feedback associated with successful player performance.[3,4] As with the Boulez example, orchestral conductor master classes offer a public display of feedback as delivered by experts to aspiring classical music

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ATYPICAL PRESENTATION OF BACTERIAL MENINGITIS

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A 60-year-old male with a past medical history of chronic systolic heart failure and methamphetamine abuse was brought to the emergency department (ED) after being found behind a gas station in a confused state. On arrival, the patient was tachycardic and hypertensive with a blood pressure of 189/100 mmHg. He was tachypneic and hypoxic and required 15 LPM oxygen on a non-rebreather mask. He was afebrile. Physical exam was notable for bilateral lower extremity edema and erythema, as well as agitation and anxiousness. No cardiac murmurs were auscultated.

It is important to perform a thorough workup in altered patients who have a history of amphetamine toxicity; a complete blood count (CBC), comprehensive metabolic panel (CMP), urinalysis, EKG, chest radiograph, and a head CT are all valuable to help lead a practitioner down the appropriate diagnostic pathway.[1]

His initial CBC revealed WBC of 11.72 X 10^3 µL. CMP revealed mild hyponatremia at 135 mmol/L. His BNP was elevated at 3062 pg/nL. Urine drug screen was positive for amphetamines. Chest radiography demonstrated a right lower lobe infiltrate, moderate cardiomegaly, as well as vascular congestion.

Amphetamine use is common, with more than 1 million amphetamine-related hospitalizations annually in the United States. Maintaining an awareness of risk factors and amphetamine-related toxicities is important when building a differential diagnosis in these patients.[1] *Amphetamines act on the central nervous system, leading to a sympathomimetic effect that can cause hypertension, cardiac arrhythmias, tachycardia, abdominal pain, alterations in mentation and even death.*

His initial workup was consistent with heart failure exacerbation, as the patient had clinical signs of hypervolemia, an elevated BNP and x-ray findings consistent with volume overload. Additionally, the patient lacked a leukocytosis and remained afebrile since admission. He was admitted to the Progressive Care Unit (PCU) due to BiPAP requirements and hypertensive urgency which required a continuous nitroglycerin infusion. He was started on IV diuretics for management of his heart failure exacerbation.

On hospital day two, the patient had decreased mentation and Cheyne-Stokes respiration. He was emergently intubated and transferred to the Intensive Care Unit (ICU). The patient's differential diagnosis was broadened to include sepsis due to his clinical deterioration and poor response to current treatment. Blood cultures were collected, and he was started on empiric antibiotics with vancomycin and cefepime.

This patient presented with findings of a heart failure exacerbation. He did not have fever, headache, nausea, vomiting, or nuchal rigidity suggesting meningitis. He was mildly confused but was able to answer questions appropriately early in his hospital course. Additionally, meningitis traditionally presents with a profound leukocytosis on CBC, which was not seen in this patient. In this case, premature closure occurred due to the classic signs and symptoms of an acute heart failure exacerbation. The patient's initial confusion was thought to be secondary to amphetamine intoxication leading to a diagnostic error due to anchoring on the first available diagnosis. An opportunity existed to further investigate the underlying cause of his presentation given his atypical symptoms, which were confounded by his amphetamine use and coexistent heart failure. It is important to recognize that the classic triad of fever, nuchal rigidity, and alterations in mental status is only seen in 41% of patients.[2] *It is critical to consider the patient population and risk factors and include meningitis as a potential diagnosis due to atypical presentations. Older adults with sepsis present with atypical, non-specific symptoms with altered mental status being one of the most common.*

After transfer to the ICU, the patient suffered cardiopulmonary arrest but was successfully resuscitated. His blood cultures grew *Streptococcus pneumoniae* and the patient was switched to ceftriaxone. A lumbar puncture was also performed, and PCR testing was positive for *Streptococcus pneumoniae*. The patient was weaned from pressor support but failed to improve clinically. Ultimately, the decision was made by the family to pursue comfort care, and the patient passed away three weeks after admission.

Discussion

This case illustrates the importance of early identification and recognition of meningitis, as well as challenges due

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WHO TEACHES THE BILLING? FINANCIAL LITERACY AS A COMPONENT OF PHYSICIAN WELLNESS

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Personal and professional financial literacy are essential components of physician wellness. Physicians are graduating from medical school and completing post-doctoral training without fully acquiring the financial toolkit for future success; they become the teachers, thereby reinforcing the cycle of inadequate preparation. Incorporating personal and professional financial literacy into medical education as a dimension of physician wellness could have positive impacts regardless of physician specialty. Future physicians, many graduating with debt burdens, deserve basic financial preparedness as they begin their professional lives. They should understand basic financial and policy aspects of health care to advocate for their patients and our profession.

Personal Financial Literacy

A study by Ahmad et al demonstrated that "residents and fellows had low financial literacy and investment-risk tolerance, high debt, and deficits in their financial preparedness."[1] Medical students are graduating with hundreds of thousands of dollars in student debt. High student debt burden is correlated with higher stress levels and increased alcohol abuse/dependence as well as negatively impacting mental health and academic success.[2] Studies also demonstrated that greater debt levels are factors in medical students choosing higher paying specialties versus primary care.[2]

The high prevalence of physician burnout is alarming and well documented. For example, a recent study revealed a dramatic increase in the rate of physician burnout from 38% in 2020 to 63% by the end of the second year of the pandemic. There was also a drop in professional satisfaction from 43% to 30%, the lowest it has ever been.[3] One of the authors of this study, Dr. Christine Sinsky, reflected that "only one in three physicians feels professionally satisfied…You have to know that something is going wrong in that external environment in which we're working…It is so true that while burnout manifests in individuals, it originates in systems."[3] Quadruple aim includes the well-being of the healthcare team as an essential component of our healthcare delivery system in addition to reducing costs and improving population health and patient experience.[3] In this context, healthcare organizations have allocated resources to ameliorate physician wellness by improving access to mental health resources and providing education about personal wellness strategies, such as mindfulness and time management. Normalizing conversations about mental health has been a win for medicine over the past decade. However, financial dimensions of wellness, both on a personal and systemic level, are often neglected in these organizational approaches to physician wellness.

Professional Financial Literacy

Systemic changes in addition to individually focused programs are also necessary to improve the well-being of the healthcare team. For example, value-based payment systems have enabled primary care practices to expand healthcare teams to provide more comprehensive and preventative care. High-performing healthcare teams enable physicians to better delegate patient care and achieve a healthier work-life balance. The American College of Physicians has highlighted the need for payment reform that both supports physician-led team-based care while also ensuring access to equitable care.[4] Developing high-functioning healthcare teams require sufficient revenue and shifting the allocation of resources at a systemic level.

As the U.S. healthcare delivery system evolves in its complexity, physicians may find it harder to engage in effective decision making about policy and payment. Additionally, medical education does not consistently provide trainees with basic information about our healthcare delivery system, policies, and payment structures. Without specialized graduate degrees or extensive reading, physicians become further removed from understanding the complex policy and payment structures that directly impact their daily practice.

Physicians not only must learn practice management as they are building their first practices but also focus on providing quality evidence-based patient care. A

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NETWORKING AND BRIDGE-BUILDING: KEYS TO GOING FAR IN ACADEMIC MEDICINE

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"If you want to go fast, go alone,
if you want to go far, go together."[1]

Medical training teaches us to put our heads down, work hard, work fast, and get the work done. Brutal efficiency is the name of the game with no time for dilly-dally. No time to pause, connect, or look too far outside our little circles. So much so, networking and connecting can almost seem like an anathema—something that will slow us down and take away from the brutal efficiency of our everyday work.

This sort of efficiency and the resultant time-poverty that often results from it can lead to myopic views, the killing of any creative juices, and the loss of any sense of generosity, as we struggle to exist in self-preservation mode.

As a junior faculty member, getting the work done—and done well—was my goal. Over time, I realized that without looking outside my space and immediate sphere, there was a sense of stagnation and loss of sparkle as I operated within the same space, around the same ideas, and with the same approaches. (That's not to say that I did not love and appreciate all my colleagues. I absolutely did—and do!)

So, what was the missing ingredient?

It was, I discovered, the need to build bridges, collaborations, and ties—both strong and weak—and seek and expand circles beyond my immediate circle. At that stage in my career, that was the key to shaking up my academic world, as well as infusing the new and the novel. I also learned that networking is pivotal to building the national reputation that is often necessary for career advancement and promotion.

What are the practical steps towards building those bridges and opening doors to new collaborations? Here are a few I have found helpful along the way. . . if only I had learned them earlier:

1. **Network! Be intentional about bridge-building.** Network broadly! This is an important way to create "bonding capital" (relationships based on your commonalities) and "bridging capital" (relationships built across differences).[2]
2. **Seek friendships and collaborations not only within, but outside your field, your institution, and even outside of the medical field.** Now more than ever, there are limitless opportunities to do this, whether in the setting of conferences, society meetings, online forums, etc. I invite you to rethink the way you consider networking and connections. They are not Machiavellian business dealings, but rather ways to connect and collaborate with others who have similar, or overlapping, interests.
3. **Strong connections are good, but do not underestimate the power of weak ties.** We mistakenly think that connections must be very strong to be meaningful and helpful. That is not true. It has been shown that "weak ties," which connect a person to networks outside their own close circle, can be just as powerful as strong ties in helping build bridges and building meaningful collaborations over time.[3]
4. **Push yourself to the edges of your comfort zone.** This is especially true if you are more introverted and are perfectly comfortable working alone. Challenge yourself to do more, to connect more.
5. **Be humble. Adopt a beginner's mindset.** As you connect, explore, and collaborate beyond your immediate circle, you will encounter new ideas, new ways of doing things, and new approaches. It's important to be open and humble at those times, however much expertise you bring to the table. The "beginner's mindset" is a powerful framework to help us put aside what we know, or think we know, about a topic, and be open to other ideas. This must be genuine to be effective, even if that putting aside is temporary.
6. **Have fun!**

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recent study found that if primary care physicians billed all prevention and coordination services to half of eligible patients, their practice annual revenue could increase by $124,435 for prevention services and $86,082 for coordination services.[5] Increased practice revenue enables physicians to develop healthcare teams and optimize EHR systems thereby improving their work-life balance while also improving patient care. Properly capturing hierarchical condition category codes to indicate patient panel medical complexity directly impacts a future revenue stream of value-based risk contracts; this necessitates an appreciation of ICD-10 codes. Billing and coding are not easily learned in brief mandatory webinars but rather require regular practice and timely feedback. Practice management should be a standard and routine component of medical education for all specialties.

The Health Policy and Practice Management Curriculum was developed in 2008 for General Internal Medicine (GIM) residents at the Warren Alpert Medical School of Brown University. Over the past 16 years, the series has been delivered to more than 150 senior-level GIM residents by leaders in primary care in Rhode Island. The curriculum is updated each year to address changes in the U.S. healthcare delivery system and is focused on primary care, though is applicable to other specialties. Lecture topics include billing and coding, electronic medical record and meaningful use, documentation requirements, value-based payment systems, team-based care models, and loss prevention.

GIM residents have recognized deficits in their billing and coding knowledge during the interactive workshops. Given the time and precepting constraints of residency training clinics, residents frequently bill "level 3" (99213) visits for most patient encounters though often perform higher levels of care; residents are conditioned to undervalue the importance of complex cognitive care. As part of this series, GIM residents are challenged to think beyond the E&M codes to better understand their value to the healthcare system. As general internists, they accomplish more than a "99213" during patient encounters. Preventive screening allows for early intervention. Chronic disease care facilitates management of patient risk profile. Diagnostic workup generates downstream revenue. Primary care serves as the referral base for the network.

Residents reflect on the fact that the United States consistently spends significantly more on health care, but experiences worse health outcomes as compared to other industrialized peer countries. There is a multitude of factors that contribute to this discrepancy. However, it is notable that the U.S. national average for primary care spending ranges between 5-10% of total healthcare spending whereas OECD (Organisation for Economic Co-operation and Development) countries spend an average of 14% on primary care. Compounding the problem, the United States is experiencing a shortage of primary care physicians.[4] The Health Policy and Practice Management Curriculum highlights the critical role of a robust primary care infrastructure that prioritizes prevention, chronic disease management, and complex cognitive care. This lecture series equips our future general internists with some of the tools, language, and confidence needed to constructively engage in this conversation and effect change.

Who Teaches the Billing? Future Directions

Personal and professional financial literacy should be better integrated into medical education during medical school, residency, and fellowship. Personal financial literacy curriculum could entail asynchronous learning, small group seminars, as well as "finance labs" with free access to interactive online tools such as budget spreadsheets, compound interest calculators for retirement and college savings plans, asset allocation/risk tolerance models, and amortization schedules for mortgages and student loans. Given the availability of online templates, medical students could graduate with a basic will and testament as they enter their professional life.

Aspects of professional financial literacy include introducing fundamentals of both practice management and healthcare policy. All clinical faculty should routinely teach coding and billing to medical trainees during patient encounters in diverse settings (inpatient, outpatient, procedural, etc.). Partnerships with affiliated graduate schools of business, public health, and health policy could create unique teaching and learning opportunities. Given its specialty-specific nature, practice management topics could be the focus during residency whereas personal finance and health policy could be integrated throughout medical school and into post-doctoral training.

Equipping physicians with the basics of personal and professional financial literacy could be a powerful tool in promoting physician wellness and effecting change for both our patients and our profession. An informed physician voice at the table is crucial.

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ings, given the serious concerns from members about recent legislation and travel bans?"[1]

The workgroup carefully examined these questions, engaged in focus groups with Florida members, conducted surveys, and examined financial models. After much deliberation, the group recommended that we proceed with holding the meeting in Florida, emphasizing the importance of SGIM remaining committed to all members, even in states where legislation may conflict with the core values of the organization. As one member put it, "Taking SGIM out of states that have restrictions removes the conversation from the places where we need to have it the most."[1]

From Ideas to Action

The steps that followed this decision were more straightforward. I selected Dominique Cosco, MD, and Thomas Radomski, MD, MS, to chair and co-chair the meeting, respectively. Together, they bring a wealth of experience as clinicians, researchers, educators, and leaders, and represent multiple SGIM regions. Having worked closely with them on Council and in other settings, I was confident in their ability to manage the detailed work required to lead this meeting successfully.

We agreed on the theme—*From Ideas to Action: Catalyzing Change in Academic General Internal Medicine*—in which we focus on taking action and leading change, most timely considering the challenging conversations surrounding this meeting. This theme also addresses the increasing concerns over decisions that could affect our learning environments, patients' access to care, and research funding. To further strengthen this commitment, we recruited Dianne Goede, MD, a health policy expert based in Florida, to take on the role of Advocacy Lead at the Annual Meeting in collaboration with our Annual Meeting team and the Health Policy Committee. In her role as the Advocacy Lead at the Annual Meeting, she is leading our efforts to connect with and engage in advocacy and action within the Florida community.

Two inspiring plenary speakers were selected who embody the theme of moving from ideas to action. Jim Withers, MD, recognized as a *CNN Hero*, is the Founder and Medical Director of Pittsburgh Mercy's Operation Safety Net and the Street Medicine Institute. He will share his decades-long work bringing health care to those who are unhoused. Author Mona Hanna, MD, MPH, will discuss her pivotal role in exposing the Flint Water Crisis and her personal journey of using science to advocate for children impacted by environmental exposures.[2]

While these two plenary speakers will provide powerful examples of individual action, our Saturday plenary will showcase the impact of collective action. Diane Goede, MD, along with Maura George, MD, advocacy co-chair, are organizing a panel discussion to engage local community members and align with our #SGIM25 Annual Meeting advocacy focus on *Promoting Equitable Access to Care Across Our States*. The conversation will explore how variations in health policies are affecting access to care for historically marginalized and vulnerable populations in Florida, with broader implications for similar communities across the nation.

The Location: On the Beach and Virtual

We are pleased to offer a pilot virtual offering for the #SGIM25 Annual Meeting which will enable SGIM to offer key portions of the meeting to those who cannot attend the Florida meeting in person. This option includes several live streamed sessions of the in-person meeting, including plenary sessions, several updates, and specific Special Symposia that reflect the meeting theme or SGIM's priorities. Attendees will be able to participate in live Q&A during these sessions and will also have access to the #SGIM25 Highlights Bundle, which will include a number of recorded sessions from #SGIM25, which will be available in June 2025. This initiative also aligns with longstanding requests from the Environmental Health Interest Group to curb the meeting's carbon footprint.[3]

I have embraced this journey to the Florida Annual Meeting. It has sparked important conversations, driven innovation—such as offering a virtual access option—and strengthened our commitment to advocacy and action. With high submission numbers by SGIM members, I am looking forward to a well-attended, informative, and inspiring meeting to motivate us to take action—whether on an individual, institutional, community, or legislative level. And, of course, it doesn't hurt that it's on the beach (#SGIM25)!

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to atypical presentations. The classic triad of meningitis (fever, nuchal rigidity, and change in mental status) is only seen in 41% of patients.[2] Nearly all patients present with at least one of the three features, and up to 95% of patients with bacterial meningitis will have at least two of the four cardinal symptoms (fever, nuchal rigidity, altered mental status, and headache).

Acute bacterial meningitis carries a mortality rate greater than 20-30% when diagnosis is delayed by more than three hours.[3] Amphetamine use damages endothelial cells, leading to disruption of tight junctions, which results in a leaky blood brain barrier (BBB). As a result, there is a higher risk associated with amphetamine use and CNS infections.[4] In severely ill patients, early antimicrobial therapy is key to successful outcomes, and delays are associated with increased mortality.

Diagnostic errors are a known phenomenon. Human reasoning is vulnerable to bias and cognitive distortion, with premature closure being one of the most common diagnostic errors. To limit this idea of settling on a diagnosis too early, a "diagnostic time out" can be helpful to recognize bias and contemplate other possible diagnoses. Literature suggests that the use of the diagnostic time-out can serve as a "second opinion" from oneself and others involved in the care of the patient and can shift thinking from solely preventing errors to managing complexity.[5] Physicians need to recognize their own biases in the decision-making process, as anchoring and premature closure can lead to inaccurate conclusions and compromised patient care.

Take-Home Points of SGIM Physicians

This article has discussed the challenges of diagnosing atypical presentations of bacterial meningitis, particularly in patients with coexisting conditions like heart failure and substance abuse. The following is a list of take-home points for SGIM physicians:

1) SGIM physicians need to maintain a heightened awareness for atypical presentations of bacterial meningitis, including risk factors that increase the risk of acquiring meningitis. The classic signs and symptoms are not present in every patient and delays in care are associated with increased morbidity and mortality.
2) SGIM physicians need to be aware of anchoring and premature closure, as these threaten outcomes and increase patient morbidity and mortality.

This case highlights the risks of premature diagnostic closure and anchoring in critically ill patients which can delay diagnosis and result in poor prognosis. Early identification and timely treatment are crucial for improving outcomes, highlighting the need for vigilance and a broad differential diagnosis.

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Let's summarize. It's ok (and good!) to put your head down, get your work done, and be efficient. Perhaps even brutally efficient at times. It's great to build strong connections locally and have an excellent relationship with your local colleagues and partners. But it's not enough. Build bridges and connections, near and far, and seek collaborations in likely and unlikely spaces. It will expand your horizons, and you—and your career—will be better for it.

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conductors.[1] These examples, while distinct from CBME, offer foundational models for the implementation of direct observation for improving feedback quality.

Examples of direct observation of feedback within CBME are limited. A survey of hospitalists at our institution (University of Washington) revealed minimal experience with observed feedback (5/72, 6.9%, 57.3% survey response rate [RR]). These sparse instances occurred in the setting of near-peer coaching programs that guided faculty development in a variety of educator roles. Notably, none of the faculty surveyed had participated in a program that primarily focused on the observation of feedback. To our knowledge, an intervention centered on the observation of feedback to learners with paired coaching on feedback delivery has not been previously described.

There are several possible explanations as to why the direct observation of feedback delivery has had limited focus in CBME. Psychologic safety in such a program is paramount, and external observers would necessarily be individuals without any ties to promotion or formal evaluation of resident or attending. Some feedback topics, like professionalism, are missuited to this educational strategy. Numerous considerations may arise from the faculty perspective, including the possibility of an observed faculty being perceived as needing "remediation" in the eyes of the learner because of being observed.

Do the potential benefits of observed feedback justify its investigation as another tool in the armament of feedback improvement? Although time and resources are currently spent on faculty feedback training, some evidence suggests that feedback quality remains poor.[5] Despite the vast feedback literature, investigations into directly observed feedback are curiously absent. Is it possible our feedback improvement practices have become inefficient due to the lack of a critical missing component of feedback quality assessment? The possibility of more efficient feedback improvement via a practically designed program of feedback observation is deserving of at least as much investigation as other training programs.

To understand our community's perspective, we surveyed internal medicine residents and hospitalists on their perspective of direct observation of feedback. We received 129 resident responses and 72 hospitalist responses (70.6% and 57.3% RR, respectively). We learned that most residents and hospitalists reported feeling comfortable with having a feedback exchange observed (105/129, 80.9%; 46/72, 63.8% respectively). This indicates an opportunity for the observation of feedback within our community. While there are limitations to the generalizability of this data, the diversity of respondents and high survey RR suggest that these findings may resonate elsewhere.

Feedback delivered by SGIM members has the potential to spur meaningful growth in trainees, yet feedback improvement is an elusive goal. What may be missing is the conceptualization of feedback as a skill like any other that benefits from observation followed by coaching for improvement. By embracing feedback delivery as a skill to be observed and improved, SGIM members can drive meaningful changes in their institutions. A conductor learning to communicate effective feedback without musicians would seem irrational. Is it so different for attending educators in CBME? If the mission of CBME is to assess trainee skills, it is the duty of SGIM members to be experts in feedback and strive towards improvement via the same observation that attending physicians ask of their learners. We encourage SGIM members to consider these insights as a tool to enhance feedback delivery in their own practices.

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as opportunities arose to rebuild health care for Veterans. I advanced from a lead clinic physician to assistant chief of medicine in 2008 followed by chief of medicine in 2013. Climbing the career ladder seemed right. I was doing good work, achieving personal success, and making a difference. My personal academic roadmap had chief of staff as the next rung up the ladder.

During this time, my involvement with SGIM was a cornerstone of my personal journey since the local internal medicine infrastructure had been washed away with the loss of many Tulane and VA faculty. One of my SGIM mentors, Dr. Bob Centor, offered me prescient advice when he opined that my current position as chief of medicine was the "sweet spot" where I was surrounded by medicine trained faculty with similar intellectual curiosities. There was some heterogeneity as I supervised cardiologists, pulmonologists, hospitalists, etc., but we were all trained in medicine. As chief of staff, I would be supervising surgeons, psychiatrists, pathologists, etc., with different trainings and academic interests. He warned that my career would change from doing things I was excited to do to chasing the things others would require me to do as chief of staff.

This nugget of wisdom did not register for a still junior faculty who only knew the academic ladder and felt the need to reach for the next rung. I interviewed for a chief of staff position and thankfully, in retrospect, I was not awarded my perceived next rung of my ladder. I even interviewed for and was offered a VISN CMO position during this ladder climbing phase. After significant deliberation, I declined the CMO position even though this would have jumped me two rungs on my ladder. I was offered interviews for chief of staff positions at other VA facilities with a high likelihood of being selected. I passed on these opportunities as they did not fit my family needs. I figured my chance to climb that next rung would come again as these chances often seem to in academic medicine.

As time passed, I would like to think I got smarter as I got older. Perspectives changed. What seemed important to me in my 20s and 30s was different in my 40s and 50s. The sage advice of Dr. Centor started to slowly reverberate in my head. I had built an excellent Medicine service in New Orleans and opened a billion-dollar replacement VA hospital. Why did I feel a need to continue to climb the ladder? I started to realize that climbing the ladder was what was "expected." Climbing the next rung was a "measure of success." I recognized that my desire to climb the ladder arose when I needed to add new challenges professionally.

The awakening came when I understood I no longer needed to climb the ladder. I was already in my "sweet spot." What I needed to do was to swing on the monkey bars. Monkey bars are nothing more than ladders spread horizontally instead of vertically. Monkey bars are fun. They have a larger footprint than a ladder. More people can be on the same monkey bar. You can stop while climbing the ladder, but you can't stop swinging on monkey bars without falling off as stopping loses momentum and gravity pulls you down. To move forward on the monkey bar, you must let go of the rung behind you.

I came to recognize that I loved being chief of medicine and the opportunities afforded to me. I found that tackling new challenges did not require me to climb the next ladder rung. Instead, I could swing to a new rung of my monkey bar while remaining as chief of medicine. I looked for new chances to participate in activities within SGIM. I became editor in chief of SGIM Forum as I tackled my long-standing aversion to writing. I searched for new ways to mentor others within the Department of Veterans Affairs by sharing skills and expertise that I had learned over the past decade with new incoming chiefs of medicine. I learned that it was more fun to promote my employees and have them recognized for shared accomplishments than being recognized myself.

I learned to love what I do in the present and appreciate my position as chief of medicine. Earlier in my career, serving as the chief of medicine where I trained seemed like such a lofty aspiration. So why was I so willing to leave this position behind? I recognized my "sweet spot" before it was too late; I decided to swing on my monkey bars and leave the ladder climbing to others. "For one person, success might mean climbing the corporate ladder, while for another it may mean finding a balance in life, nurturing a relationship or pursuing a passion that brings them joy. The beauty of success is that it does not come with a one size fits all definition."[1]

Personally, I'll stick to my monkey bars instead of climbing ladders as this brings me happiness. Success to me was finding my happiness.

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tion and alternate working monthly between outpatient and inpatient settings. During outpatient months, they care for their patient panel without hospitalist duties. During inpatient months, they work hospitalist shifts with minimal clinic requirements. Our clinic support staff know their hybrid physician schedules and triage patient concerns and medication refills accordingly while physicians manage their clinic in-basket and direct clinic staff in the care of their patient panel. Continuity patients who need to be seen in clinic—for acute or time-sensitive needs—during a hospitalist month are treated by their hybrid partner or advanced practice practitioners embedded in their respective clinics. The hybrid model differs from a traditional model in two significant ways: 1) providers are not responsible for the direct care of their clinic patients when hospitalized (which decreases on-call demands) and 2) providers don't practice full inpatient and outpatient duties simultaneously, allowing for a break from each role and protected time to practice in each setting with fewer interruptions.

The hybrid model offers several advantages to physicians (see table). It allows for the practice of full-scope general internal medicine with the ability to develop longitudinal relationships with patients. Scheduling is flexible, but predictable, creating opportunities for non-clinical pursuits. Alternating inpatient and outpatient work on a month-by-month basis means that hybrids enjoy more weekends, holidays, and nights off compared to full-time hospitalists. Salaries are higher compared to primary care alone. The hybrid physician carries a smaller patient panel and has reduced demands from the invisible and largely unpaid workload of the in-basket. The hybrid role may be more desirable for physicians who wish to diversify work, prioritize work-life integration, or pursue non-clinical interests.

Initial evidence of the success of the hybrid model is apparent in retention numbers and physician testimonials. In the last eight years, UNMC/NM has hired 29 outpatient internists: 13 into full-time primary care and 16 into hybrid roles. During this same time, 15 primary care internists departed due to retirement, relocation, or a change in career path. Only three hybrids have left the model, instead transitioning to full-time hospitalist or primary care roles within the institution. Interviews with hybrid physicians revealed a consensus on the model's benefits including improved job satisfaction, reduced burnout, and a preference for the variety in scope of work. One physician stated, "the hybrid model is a shield against a lot of broken things in primary care." Many providers indicated they may have chosen a career in hospitalist medicine if the opportunity to work as a hybrid was not available.

The hybrid model's impact extends beyond physician experience to patient care and system-wide efficiency. Hybrid physicians communicate their alternating monthly roles to ensure continuity patients are informed and supported by clinic colleagues. Continuity of care is maintained through follow-up appointments intentionally scheduled at two-, four-, or six-month intervals. Institutionally, the hybrid model's dyadic approach has facilitated smooth integration, with minimal disruption to the master hospitalist schedule and optimal use of clinic staff and resources. Administrators initially faced challenges in adjusting work targets and managing hybrid physicians across different divisions, but these processes have since been refined.

Challenges exist within the model. Inherently, the hybrid model requires a commitment of two physicians to a dyad pair. We have found this to be less of an issue thanks to our physician retention and creative scheduling. Before implementing this model, we planned for the dyad hybrid physician assigned to the

Comparison of General Internist Job Models

Job Model	Primary Care	Traditional General Internist	Hybrid General Internist	Hospitalist
Setting	Outpatient	Concurrent Inpatient & Outpatient	Separated Inpatient & Outpatient	Inpatient
Salary	Lowest	Middle	Middle	Highest
In-Basket Requirements	Highest	Highest	Middle	Lowest
On-Call Demands	Variable	Highest	Middle	Lowest
Patient Continuity	Highest	Highest	Middle	Lowest
Number of Continuity Patients	Highest	Highest	Middle	Lowest
Variety in Scope of Work	Lowest	Highest	Highest	Lowest
Scheduled Hours Outside of 8:00-5:00	Lowest	Middle	Middle	Highest

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clinic each month to manage their partner's in-basket to protect the partner working hospitalist shifts. However, all hybrid pairs stated a preference for patient continuity. Each physician thus chose to manage their own in-basket while on hospital months. Because of this, continuity clinic patients will occasionally have needs that arise during a busy hospitalist shift. Although backup systems are available to care for these patients, many of our hybrids prefer to personally manage these concerns due to their strong commitment to and longstanding relationship with their patients. Ultimately, our hybrid physicians felt the advantages of the hybrid model outweighed these challenges.

Conclusion

The hybrid model offers a novel solution to the challenges in traditional primary care, appealing to SGIM physicians seeking a balanced career in general internal medicine. It merges the dynamic inpatient environment with primary care's preventive focus, enduring patient bonds, and reduced after-hours duties. This model's versatility and simplicity in practice may not only guard against burnout but also enhance job satisfaction, making it a viable option for SGIM members in various practice settings—whether large, small, academic, or private. Its adaptability suggests potential as a broader remedy for the escalating crisis in primary care.

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primary care clinicians and staff to deliver interventions.

EB: What do you see as the biggest challenges in achieving Life's Essential 8 and how can we overcome those challenges?

MS: To improve cardiovascular health in the United States, it will be necessary to address the challenges plaguing primary care in this country, especially the shortage of primary care clinicians and lack of access to primary care for many people. We really need to advocate for greater investment in primary care. Primary care clinicians need better reimbursement for the time required to incorporate behavioral counseling into visits. Far too often, we spend considerable time with patients to screen, counsel, and treat, yet that time is not adequately reimbursed. Healthcare systems need to invest in technology and data infrastructure that will make it easier to coordinate care among primary care clinicians, specialists, and other healthcare professionals, who all have a role to play in improving cardiovascular health. To make such changes, we must advocate for payment reform that prioritizes team-based care and integration of behavioral health care into primary care. Lastly, we should advocate for a greater commitment to implementation science focusing on how to promote more effective and equitable use of evidence-based interventions for improving cardiovascular health.

EB: Anything else you want to add?

MS/JS: It was a joy to work on this statement and showcase what we do as a field and why it matters. We personally want to applaud our SGIM members who have advanced the field and whose work we cited in the statement. Happy reading!

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