VOL. 48 ■ NUMBER 3 ■ MAR 25

SGIM FORUM

Society of General Internal Medicine

MEDICAL EDUCATION: PART I

THE MEDICAL EDUCATOR PORTFOLIO PUZZLE: PUTTING TOGETHER THE PIECES OF YOUR TEACHING CAREER

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Medical Educator Portfolios (MEPs) highlight teaching achievements and educational philosophy to create a narrative of a clinician educator's niche and reach.[1, 2] MEPs help communicate an educator's impact to a mentor, senior faculty, or a promotion committee. For the educator, an MEP is a tool to build a narrative, reflect on a career, and set future goals. This article illustrates elements of a portfolio, distinguishes it from the *curriculum vitae* (CV), and outlines the steps to create an MEP.

Yes, You Need a CV and a Medical Educator Portfolio

While a CV is essential for documenting qualifications, it often focuses on non-educational scholarship. The MEP provides a more comprehensive perspective on an educator's scholarly contributions, including details of teaching methods, approach, innovation, and impact.

While a CV might list a teaching award, an MEP would include the criteria for selection, the impact on teaching practices, and commentary on the educator's approach. This depth and context are crucial for understanding the educator's contributions. Combined, a CV and an MEP create a holistic view to highlight individual educational strengths and successes. The following illustrates how there exists overlap and important distinctions between a CV and an MEP:

CV

- **Focus:** academic and research accomplishments and experiences
- **Content:** qualifications, positions, and publications that demonstrate educator responsibilities and accomplishments
- **Format:** direct, often chronological, with minimal context
- **Purpose:** job applications, grant submissions, and academic promotion.

Portfolio

- **Focus:** highlights comprehensive view of educational contributions highlighting high impact items
- **Content:** detailed descriptions, context, and reflective narratives on teaching, projects, and professional development that demonstrate educator orientation and impact
- **Format:** narrative, reflective, and contextual, offering depth to achievements
- **Purpose:** job, award, and committee applications, career planning, and academic promotion.

In summary, the MEP provides context and illuminates the impact of educational work listed in a CV.

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MODELING THE FUTURE OF PRIMARY CARE: A CHANCE TO FIX A BROKEN HEALTHCARE SYSTEM

Michael Landry, MD, MSc, FACP,
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"Every system is perfectly designed to get the result that it does."[1]

Our primary care system is broken. SGIM members recognize this through our daily interactions with the system. The Commonwealth Fund noted that the state of primary care within the United States is challenged when compared to other countries.[2] The United States has one of the highest healthcare expenditures per person with overall poor health quality per dollar spent when compared to nine similar countries.[2] We have an outdated reimbursement system that does not recognize the work of primary care as the Relative Value Scale Update Committee (RUC) pays more for procedural and operative care and less for the coordination of complex care done in primary care. Medical education and training now produce more specialists and superspecialists with little increase in primary care physicians. Student loan debt is all consuming for some trainees which drives subsequent career choices. Where do we turn next?

The first step in solving a problem is acknowledging that one exists. There are many healthcare executives, physician leaders, and policy makers in the United States who do not recognize the primary care shortage as a problem. However, there are individuals who do, and they have been leading efforts to address the reimbursement reform, overhauling healthcare expenditures, redefining medical education, etc. Many SGIM members have been central to these reform efforts with some success; however, challenges remain that need SGIM's attention.

The first part of any solution is to measure the scope of the problem. Measurements are often static in nature and unchanging at any specific moment. This becomes our eventual baseline data. Once we establish this baseline status, we consider how best to address the problem with our hypotheses. Our SGIM research colleagues do this repeatedly when obtaining their baseline data and designing their interventions.

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HEALING THROUGH ADVOCACY AND ACTION: THE VITAL ROLE OF PHYSICIANS AS AGENTS OF CHANGE

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

"No matter the timing or political landscape, physicians have a vital role as changemakers—driving improvements in healthcare systems and beyond to promote the health of our patients and communities. This work serves as both a source of healing for us and, more importantly, a lifeline for our patients."

As a medical student in the 1980s, my education consisted of hours in classrooms to learn to diagnose and treat clinical diseases. I soon found out that clinical skills represent only a fraction of what is needed to maintain good health for my patients. Like many learners, I entered medical school with an idealized view that overestimated the role of clinicians and the healthcare system in sustaining health. Over time, idealism was replaced by frustration as I began to see the limitations of clinical care. I'm embarrassed to admit that in stressful moments, I blamed and labeled patients as "noncompliant" or made light of choices that I assumed contributed to their illness. Unfortunately, I was not alone in this behavior. A large body of research suggests that the idealism many medical students bring to their training fades over time and is replaced by diminished empathy, frustration, and even cynicism as they progress through medical education.[1]

Health Is Not Just Health Care

The likely source of frustration for learners and clinicians is the understanding that only 20% of health outcomes are directly influenced by the work done in health care.[2] The remaining factors, known as the *social (or nonmedical) determinants of health*—education, housing, neighborhood conditions, and income—are largely shaped by factors outside health care and driven by broader policies, norms, and systems, including the pervasive influence of racism.[2]

My education in large, impersonal classrooms offered few opportunities for meaningful interaction with

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Q & A ON THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC) MODEL FOR PROJECTIONS ABOUT THE SHORTAGE OF PRIMARY CARE PHYSICIANS

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The AAMC recently presented preliminary findings from a new workforce projections model suggesting that the rapidly increasing supply of Nurse Practitioners (NPs) and Physician Assistants (PAs) can help meet the nation's demand for primary care within the next decade if the nation continues to increase the number of primary care physicians it trains.[1] I was concerned about the assumptions in the model, so I reached out to Dr. Grover and Michael Dill to learn more about the AAMC's methods and projections.

EB: How does the AAMC's new workforce projections model differ from previous models?
AG/MD: The differences are numerous and begin with the underlying methodology: the new model uses a system dynamics methodology, which relies on building a model structure that reflects our understanding of how factors and forces affect the physician workforce. Other differences from the previous model include: 1) we now differentiate among utilization, demand and need, rather than equating utilization with demand; 2) the new model explicitly includes task-shifting among physicians, PAs, and NPs; 3) physician supply "production" now begins with medical school, while the old model began upon completion of training; 4) we now include residents and fellows in capacity; 5) our projections now begin in 2002 (a date chosen based on data availability and quality), which allows us to compare model results with real world data from 2002 to the present (a critical model validation measure); 6) the new model includes feedback loops and thus non-linear behavior (e.g., utilization affects health affects demand affects utilization); 7) the model has been developed as a unique co-ownership collaborative with the RAND Corporation; and 8) there is no "black box" with the new model (we are working on publishing the full methodology as we speak and invite interested experts to investigate and improve it with us).

EB: How do projections from the new model compare to historical data in your simulation analyses?
AG/MD: As mentioned, our new model begins in 2002, so we can make comparisons with historical data from 2002 to the present; and our new model matches historical data (such as those for medical students, residents, fellows, and practicing physicians) with high accuracy.

EB: How does the projected supply of primary care clinicians compare to expected demand in the next 20-30 years?
AG/MD: The answer to this question depends on the assumptions we make. The point to the model is to allow us to assess "what if" scenarios to inform policy. For example, the policy brief that led you to contact us looked at a scenario that asked "What if the number of primary care physicians we train continues to grow *and* scope of practice for PAs and NPs continues to expand *and* the willingness of healthcare systems and providers to shift appropriate tasks among physicians, PAs, and NPs continues to increase?" The answer was that, if those things happen, then we could get to a point over the next decade where we meet the nation's demand for primary care services, assuming current utilization patterns (i.e., we are not saying that the way we currently use primary care is ideal, we are simply saying the data tell us that is how we use it). However, if we do not make those assumptions, our model projects a sustained national shortage of primary care physicians. This last point is critical. Our new model allows us to alter assumptions as new data becomes available, and as new policy possibilities arise.

> **"Our new model allows us to alter assumptions as new data becomes available, and as new policy possibilities arise."**

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TOGETHER FOR CHANGE: ADVOCATING FOR PATIENTS AT SGIM 2025

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As the SGIM 2025 Annual Meeting draws near, SGIM members anticipate the surge of inspiration experienced each year, the synergies cultivated with colleagues from around the country, and a renewal of purpose and mission as academic internists.

This year is no different in many respects, but, in other ways, it may feel profoundly different. Regardless of political leaning, SGIM members feel the country's deepening divisions as they advocate for changes important for the care of patients, the education of learners, and the well-being of colleagues. How can members advocate most effectively at the bedside and upstream of patient care in C suites and legislator's offices during a time of political divisiveness? How can members effectively amplify patients' needs in a way that resonates with everyone, navigating these discussions without alienating people across the political divide?

Across the United States, patients experience disparate access to medical care. Many SGIM members feel that advocacy is an essential part of their career. As burnout increases in the medical profession,[1] advocacy can be an effective mitigator.[2, 3] Metaphorically pulling drowning people out of a river time and again leads us to move upstream in our efforts to enact meaningful systemic change. Health advocacy work affords a mechanism to channel the challenges experienced by clinicians and patients to affect system change. One major issue drowning our patients is barriers accessing care. Long wait times, restrictive coverage networks, and inequitable insurance plans and coverage options plague the medical system.

As physicians practicing in Florida and Georgia respectively, we see the impact of the Medicaid coverage gap. We see patients presenting too late or too infrequently, suffering bad outcomes due to missed medication doses, and choosing between health care and necessities. The 2025 SGIM Annual Meeting advocacy focus, "Promoting Equitable Access to Care Across Our States," spotlights the unifying challenge our patients experience trying to access care. As general internists, members see this in their practice regardless of their practice location. At SGIM 2025, SGIM examines state-level variations in health policy that impact patient access to care, focusing on marginalized and vulnerable patient populations.

During the SGIM Annual Meeting in Hollywood, Florida, (#SGIM25), there will be special symposia[4] and workshops surrounding advocacy topics as well as opportunities to engage in real-time advocacy work during the meeting. The most effective and informed advocacy occurs when physicians partner with others (organizations, communities, leaders) engaged full-time in such efforts. SGIM is partnering with Florida Voices for Health (FVH), a local grassroots organization, as Dr. Goede has worked alongside FVH in their mission "to build healthy communities through an equitable and people-driven health care system."[5] Many states around the country have analogous organizations that may benefit from physician partnership.

The Saturday plenary session "Equitable Access to Care: Harnessing the Patient Experience for Change," highlights Scott Darius, Executive Director of FVH, and a patient from FVH. They share their knowledge and experience of successful advocacy efforts for access to care in Florida and how these efforts relate to other state and national efforts. The session will explore how physicians can amplify their patients' experiences and engage with community partners to advocate locally and nationally to improve equitable access to care. The plenary will also demonstrate how clinician researchers and educators can leverage their research and teaching towards health equity advocacy.

Join FVH all day Friday at the #SGIM25 Expo and Career Fair. FVH will provide physicians with an opportunity to share their stories describing the impacts of inequitable medical access on their patients. Many of you carry such stories with you! FVH will coach you in relaying those stories and then capture them on video for advocacy efforts in Florida and beyond. To increase the sharing of perspectives among all SGIM members, reflect on the following:

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HIGHLIGHTS FROM THE 2024 ACLGIM SUMMIT: STRENGTHENING OUR GIM FOUNDATION

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The Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) held the 2024 ACLGIM Summit from December 8-10, 2024, at the Andaz Resort in Scottsdale, AZ. More than 100 general internal medicine division chiefs and leaders gathered to strengthen our foundations. ACLGIM members' work is foundational to the healthcare systems in which we work, the education of residents, medical students, and other learners, as well as research that adds to our clinical and educational work. There is also the idea of our individual professional/personal foundation—being grounded as leaders, clinicians, educators, researchers, and people. A foundation is often taken for granted or considered nonessential—until it is at risk of being cracked or unstable, at which point, all that rests upon it is imperiled.

> **"Our ACLGIM Summit objectives were achieved through laying a solid foundation, examining our foundation for possibly damaging stresses, such as administrative harm and leadership loneliness, and shoring up our foundation through relational coordination, improved strategic planning as well as tending to the topics of our Hess Initiative workgroups."**

The 2024 Summit focused on these personal/professional and organizational foundations. We first examined threats to the foundations and then considered how ACLGIM members might strengthen these foundations.

We opened the Summit with a pre-session for new Chiefs/Leaders led by two Division Chief and Administrator dyads. The first from the Division of General Internal Medicine at the University of Pittsburgh Medical Center included Jane Liebschutz, MD, Division Chief, and Emily Buland, Executive Administrator, while the second from the Division of General, Geriatric, and Hospital Medicine, University of Virginia Health System, included Mohan Nadkarni, MD, Division Chief, and Cynthia D. Smith, Division Administrator. This engaging discussion focused on maximizing the relationship between the division chief and executive administrator, assessing and managing high- and low-performing faculty and physicians, and navigating financial demands from the institution.

We concluded the first day concentrating on foundational threats. Marisha Burden, MD, University of Colorado, presented "Administrative Harm: Recognition to Resolution—Better Work for Better Care."[1] Her talk defined and framed the concern of administrative harm and offered five solutions to address this pervasive issue: develop a definition and understanding of administrative harm, foster a collaborative culture and psychological safety, create structure and processes to support optimal decision-making, prepare measurement and data strategies, and build reporting and learning systems. Jennifer K. Clark, MD, from the Institute for Healthcare Excellence, shared "It's Lonely Up Here: Cultivating Connected Leadership." Her presentation explained leadership loneliness, tied this concept to the more commonly discussed clinician burnout, and linked it back to the discussion on administrative harm. Tactics to address leadership loneliness include enhancing psychological safety, building skills for resilience, and making deliberate connections.[2,3]

On the Summit's second day, speakers offered frameworks for strengthening our foundations. Jody Hoffer Gittell, PhD, from The Heller School for Social Policy & Management, Brandeis University, offered Relational Coordination as one such framework in her talk "Transforming Relationships for High Performance—A Relational Model of Change."[4] In this session, she defined

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CRAFTING YOUR TEACHING PHILOSOPHY: FIVE ESSENTIAL ELEMENTS TO DESCRIBE YOUR PURPOSE, PRACTICE, AND PROGRESS

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Introduction

A teaching philosophy (TP) statement is one component of a teaching portfolio that allows educators to describe their teaching practice as informed by educational theories.[1] This article highlights the importance of the TP, consolidates best practices for its content by considering general principles and theories integral to medical education, and provides an example TP. This contribution is significant for academic medical centers that lack a standardized approach to the TP or corresponding internal faculty development resources. Academic medical centers that place high organizational value on the TP will be better positioned to recruit clinician-educators who are enthusiastic, evidence-based, and willing to evolve with the dynamic nature of medical education.

> **"The teaching philosophy statement is a dynamic document that demonstrates an educator's commitment to teaching, learning, and professional development."**

Rationale for the Teaching Philosophy

A well-articulated TP is important for several reasons. First, it clarifies the teaching approach by helping the writer articulate their beliefs about learning and teaching objectives. This clarity can guide instructional strategies and interactions with learners, aligning teaching practices with core values and objectives. Additionally, reflecting on the TP can improve teaching effectiveness. Engaging in ongoing reflection and self-assessment of teaching methods may lead to more effective teaching practices and improved learner outcomes.[2]

A clear TP enhances learning by creating a coherent and consistent learning environment. When learners understand the teaching approach and expectations, they are more likely to engage with the material and achieve better learning outcomes. A TP also supports reflective practice by considering the ethical dimensions of teaching, such as fairness, inclusivity, and respect for student diversity. It helps the educator continually evaluate and refine their approach to better meet the needs of learners.[3] The TP can guide curriculum development by informing choices about curriculum design, instructional materials, and assessment methods.[1]

Engaging with the TP facilitates professional development by encouraging continuous professional growth. It prompts an educator to stay current with educational research and explore new teaching strategies thereby enhancing their effectiveness. Furthermore, a well-articulated TP provides a clear framework for discussing and sharing teaching practices with colleagues and helps in communicating a teaching approach with learners and administrators.[2,4]

In terms of career advancement, a TP is often required for job applications, promotion dossiers, and tenure portfolios in educational settings.[1-4] A thoughtfully written teaching philosophy can demonstrate a commitment to teaching, reflective practice, and alignment with the institution's educational mission, thereby enhancing career prospects.

Teaching Philosophy Content

A TP might vary significantly between clinician-educators according to their unique journeys. This is a personal reflective essay that outlines beliefs, values, and

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CREATING POSITIVE CHANGE THROUGH CONNECTION AND COLLABORATION IN ACADEMIC GENERAL INTERNAL MEDICINE

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On a warm Florida day in April 2022, we walked into an overly airconditioned hotel conference room at the Society of General Internal Medicine (SGIM) Annual Meeting for a workshop "Creating Joy for Trainees in Primary Care: A Focus on VA Primary Care Clinics." Could this really be true? Clinical medicine is challenging and the number of residents going into primary care is declining every year. Although a considerable number of medical students find primary care attractive, interest wanes during residency.[1] Yet we know that a positive continuity clinic experience increases the likelihood of choosing a career in General Internal Medicine (GIM).[2]

The room was filled with fellow clinician educators and clinic directors hoping to improve the clinic experiences for residents in primary care. As we worked through the workshop goals with our colleagues from other VA hospitals and outpatient clinics, we focused on goals that could create a fulfilling primary care experience. Identifying team roles and responsibilities, supporting asynchronous care, defining how primary care processes work in the setting of residents allowed us to create a list of best practices to implement in our academic clinics.

Two years later, while tidying the office, the list of priorities from the workshop hastily written on hotel paper was rediscovered. We were a bit shocked to realize that we had implemented all of them! We reflected on how much time we had committed to this work:

- Improving inter-visit care by obtaining laptops for residents
- Revamping education around the electronic health record
- Convincing administration to hire an educational officer for the residency program
- Creating a new resident staffed urgent care clinic
- Improving evaluation and feedback for residents in continuity clinic.

It hadn't happened overnight. Slowly, each goal had taken shape and moved us towards improving the working and learning environment for us, our learners, and our patients. The workshop helped us to create more joy in our resident clinic.

Reflecting on our successful journey, we recognized that we did not do this alone. From walking into that workshop to implementing our plans, the connections with other clinician educators and leaders who share similar passions, goals, and struggles inspired and supported us throughout the change process. These SGIM members may not get any accolades or lines on their curriculum vitae, but they are the reason our clinic is better. Answering our questions, sharing best practices, models, policies, and connecting us to other peers allowed us to be more innovative and successful with our improvements. Thinking about our efforts, we realized that the lessons we learned—the importance of a professional home where you can build a network, the value of reflecting on accomplishments, and the benefits of disseminating scholarly work—could help others in their career growth.

> **"Creating connections, building communities of practice, and pulling together our collaborative efforts will elevate clinical education throughout the country."**

As a professional home, SGIM and Association of Chiefs and Leaders in General Internal Medicine (ACLGIM) provide a supportive and stimulating environment for educators as well as clinicians, researchers, and leaders to collaborate on creating positive changes in clinical practice. The SGIM regional and national meetings allow members to connect with colleagues working towards similar goals. The ability to present ideas, provide and accept feedback, and develop strategies for improvement across academic centers improves our

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patients, communities, or even peers and faculty. Additionally, there was a gap in the curriculum addressing the structural, nonmedical determinants of health, which have a far greater impact on how long and well people live. It is essential that curricula include content that increases awareness of the root causes of disease, the effective strategies for improving health and health care, and the role of physicians as agents of change. This approach has the potential not only to foster resilience and address the frustrations I experienced but also to empower the next generation of physicians to drive change.

Physicians as Agents of Change

Not everyone agrees. Some argue that physicians should "stay in our lane," focusing solely on clinical care and avoiding engaging or commenting on broader social issues. One notable example of this mindset came when physicians were criticized for speaking out against gun violence. After the American College of Physicians published a position paper on the topic, the National Rifle Association responded on social media and urged physicians to limit their focus to matters within our medical expertise.[3] This led to the #ThisIsOurLane campaign in which medical professionals shared powerful, often bloody images and stories about the impact of gun violence on their patients and healthcare systems.[3]

While detractors remain, there is widespread support for an expanded role for physicians. The 2002 Physician Charter, established by the American Board of Internal Medicine, emphasizes the principles of patient welfare, patient autonomy, and social justice as central to our profession.[4] It underscores a commitment not only to the welfare of individual patients but also to collective efforts aimed at improving the healthcare system for the broader well-being of society.

I believe that addressing these broader societal issues, which directly affect health, is in our lane. Whether medical or nonmedical determinants of health, taking action to safeguard the well-being of our patients, communities, and learners is central to our role as academic general internists. My clinical practice regularly reinforces my position. Even when I get the diagnosis and treatment right, the desired patient outcome may still be out of reach. A prescribed medication may be unaffordable, a Dietary Approaches to Stop Hypertension (DASH) meal plan may be impractical in a food desert, recommendations for exercise may be hindered by unsafe neighborhoods without sidewalks, or adherence to an asthma action plan may have less impact in a mold-infested apartment. These situations underscore the importance of broader advocacy and action by physicians.

No Time to Retreat

Engaging in advocacy beyond clinical care is challenging at any time, but it can feel especially difficult following an election. I was disheartened by the presidential election results. As a Black woman, my reaction may not be surprising, given that 92% of Black women voted for Kamala Harris. Along with the loss of policies that more closely reflect my values, I also had the painful realization that we have yet to elect a woman as President. I needed time to process and grieve.

My role as the Society of General Internal Medicine (SGIM) President helped me move beyond my personal grief and focus on action. There are compelling reasons to sustain our efforts. First, election results and political terms are temporary; real, lasting change requires sustained dedication over time. Moreover, advocacy and action can play a crucial role in supporting resilience and healing in the face of loss. Staying engaged drives progress and helps combat feelings of helplessness and despair.

As an organization, SGIM is uniquely positioned to be a powerful change agent. During the December retreat, Council began by reaffirming our commitment to our core values and our vision of "a just system of care in which all people can achieve optimal health."[5] Next, Council identified anticipated priorities of the new administration that might align with SGIM's vision and values, thus offering opportunities for collaboration. These include areas such as preventive care, chronic disease management, nutrition, and whole-person health (as defined by the NIH: restoring health, promoting resilience, and preventing disease across the lifespan). We also discussed potential challenges that could undermine SGIM's mission, particularly threats to women's health and efforts related to diversity, equity, and inclusion. Council sent letters to SGIM committees and commissions, urging them to consider current and future activities considering these opportunities and challenges.

With support from the Health Policy Committee and our advocacy partners Cavarocchi, Ruscio, Dennis (CRD) Associates LLC, SGIM drafted a letter to the Trump transition team on areas of potential opportunities, supporting the delivery of comprehensive primary care to address the administration's stated priority of combating chronic disease.

This letter highlighted several key priority areas:

1. Implement payment models for primary care services that support the care coordination and complex care required for both chronic care management services and high-quality primary care
2. Establish a technical advisory committee to define and assign value to evaluation and management services to appropriately reimburse for primary care services and support high-quality comprehensive care
3. Prioritize policies that strengthen the primary care workforce
4. Support the Agency for Healthcare Research and

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Quality (AHRQ) and their vital work in supporting groundbreaking research initiatives, disseminating best practices, and facilitating collaboration among researchers, health providers, and policymakers.

In addition to these organizational level efforts, academic general internists have an opportunity to drive meaningful individual changes. At the patient level, providing high-quality clinical care remains our core expertise. Beyond prescribing medications and performing procedures, SGIM members can also screen for and address non-medical determinants of health. Additionally, members have the power to transform our educational and healthcare systems. As educators, we can design curricular interventions to provide a broader context for health and foster humility about our role in clinical care. This training can empower our learners to become change-makers, helping them navigate the challenges that arise when "life" impacts our patients, while maintaining empathy and reducing frustration. Furthermore, members can advocate for institutions that better represent our learners and patients - reflecting a range of backgrounds and experiences that enhance both the learning environment and the quality of clinical care. As academic physicians, we can conduct research, engage with communities, and participate in legislative and community advocacy, leveraging our expertise to drive positive change.

Summary

No matter the timing or political landscape, physicians have a vital role as change-makers—driving improvements in healthcare systems and beyond to promote the health of our patients and communities. This work serves as both a source of healing for us and, more importantly, a lifeline for our patients. This is "our lane!"

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If a problem is long-term and its solution takes even longer, we may not have the luxury of waiting—especially if we're unsure the solution will effectively address the issue. Modeling scenarios with the ability to change input variables allow for predictions that create a better understanding of individual solutions, as the definitive answer may be months or years down the line. When it comes to our primary care system, we do not have time to wait considering our current crisis. We have an increasing population of older adults with multiple medical problems and coordinating their care is becoming more complex—this is occurring as primary care is struggling to fill their ranks and train future primary care physicians.

In this issue, SGIM members are fortunate to have SGIM CEO Dr. Eric Bass engage in conversation with Dr. Atul Grover and Mr. Michael Dill of the Association of the American Medical Colleges (AAMC). In this exclusive SGIM Forum article, our AAMC colleagues walk us through their new predictive primary care model and highlight the eight areas where their new model differs from prior modeling. They discuss the impact of advanced practice professionals (nurse practitioners and physician assistants) as a necessary component in their modeling to help fill the primary care gap, but only if other variables remain the same. They also discuss limitations of the modeling when it comes to other specialties who might engage in primary care delivery as these are difficult to address in the model without added participation by these specialty groups.

Dr. Grover and Mr. Dill highlight the important areas of the model that affect supply-demand including:

- Aging of the United States population
- Task shifting
- Limitations on healthcare delivery by non-physicians for certain conditions
- Work hour restrictions
- Physician time dedicated to patient care.

These aspects are all critical to the current and future ability to deliver high quality care to our patients.

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relational coordination, provided its context and relevance, and led participants in a tabletop exercise of relational mapping.[4] Bill Logue, from The Logue Group, addressed how to approach strategic planning as another approach to shoring up our foundation in "Strategic Planning: Is It Ever Done?". He reviewed key considerations in formulating and implementing a strategic plan including techniques for decision making and prioritizing. In a presentation entitled "Transforming Primary Care," Luci Leykum, MD, from the Elizabeth Dole Center of Excellence for Veteran and Caregiver Research, offered her perspectives and experience in exploring future models of primary care delivery.[5] We rounded out our considerations on how to shore up our foundations with a panel discussion on the ACLGIM Site Visit Program. Moderated by Larry McMahon, MD, University of Michigan Medical School, the panel was comprised of Sunil Sahai, MD, University of Texas Medical Branch School of Medicine; Jennifer Schmidt, MD, Washington University in St. Louis School of Medicine; and Shin-Ping Tu, MD, University of California-Davis Clinical and Translational Science Center. Each discussant shared why they had requested a site visit, described the team that did the site visits, related their experience of the visit as well as the recommendations that were generated, and expressed the benefits of the site visit.

We continued our attention on foundational issues through updates from the ACLGIM Hess Initiative Workgroups. The Rebalancing Compensation and Team-Based Care Workgroup presenters, future physician Estelle Martin, Mark Earnest, MD, University of Colorado, and Mitch Feldman, MD, University of California San Francisco, communicated their initial findings from interviews with high-performing academic medical centers. These findings demonstrated how their practices approaches primary care clinician compensation, staffing and structuring the primary care team, and quantification and organization of primary care work. Anne Cioletti, MD, from the University of Utah, provided an update from the Trainee Experience Workgroup. One goal of this workgroup is to propose recommendations prioritizing high-functioning primary care experiences and continuity for internal medicine residents to ACGME. In the update, there was a focus on recommended changes to curricular, structural, leadership, clinic time and timing of the clinic experience, and other aspects of the resident primary care experience.

> The #ACLGIM Summit took place Dec 8–10 at the Andaz Resort in Scottsdale, AZ. 100+ GIM division chiefs & leaders gathered to explore this year's theme: Strengthening Our Foundation. #Leadership

Each morning, we had open discussions over breakfast including breakout sessions for Clinical Leaders, Education Leaders, and Research Leaders. In addition, Richard Gitomer, MD, from Virtual Primary Care, led a special breakfast session that weighed the pros and cons of having Primary Care Service Lines where attendees shared experiences and insights from their institutions. Cynthia Chuang, MD, ACLGIM President, led another special session later in the day on when and how to transition out of leadership positions.

Lastly, Michael Fischer, MD, Boston Medical Center, led a session with a presentation by Erika Miller, JD, Partner at CRD Associates, on Health Policy Threats and Opportunities in the new Congress and administration which was enlightening and laid out challenges in the year to come.

Our ACLGIM Summit objectives were achieved through laying a solid foundation, examining our foundation for damaging stresses such as administrative harm and leadership loneliness, and shoring up our foundation through relational coordination, improved strategic planning as well as tending to the topics of our Hess Initiative workgroups. We are already beginning to plan the 2025 ACLGIM Summit and hope you can join us in Scottsdale later this year.

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practices regarding teaching and learning. The five essential elements of your TP are goals, learners, theories, instructional methods, and teaching evolution:

1. **What are your personal goals?** Essentially your mission statement. Begin with a brief introduction to provide an overview of your core beliefs about education and explain their importance. Introduce key topics important to teaching, such as your general teaching approach, learning environment, and how you engage learners, laying the foundation for other sections of your philosophy.

   Example: "As a physician-educator, my teaching philosophy is deeply rooted in a commitment to developing future medical professionals who are not only knowledgeable and skilled but also compassionate and ethical. My approach is guided by a learner-centered philosophy, with a strong emphasis on the flipped classroom model, which I believe fosters a more interactive and engaging learning experience. My primary goals as an educator are to:

   a. Inspire and motivate medical students to achieve excellence in their academic and clinical pursuits
   b. Foster critical thinking and problem-solving skills that are essential for medical practice
   c. Cultivate a learning environment that promotes empathy, ethical decision-making, and lifelong learning
   d. Ensure that students are well-prepared for the challenges of residency and beyond."

2. **Who are your learners?** In this section, describe the types of learners to whom your TP applies. Include learners' specific needs and your perspective on how your teaching approach furthers their development. Describe specific academic achievements, the development of clinical skills, or personal growth that your learners could achieve through your teaching methods.

   Example: "My learners are medical students who come from diverse backgrounds and bring a wide range of experiences and perspectives to the classroom. These students are at a critical stage of their professional development, transitioning from theoretical knowledge to practical application in clinical settings. Understanding their unique needs and learning styles is crucial to tailoring my teaching methods to support their growth effectively."

3. **What educational theories are you applying?** There are many educational theories applicable to academic medicine. At minimum, we recommend you familiarize yourself with the most common theories, some outlined in Baker et al's "Aligning and Applying the Paradigms and Practices of Education."[5] In your TP, describe what theories you utilize in your teaching, and their importance.

   Example: "I firmly believe in the learner-centered approach, which places students at the heart of the educational process. This philosophy emphasizes active learning, where students engage with the material, collaborate with peers, and take responsibility for their learning journey. By focusing on the needs, interests, and experiences of the learners, I aim to create a dynamic and supportive learning environment that encourages deeper understanding and retention of knowledge."

4. **What are your preferred instructional methods?** Detail the specific strategies and approaches you employ in your teaching practice, which could include collaboration, project-based, flipped classroom, inquiry-based, and technology integration to name a few. Provide specific examples and explain the rationale behind your chosen methods to communicate your instructional philosophy and its impact on learning effectively.

   Example: "The flipped classroom model is central to my teaching strategy. This approach provides students with pre-class materials, such as recorded lectures, readings, and interactive modules, and allows them to familiarize themselves with the content at their own pace. In-class time is then dedicated to active learning activities, such as case discussions, problem-solving exercises, and firsthand practice. This method not only enhances student engagement but also allows for more meaningful interactions and personalized feedback during class."

5. **How have things evolved for you?** As you conclude your TP, articulate your commitment to continuous learning and professional growth. Mention the professional development activities you have pursued (i.e., certificates, conferences, workshops). Provide some reflection on the feedback you receive and how this reflection helps you improve.

   Example: "My teaching practices have significantly evolved over time, driven by ongoing professional development and feedback from students and colleagues. Participation in educational workshops, conferences, and peer observations has provided me with new insights and inno-

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vative strategies to enhance my teaching. These include modern technologies and pedagogical techniques, such as incorporating virtual simulations and interactive case studies, which have enriched my flipped classroom model. Additionally, constructive feedback from students has been invaluable in refining my approach, helping me to identify areas for improvement and adapt my methods to better meet their needs. Initial feedback highlighted the need for clearer guidance on pre-class materials, leading me to create more structured and accessible resources."

Educators are encouraged to review and update their TP at regular intervals since goals and values change with experience and skills development.

Conclusion

The TP statement is a dynamic document that demonstrates an SGIM educator's commitment to teaching, learning, and professional development. The content and style are unique to each SGIM educator, but often include the components outlined in this article. Academic medical centers can adopt this approach to the TP, integrating organizational values to promote a culture of teaching excellence, effectiveness, and innovation.

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EB: How does the model account for differences in the types and extent of services provided by different types of primary care clinicians?

AG/MD: The model divides services which may be provided by physicians or others into two categories: those that are only provided by physicians, and those that are provided by either physicians or PAs/NPs. The model currently includes two groups for physicians: primary care and specialty care. We are working on further disaggregation, and we hope to use it to produce projections for individual specialties—if we can find partners in those specialties who are interested in collaborating with us.

EB: Does the model account for primary care services that are delivered by physicians in other specialties such as gynecology and internal medicine subspecialties?

AG/MD: As noted, the model does not disaggregate to that level of detail, though we are working toward it and hope to find partners who are willing to work with us on that (we do not want to develop the model for a specific specialty without working with that specialty).

EB: What are the most important factors that affect projections of how the future supply of primary care clinicians compares to expected demand?

AG/MD: The growth and aging of the U.S. population is the most decisive factor on the demand side, though the policy levers available to affect that are limited. We have explored other more policy-amenable factors, like task shifting, and that appears to be one way in which we can do a better job of meeting demand—up to a point. The model assumes a limit on what patients and conditions can be treated by non-physicians, such that continuing to grow the nation's capacity for training primary care physicians (e.g., expanding Title VII training programs) is critical for ensuring primary care capacity. One other factor that has a significant effect on physician supply is work hours. The downward trend in physician work hours has had a substantial impact on effectively available supply. We also note that physicians' percentage of time on patient care could be an important factor, and the new model has the capacity to examine that.

EB: What questions are you asking as you update the model moving forward?

AG/MD: In the next two years, we hope to improve the model by including data that can answer the following questions:

- What types of services are being provided by, and patients seen by, non-physicians? How do these differ by specialty, setting, and location?
- What are the primary factors driving trends in physician work hours?
- What does physician retirement involve? (We know many do not simply work a set number of hours up to a point and then abruptly stop.)
- What are the dynamics driving physician recruitment and retention, including intent to leave practice?
- How does time allocation for different professions vary by specialty, setting, location, care delivery model, etc.?
- What systemic factors are directly affecting clinician well-being and how does this affect capacity?

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- The stories that sit in your memory
- The times you treated a patient late in their disease course after they experienced a delay in accessing medical care
- The students who stepped forward to provide free medical clinics when community health systems could not meet patient needs
- The health disparities you have witnessed.

Come prepared to share these stories that support health advocacy efforts aimed at improving access, both in Florida and in your own states.

At the meeting, sessions will focus on equipping participants with the skills and knowledge necessary for effective advocacy and activism in health care, emphasizing civil discourse, legislative engagement, and the development of advocacy curricula for medical trainees. Please look for the following advocacy pieces, among others,[4] as you plan your trip:

- Advocacy, Activism, and Resistance: Teaching Civil Discourse to Harness Changemakers' Passion
- Medicaid Expansion: Unfinished Business of the Affordable Care Act (ACA)
- Climbing the Hill: Empowering Physicians to Participate in Legislative Advocacy
- Building Advocacy Curricula for Internal Medicine Trainees
- Is the Pen Mightier than the Stethoscope? How to Write Op-Eds and Make an Impact.

The planning committee hopes that discussing these issues, especially during the meeting in Florida, will bring the recharge SGIM members seek at every meeting.

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Educator Portfolios in Three Words: Why, What, and Impact

The MEP can be divided into three themes: *why* you are an educator, *what* you do as an educator, and your educational *impact*. Each theme includes multiple domains that help illustrate an educational career story:

Why

- **Teaching Philosophy:** An MEP includes a section on teaching philosophy summarizing the values and goals surrounding teaching and learning. An educator's teaching approach is borne from values and experiences as a teacher and learner; it is an extension of who they are. This is often the most challenging part of the portfolio to tackle. Fortunately, writing this can be a diagnostic and therapeutic exercise: attempting to articulate one's teaching philosophy can help it take shape.

What

- **Teaching Activities:** An opportunity to build a story tying together the work that has been done to build a niche and area of expertise. This broad category can include clinical and didactic settings, small and large groups, and items such as organizing a teaching club. The MEP highlights the most impactful teaching activities, curated, and summarized to highlight innovation and significance.
- **Professional Development:** Identify the steps taken to improve teaching. This may include formal coursework, workshop attendance, teaching certificates, or direct observation.
- **Educational Administration and Leadership:** Include committee work, course administration, curriculum development, educational leadership positions, or other educational work not considered direct teaching.

Impact

- **Assessment of Teaching:** Includes learner evaluations, peer evaluations, and other evidence of impact. Quantitative measures include the number of learners and/or the reach of scholarly work: How large was the audience? How many book copies were sold or downloaded? Teaching impact can be assessed by Kirkpatrick's levels of learning in order of increasing importance: reaction, attitudes,

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The most critical component of Dr. Bass' article and discussion with AAMC leadership revolves around the ability for the AAMC to change the model inputs. The authors list nine "what if…" and "what are…" questions that that they hope to answer in future years based upon the adeptness of this new model to accept new inputs. These questions and associated solutions will assist physician leaders and policy makers in creating optimal primary care practices that retain and recruit excellent primary care providers. These future solutions will create an optimal work-life balance and payment reforms recognizing the value that primary care physicians provide. The authors also challenge SGIM researchers to provide data that can be incorporated into the model to create new outputs for unanswered questions.

SGIM members have realized the inadequacies of the healthcare system over many decades. In a quote often mistakenly attributed to Albert Einstein, mystery writer Rita Mae Brown states: "Insanity is doing the same thing over and over again but expecting different results."[3] If SGIM members know that our current primary care model is not working, we are obligated to change it. AAMC is leading an effort to provide this impetus with data driven modeling, but it will be essential that SGIM members actively participate and "provide the data" that AAMC is requesting.

"The difference between insanity and genius is measured only by success and failure."[4] Let's work together with AAMC to redesign primary care so that future generations of physicians celebrate SGIM members' successes in changing the future of primary care.

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knowledge/skill, behavior, and practice.[3] Reaction is often the easiest impact to assess, but there may be opportunities to note changes in knowledge, behavior, or practice.

- **Recognition and Awards:** In addition to specific awards, include other ways that excellence in teaching has been acknowledged—chosen for committees, initiatives, or leadership that indicate the reputation of the educator.

Individual institutions vary in their MEP structure and nomenclature, but the general themes are universal. Educators should work within the recommended structure to ensure their message is communicated effectively. While a single activity may be listed in multiple sections, the emphasis and detail should be limited to the most relevant section.

Glassick's criteria suggest educational scholarship should be assessed for clear goals, adequate preparation, appropriate methods, noteworthy results, effective presentation, and reflective critique.[4] These criteria provide a useful lens to evaluate the work of the educator and guidance on what information to include within the portfolio.

I Need a Portfolio: How Do I Get Started?

An MEP can include a daunting number of sections. To effectively build a portfolio there are three key steps: What is the *goal* of your MEP, create a *blueprint*, and develop a process to *collect elements*.

1. **Goal:** First, it's crucial to define the purpose of a portfolio. Whether for academic promotion or career development, understanding this goal will shape both the content and structure. Review the institution's specific requirements and preferred format if academic promotion is the primary endpoint. Requirements for award applications are usually less stringent.
2. **Blueprint:** Once the portfolio's purpose has been clarified, it's time to create a blueprint.[5] Some institutions and websites offer templates. Online platforms allow for broader dissemination of portfolios and access to audiovisuals that cannot be shared on paper. If the decision is to create a website, choose the platform thoughtfully, considering factors such as ease of use, accessibility, and security.
3. **Collect Elements:** Once the planning is completed, start gathering data! Adopting a proactive approach to collecting information is beneficial: creating this list after the fact can require

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a near-archeological investigation of email, calendar, and memories. Start by creating an electronic folder to consolidate all materials. Place a copy of your CV there and highlight any education-related items including teaching, mentoring, scholarship, administrative work, and leadership. Aim for breadth and depth in the collection efforts. Include videos, photos, audio files, and slide decks to illustrate your work, as well as thank-you notes (formal and informal), invitations to join committees—anything that demonstrates teaching impact and reputation.

Tips for Collecting Teaching Evaluations Data

Teaching evaluations are important and should be gathered on a regular basis. Medical schools and residency programs provide faculty evaluations based on learner feedback. These are proactively collected but should also be available on request. Evaluations of conferences and presentations should also be included. Some institutions have an educational branch that can provide an objective, thematic analysis of trainee feedback.

Educators may perform teaching activities that are not formally evaluated. In this case, consider creating and delivering individualized evaluation requests; for example, a QR code that links to an anonymous survey at the end of your slides is an efficient way to collect this. Focus on brief, specific questions and consider a combination of numerical and qualitative input so holistic data can be collected over time.

Once the initial MEP has been completed, continue to collect data to keep the portfolio updated. New versions of your portfolio will come together quickly, even if your educational niche changes over time.

Conclusion

The educator portfolio is a dynamic tool to organize, document, and highlight educational excellence. Educational contributions are increasingly recognized as a form of scholarship, so portfolios are essential tools for demonstrating academic achievements of SGIM members. We encourage institutions to embrace the educator portfolio as a valuable resource to advance teaching and learning in academic medicine. With increasing understanding of the purpose and components of an MEP, we hope that SGIM members begin to create or enhance their educator portfolios.

Acknowledgements: The authors would like to thank Aditi Puri, MD, MSEd, assistant professor of Medicine at Loyola University MacNeal Hospital, and Sreekala Raghavan, MD, associate professor of Medicine at Icahn School of Medicine, for their contributions.

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FROM THE SOCIETY *(continued from page 13)*

- What are the factors driving physician practice location decisions and what are the most effective ways to address disparities in access?
- What if we were to develop the model to make projections for a specific specialty like general internal medicine? What other model structures and data would we need (e.g., for the role of hospitalists)?
- What if we were to develop the model to make projections at the state level? What other model structures and data would we need (e.g., for in- and out-migration, retention of in-state trainees)?

Beyond these questions, we hope that health services researchers can provide data addressing other factors that could be built into the model.

- What do patient visits look like for non-physicians in collaborative, co-located primary care practices?
- How is care provided by different clinicians in specialty care settings?
- Does primary care delivered independently by advanced practice providers differ from other care models? Is it different where non-physicians are supervised virtually?
- What are the conditions and patient parameters that general internists feel are effectively managed by non-physicians?
- Are there age restrictions (e.g., patients below a certain age) or

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work. Sharing ideas allows members to not "reinvent the wheel" but make a better wheel! Working together as educators, researchers, and leaders, we can create a collaborative and innovative environment for not only education but also for clinical care.

The power of connection and collaboration to bring positive change to the work of academic clinicians underscores the importance

> A #SGIM22 workshop led to real changes in primary care clinics. #AcademicGIM #MedEd

of investing time in network and community. Too often "networking" triggers negative connotations of self-serving superficial cocktail talk, yet it is a vital tool towards building meaningful professional connections.[3] Finding a professional home where like-minded individuals can connect not only helps academicians obtain their professional goals but also facilitates more meaningful change.

Academicians should be intentional about reflecting on their accomplishments not only in research and publications, but also in education and collaboration. Leaders in academic medicine do not always acknowledge the role they play in developing programs, mentoring, and connecting with other colleagues to disseminate ideas. Educators frequently do not spend the time needed to track and account for our efforts. With an emphasis on revenue generating care, the work of clinician educators is often undervalued in academic medicine. Although they may not generate Relative Value Units (RVUs) or grant funding, the role of clinician educators is invaluable in promoting the development of our researchers and leaders of the future.

Yet, as fewer trainees enter primary care, the value of an inspiring educational and clinical experience should become more of a priority. While some educators are fortunate that they have formal defined roles and dedicated Full-time Equivalent (FTE), others must invest their own time to innovate, grow a program, or build a curriculum. Educators must partner with clinicians and assess the critical work they do for themselves and their career goals. Demonstrating to leadership their impact on practice and education can help them justify the importance of FTE for resident education.

Going the extra step to disseminate work through workshops, posters, and publications allows members to learn from each other and create valuable connections with fellow academicians. In our case, this happened at an SGIM workshop. Thankfully, we are invigorated when we remember and rediscover the work of colleagues with similar goals and passions. Creating connections, building communities of practice, and pulling together our collaborative efforts will elevate clinical education throughout the country.

We hope that educators, clinicians, researchers, and leaders can learn from our experience as they work towards improving the quality of training for medical students and residents. Remembering to take time to reflect and account for their work, network, and connect to peers, and disseminate innovations to their local leadership and beyond will support SGIM members in their goal to create excellent physicians. Wherever you choose to have your professional home, the sense of community and collaboration can improve our innovations. With intentionality, we can all bring more joy to our work for ourselves and our learners.

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complexity parameters (e.g., no more than two comorbidities) guiding which patients are seen by which provider types?

- What types of patients in internal medicine sub-specialty practices can safely be evaluated and, under what conditions, treated by advanced practice providers?
- Where can other clinicians (e.g., pharmacists) bridge care, assuming interoperability of records?

And for all of these, we always ask:

- How can we improve data collection to inform the above?

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