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SGIM FORUM

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IMPROVING CARE

CHANGING THE GENERAL INTERNIST'S APPROACH TO AUTISM SPECTRUM DISORDER

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More than five million adults in the United States are estimated to have autism spectrum disorder (ASD).[1] These adults face significant barriers to accessing quality health care; not least among them is finding a physician who is comfortable caring for them. Physicians report feeling ill-equipped to care for autistic adults.[2] Academic general internists pride themselves on making challenging diagnoses and caring for medically complex patients while simultaneously teaching and pursuing research goals. SGIM promotes a vision of just care, in which all groups are cared for optimally by empathetic clinicians. In our practices, we find that general internists lack knowledge about how to best meet the needs of patients with autism and shy away from caring for this population. This article provides actionable concepts that physicians can implement in their practice to improve the care of their autistic patients.

We focus on patients who have already been diagnosed with autism. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM V)* defines autism spectrum disorder as a neurodevelopmental disorder in which impairment in social communication and interaction and repetitive, restrictive patterns of behavior have been present since early childhood.[3] The autism spectrum is broad and encompasses people of varying intellectual abilities and needs. However, the following three suggestions are applicable for patients across the autism spectrum.

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Screen for Medical Conditions Associated with Autism

Although sensory processing challenges are not a core component of the DSM V definition of autism, many patients with autism have sensory dysregulation. This can result in strong food aversions or fixations. Autistic patients are more at risk of obesity[4] and of severe nutritional deficiencies[5] than the general population. Taking careful dietary history in a patient with autism is critical. It is necessary to perform a wider array of nutritional testing beyond what typically might be ordered. Vitamin C deficiency is rarely encountered in the general population but must be considered in the patient with extremely restrictive eating behaviors.

Constipation is an extremely common co-occurring issue in a patient with poor nutritional status. If a patient can communicate, asking about constipation routinely is excellent practice. If a patient does not have communication abilities, a caregiver may or may not be aware of bowel movement patterns. Collaborating with the patient's care partners to assess constipation is often beneficial, as constipation can impact behavior. When considering changes in behavior in a patient with autism, constipation should be high on the list of possibilities.

Finally, it is paramount to ensure that patients with autism have been appropriately evaluated for genetic conditions. Even if they saw a geneticist when they were children, it is worthwhile to re-refer, as genetic testing capacity has expanded rapidly. A child born with autism 10 years ago may have received some genetic testing, such as a karyotype and single gene testing (for conditions such as Fragile X syndrome). Now, most patients with autism who see a geneticist will receive whole genome sequencing. As a medical community, we continue to discover that many patients with autism have underlying genetic disorders. This is especially true when a patient has both autism and one or more secondary conditions such as intellectual disability or epilepsy. A genetic diagnosis is unlikely to change a patient's management, but occasionally it can. However, it does provide important answers for patients and their families. This genetic testing can also help patients form a community around a rare diagnosis associated with autism.

Consider Performing a Sensory-Informed Exam

Just as sensory processing difficulties can impact an autistic patient's food choices, they can drastically impact the patient's experience in a healthcare setting. Most healthcare settings have bright lights, are loud, and can often involve invasive and painful testing. Many autistic patients struggle to feel at ease in these scenarios.

When engaging with an autistic patient, make sure to greet the patient before their caregiver, even if (especially if!) the patient's chart reports that he or she is nonverbal. If the patient prefers to stand, do not try to force the patient to sit or lie on the exam table while you begin your encounter. Allow them to maintain whatever comfortable position they choose while you build rapport. If the patient is performing repetitive actions or movements (called *stimming*), do not attempt to suppress these. These movements can be a way that the patient copes with an unfamiliar environment.

A physical exam involving physical contact with the patient may not be necessary, especially if this is a first encounter and the goal is relationship development. If the exam is necessary, make sure to follow the "*tell, show, do*" framework. First, *tell* the patient what maneuvers you're planning to perform. Then, *show* the patient. You can use yourself as a model or a willing care partner. Finally, if the patient consents, *do* the maneuver. If this doesn't work, you can break down an exam component into even smaller steps. For example, you can ask a patient to allow you to hold the stethoscope against the skin for one second, then remove it. If that goes well and the patient agrees, you can ask if you can hold it against the skin for five seconds. Thanking and praising the patient, offering an incentive, incorporating breaks can all be helpful practices.

If you perform a certain exam routinely, consider creating story boards of the exam process—a story board is a sequence of pictures (photos or drawings) that represent an action. You can then use the story board to help the patient process what will happen during the exam. These can even be given to patients by staff prior to the exam.

Utilize Affordable, Effective Sensory Toolkits

In addition to taking the exam slowly, there are small tools that inpatient wards and outpatient offices can stock that can make the experience for patients with autism much smoother. Items such as noise-cancelling headphones, a weighted lap pad, sunglasses, and fidget devices can all be helpful for comforting patients who may be over- or under-stimulated.

A Call to Action

Adults with autism face major hurdles when it comes to accessing health care. These patients should be able to easily find informed physicians who are willing and able

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to care for them compassionately. As general internists who practice primary care, we urge our SGIM colleagues to learn more about caring for autistic patients so that they can lead the way in providing excellent health care for this overlooked and underserved patient population.

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SGIM

FROM THE EDITOR

WHY PHYSICIANS ARE DECLINING ADDITIONAL DUTIES OUTSIDE OF CLINICAL CARE

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"If your actions inspire others to dream more, learn more, do more and become more, you are a leader."[1]

SGIM is an organization composed of physician leaders. There are SGIM members who are leaders within the organization and members who are leaders in their respective fields of medical education, geriatrics, research, women's health, LGBTQIA+, etc. There are other members who are leaders at their home institutions. So why this specific title for this month's Forum editorial? In this article, I describe the deliberate career choices physicians are making in declining leadership opportunities within the field of medicine and why SGIM members should advocate for change in time allotted to be healthcare leaders.

In the June 6, 2025, issue of *Becker's Hospital Review*, Mariah Taylor describes the shrinking pipeline of physician leaders. She notes "physicians seem less willing and interested in taking on roles beyond their clinical work. Traditionally, physicians have balanced full-time clinical loads with extra responsibility as a leader or educator."[2] Physician leaders have been told that it is necessary to keep a foot in the direct care clinical spectrum. But definite pros and cons exist especially if there is no time allocated for additional responsibilities.

Physicians enter clinical practice to provide patient care with a desire to make a difference. This is the essence of medical school and residency training. But, along the way, things change as new opportunities and passions emerge. Physicians become invested in these new opportunities to become clinician-investigators, clinician-educators, or clinician-administrators. They develop special interests and niches which drive their commitments and time management.

But where does that extra time come from? Who makes the decision on the allocation of effort towards direct patient care versus medical education, administration, or research? The deciding official may be a physician (e.g., the individual themselves or a section chief,

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service chief, or chair) or a non-physician leader (clinical or non-clinical). Historically, physicians have often abdicated many nonpatient care duties to other healthcare or business professionals. This has led to past concerns with business practices, insurance payments, healthcare reform, etc. Could this current physician leadership crisis mirror past missteps?

Times are changing. "As people and the workforce have evolved, there's a growing understanding: if you're going to commit to something and do it well, you need dedicated time to focus on it…As they assume leadership and educational roles, they want those responsibilities to be part of their identity and integrated into their day-to-day work. That's different from how these roles have historically been structured."[2] The potential physician leaders today no longer want their Full Time Equivalent (FTE) position to be greater than one FTE. They demand the dedicated time to perform their duties well.

There is increased recognition of physician burnout and a desire to achieve a better work-life balance. Recent generations have different career expectations:

- **Generation X (born 1965-1980):** Known for their self-reliance and adaptability, they began to witness the rise of work-life balance as a significant workplace issue. Value flexibility and often seek to blend their professional and personal lives. For Gen Xers, achieving balance might involve negotiating flexible hours or working from home. This generation was also among the first to experience the pressures of dual-income households, which influenced their approach to balancing work and family life.[3]
- **Millennials (born 1981-1996):** They place a strong emphasis on work-life balance, seeking more than just a paycheck. Value purpose and personal fulfillment, often prioritizing jobs that offer flexible schedules and remote work options. For many Millennials, work-life balance also means integrating their personal values with their professional roles. This generation tends to view work as a part of their identity but insists on maintaining time for personal interests and overall well-being.[3]
- **Generation Z (born 1997-2012):** Entering the workforce with a fresh perspective on work-life balance. They are highly digital-native and expect flexibility and adaptability from their employers. For Gen Z, work-life balance includes not only flexible working conditions but also a focus on mental health and job satisfaction. Likely to seek roles that align with their values and offer opportunities for personal growth.[3]

"The increased interest in work-life balance for medical professionals has also contributed to younger physicians declining extra responsibilities."[2] Physicians still want to take care of patients but are reticent to accept duties they are expected to do on their personal time and for which there may not be extra compensation.

Burnout also impacts physicians' acceptance of leadership responsibilities or added duties. Electronic medical records, administrative burdens, clinical inefficiencies, and staffing shortages all contribute to extra work for physicians. A Doximity study conducted in May 2025 shows that 85% of US physicians report being overworked—this has ranged from 74% to 88% over the past four years. "Reports of overwork among physicians also mostly trend upward with age. About 78% of physicians 29 and under say they are overworked, compared with 85% in their 30s and 40s, and 88% in their 50s and 60s. This percentage does drop to 75% among physicians aged 70 and older, due to their being closer to the average retirement age."[4]

How do physicians respond to feeling overworked? Physicians may seek work with a different employer or a different position or even a different career. They may choose to work part time or retire early. But another increasing option is the decision not to accept additional duties, such as teaching, research, or administrative positions.

SGIM and other organizations need to recognize and address this trend. "One piece of the pie is working on our culture, and a lot of that culture is shaped by leadership behaviors, ... it's really important to help make sure leaders are inspiring and motivating their team, equipping them with what they need, helping them grow, and treating them with respect."[2] Leaders need to recognize the causes of burnout and overwork at the local and national level. We need to balance workload with expectations. We need to dedicate time for physician leaders to be healthcare leaders. Understanding that physicians care about patients is not enough. We must ensure that providers have protected time outside of patient care to complete the duties that only physicians can do. When physician leaders are providing direct patient care, who is completing the additional duties that these leaders are especially trained to complete?

"We've moved away from 'this is the way it must be done' to 'let's explore the different ways we can do this and find what works best.' As it becomes harder to fill these roles, flexibility is key. You'll have some people who want to fully dedicate themselves to leadership. Others might want a mix: some clinical, some leadership. Others still might want to split time between teaching and administration. Some may want to go part-time but still contribute across those domains. If the work gets done, as long as they're helping lead, caring for patients, and contributing to system design—it works. Flexibility isn't just acceptable anymore; it's necessary to attract talent. Everyone has limited time and energy, and we have to make a compelling case for why some of that should be

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dedicated to leadership."[2] Additional duties take time but there are only so many hours in a day and a limit on the effort that physicians are willing to dedicate to these duties. Leader and organizational flexibility are the keys to ensuring that the necessary duties are completed and the physicians feel valued.

As physician expectations change, health care must change. How will SGIM members advocate for dedicated time for the duties we love to do, the health of our members and the sustainment of the healthcare system? The future depends on our efforts.

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SGIM

PRESIDENT'S COLUMN

INSIDE SGIM LEADERSHIP: MAKING DECISIONS AND BUILDING COMMUNITY

Carlos Estrada, MD, MS, FACP
President, SGIM

"Council examined our essential core principles for working together. Council commits to being prepared, communicating openly, working unified, staying solution-focused, and prioritizing SGIM."

This article provides SGIM members with an overview of SGIM's organizational structure and key processes that drive Society operations. Over the years, SGIM's structure has changed to better serve our members and profession. I share how this organizational structure and decision-making processes functioned during the recent 2025 SGIM Council retreat.

SGIM Organizational Structure and Functions

SGIM's leadership structure combines elected and appointed roles (see chart). The President leads SGIM during their three-year rotation, serving consecutively as President-Elect, President, and Past President. The Chief Executive Officer (CEO), Dr. Eric Bass, and Deputy CEO, Kay Ovington, CAE, guide the execution of the Council's strategic vision and goals. The CEO has served a 50% part-time effort since 2017 with annual reviews by the SGIM Executive Committee using a structured evaluation framework. The CEO also plays a significant role in engaging with other healthcare organizations.

The SGIM Council serves as the main governance board with elected and ex-officio members overseeing SGIM's strategic direction. SGIM Council evaluates existing programs, launches new initiatives, and establishes annual priorities. Each Council member serves as a liaison to one or more organizational groups. A resolute SGIM team supports membership services, finances, communications, education, technology, committee support, and event management. SGIM's work is conducted via permanent core mission Committees and cross cutting Commissions that report directly to Council. The Council establishes temporary task forces to address specific challenges or pursue opportunities within GIM. Each of the six SGIM

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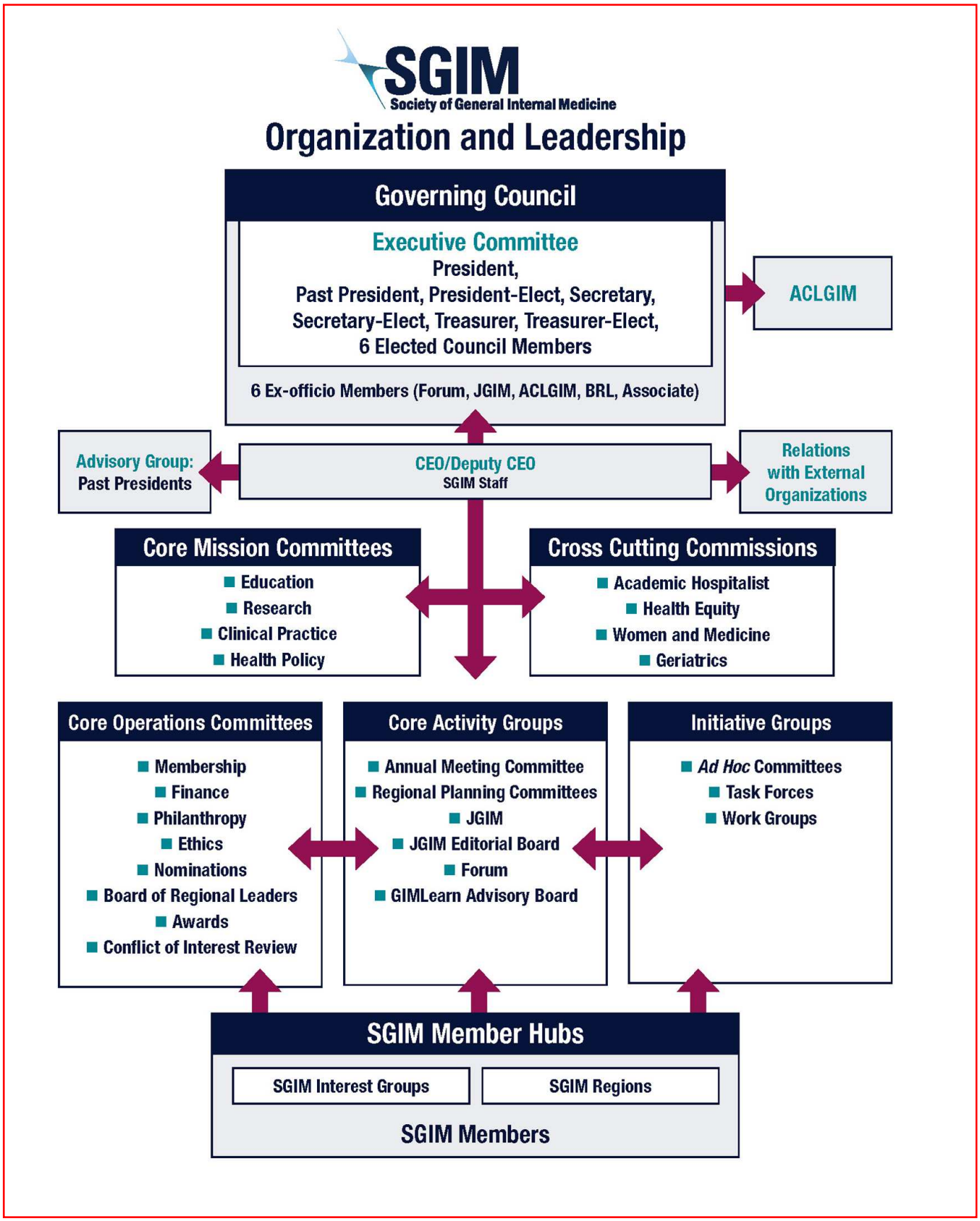

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regions and the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) maintain their own elected leadership structure.

Council holds monthly calls and meets in person during the Annual Meeting and two retreats. I will describe the process and initial outcomes of the most recent Council retreat held at the SGIM office in Alexandria, VA.

Council Retreat

During the June 2025 retreat, Council reviewed progress toward annual goals, evaluated governance, and approved the new fiscal budget. As SGIM President, I reminded Council members of the organizational mission and goals to anchor our conversations.

Council examined our essential core principles for working together. Council commits to being prepared, communicating openly, working unified, staying purposeful, and prioritizing SGIM. Similarly, SGIM staff are committed to workplace standards emphasizing respectful communication, collaborative teamwork, and transparent practices. These staff-developed principles create a supportive work environment. Until a few years ago, SGIM did not have such principles in writing; as words matter, I have updated the principles and will share them with SGIM leadership.

Dr. Bass welcomed Council to the SGIM office and provided a brief orientation. He highlighted the difference between governance and management—boards focus on oversight, strategy, and advocacy while management handles operations and implementation. This distinction extends to planning approaches. Strategic planning focuses on long-term vision and direction (governance), while operational planning handles execution and day-to-day priorities (management).

Building Community: Council

One of the most valuable aspects of meeting in person is fostering rich, in-depth discussions while building personal connections. These gatherings allow members to learn about each other and connect with SGIM staff who drive the organization forward.

I intentionally designed community-building activities that aligned with my leadership style. Throughout the meeting, I organized three exercises that were completed by small groups of two or three people. My strategy was to pair participants with different colleagues each time to maximize new connections.

The first exercise asked participants to introduce themselves, share a fun fact they're known for, and describe what superpower they would choose to possess and why. The second focused on professional pride, as participants shared a highlight or accomplishment from the past year that brought them joy. The third addressed growth through challenges, asking participants to discuss a difficult professional moment or failure, how they navigated it, and what they learned from the experience. The progression from personal introduction to professional celebration to learning from challenges creates a nice arc that helps participants connect on multiple levels.[1]

Building Community: Staff

To build community and connect with SGIM staff on a personal level, I partnered with SGIM President-Elect, Dr. Mark Schwartz, to conduct individual conversations with team members. Our goals were to get to know SGIM staff as people, learn about their roles in SGIM, understand their views on the greatest challenges and opportunities for SGIM over the next 1-2 years, and discover how SGIM leaders can assist them as they support SGIM members.

Since staff serve as the engine for our organization, understanding their perspective is crucial. Mark and I were pleasantly surprised by what emerged from these conversations:

- First, staff is dedicated to SGIM's mission, vision, and values, as well as to serving members and their patients. This work represents more than just a job for them—it's something they genuinely want to do because it fulfills them personally.
- Second, they value flexibility, professional development, and a positive work environment. Staff work in the SGIM office and remotely across multiple states and internationally, demonstrating organizational support for our valued team.

Our meeting with staff made Mark and I realize how lucky SGIM is to have these dedicated professionals supporting our organization.

Strategic Discussions and Moving Forward

Given artificial intelligence's (AI) expanding importance in medicine, I invited Dr. Byron Crowe, SGIM member and lead author of the SGIM white paper on AI published in JGIM,[2] to guide our strategic discussion. Small groups explored future AI priorities and member engagement strategies, generating lively discussion. Top priorities included securing seats with national organizations for responsible AI curriculum development, preserving humanistic care in electronic health records, leveraging relationships to develop guidance for use in medical education, and engaging members through AI content at meetings and practical "promptathons" (i.e., a competitive event where participants create prompts to solve challenges within a set timeframe).[3] Council decided to form a time-limited task force to guide our next steps in AI for SGIM; I am drafting the charge for the group.

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The discussion validated the decision by the 2026 Annual Meeting (#SGIM26) planning committee to incorporate content on practical applications of AI in GIM. The program will include special symposia and workshops focusing on AI, emphasizing practical applications, cautionary tales, and equity.

Council also reviewed key initiatives including results of the community forum held at the 2025 Annual Meeting as well as existing task forces. Additional details about these initiatives will be shared in upcoming SGIM communications.

The retreat concluded with discussions on operational matters, including the 2025 virtual meeting pilot results. The 2025 virtual meeting option generated $32,240 from 38 registrants, but cost $126,510, with overall low participation and mixed member support. Although this pilot effort did not yield the anticipated results, member feedback emphasized the value of in person attendance for the networking and collaboration. Council concluded the hybrid format was not financially viable for future meetings.

Conclusion

The June 2025 Council retreat showcased how intentional leadership and open communication drive innovation at SGIM. Through community-building, staff engagement, and strategic AI discussions, the retreat highlighted our commitment to transparent governance and serving members and their patients. I pledge to continue my intentional leadership and open communication with SGIM members, staff, and leaders.

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SGIM

Q & A WITH SGIM'S CEO AND THE CHAIRS OF THE 2025 SGIM ANNUAL MEETING IN FLORIDA

Eric B. Bass, MD, MPH; Dominique Cosco, MD, FACP; Thomas Radomski, MD, MS

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Drs. Cosco (dcosco@wustl.edu) and Radomski (radomskitr@upmc.edu) were Chair and Co-Chair, respectively, of the 2025 Annual Meeting Program Committee.

SGIM held its 48th Annual Meeting on May 14-17, 2025, in Hollywood, Florida. The meeting was held at a time when academic medical centers were reeling from the effects of new federal policies that threaten many aspects of SGIM's mission. Even though many SGIM members reported that their institutions recently imposed restrictions on spending for professional meetings, 2,694 people attended this year's meeting, the third highest in SGIM's history! To show my appreciation for the tremendous leadership of the dynamic duo that Dr. Jada Bussey-Jones invited to lead the meeting, I decided to interview that duo, Drs. Dominique Cosco and Thomas Radomski.

EB: How did you go about choosing the theme for the Annual Meeting?

TR: Our theme for this year's Annual Meeting was "From Ideas to Action: Catalyzing Change in Academic General Internal Medicine." There were three key areas we wanted to focus on that helped us arrive at our theme. First, we wanted to choose a theme that highlighted the big ideas and great work that academic general internists are engaged in all over the country. Whether it is in research, education, or clinical care, there's tremendous innovation going on in our divisions that we wanted to be sure attendees could disseminate. Second, this theme also incorporated advocacy in a way that focused on the actions we can take in our professional lives to improve the practice of medicine for both our patients and ourselves. Third, this theme also allowed us to invite plenary speakers whose life work could serve as an inspiration to all.

EB: What are the best examples of how the meeting addressed the theme?

DC: As Tom mentioned, our theme allowed us to invite plenary speakers whose work embodied advocacy in action and imparted keys to their success with the SGIM community. We were incredibly lucky to have such inspiring plenary speakers present at the 2025 Annual Meeting. Both Dr. Jim Withers and Dr. Mona Hanna shared their paths to advocacy and how curiosity transformed an idea into a permanent contribution to improve the health of patients and communities they serve. Florida Voices for Health illustrated how critical advocacy is in patient care and how physicians can commit support on local, regional and national levels.

EB: What was the most powerful and/or inspiring memory of the meeting?

TR: There were many! But I was particularly moved by our Plenary speakers—Dr. Jim Withers, founder of the Street Medicine Institute, and Dr. Mona Hanna, who brought to light the lead crisis in Flint, Michigan. Both speakers' presentations were especially compelling and beautifully encapsulated our theme in their work. In the presentation that Dr. Withers gave, the photographs and stories of people left an indelible impression of the tremendous impact of his compassion for people living on the streets of Pittsburgh. In Dr. Hanna's presentation, the story of how she became a fierce advocate for the people of Flint made me realize how much could be done if more physicians had the courage and passion to advocate for vulnerable communities.

EB: What do you appreciate most about the people who served on your Program Committee?

DC: Our Program Committee was integral to the success of the meeting. Every chair and co-chair embraced the responsibilities and magnitude of the work of their respective committees. What we most appreciated was the high level of engagement and creative ideas to continue to innovate and improve the Annual Meeting experience for the SGIM community.

EB: What is the most important advice you'd give to the Chairs of the 2026 Annual Meeting?

DC and TR: We are in great hands with our chairs for the 2026 meeting, but there are three tips that we would like to pass along. First, develop a cohesive theme that represents your vision for the meeting and be sure to use that theme to guide your decision making about programming. Second, empower your program committee members to serve in their roles. There's way too much

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work for the overall chair and co-chair to tackle on their own; therefore, effectively working with the program committee is crucial. Lastly, work closely with the SGIM staff! They will be your greatest asset in planning the meeting and bring a wealth of knowledge and experience to the table. SGIM

SIGN OF THE TIMES

TREATMENT OF HIV INFECTION IN TRANSGENDER PATIENTS: OPPORTUNITIES FOR TAILORED CARE

Aprotim C. Bhowmik, MD, MPH, EdM

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Many governments in the Global North (and some in the Global South) operate a healthcare system that offers priority treatment to people with means. In these areas, it is disadvantageous to be in poverty, incarcerated, unhoused, unemployed, or possessing other marginalizing characteristics. These populations are often oppressed by social systems, including the healthcare system, and are at increased risk of being adversely affected by diseases, such as Human Immunodeficiency Virus (HIV).

HIV is an infectious pathogen that can involve almost every system in the body. Because HIV can be such a debilitating disease, the healthcare community has been working to prevent and treat this infection for the past 40 years. Public health studies have found patterns in HIV epidemiology—specific populations are at increased risk of infection and require unique interventions for proper treatment. One such population is transgender patients who face an increased burden of HIV and have unique challenges with respect to testing and treatment. To better deliver appropriate treatment to these patients, SGIM members need to better understand the milieu that surrounds the HIV-positive transgender community.

Burden of HIV in Transgender Patients

Transgender is an "umbrella term that includes persons whose gender identity, expression, or behavior does not conform to societal gender norms associated with sex at birth."[1] This lack of conformity between traditional gender norms and sex assigned at birth has now become stigmatized, such that many transgender people are confronted with ridicule or public violence. Transgender people are documented to face significant stigma, discrimination, and violence from their local communities and families—and because of these societal challenges, they are more likely to be unemployed, unhoused, and/or incarcerated.[2,3]

But not all societies view transgender people in the same way. There are many in which a transgender identity is viewed as a "third gender," termed *hijra* in India, *katoy* in Thailand, and *two-spirit* in many Native American populations.[2]

In the United States, transgender people make up about 0.3% of the population but comprise approximately 2% of HIV cases.[3] Because many transgender people use hormonal therapy and/or turn to substance use due to stigma, they are likely to use needles for injection.[4] Other factors that increase the burden of HIV in the transgender population is their high rate of receptive anal sex, low rate of condom use, and high likelihood of participating in sex work.[2,3] For example, transgender women who are sex workers are four times as likely to have HIV than those who are not sex workers.[3] There is also a significant intersection of HIV with race, wherein Black/Brown

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transgender people are more likely to contract HIV and have difficulty with subsequent treatment. This challenge is exacerbated by Black/Brown transgender people lacking social supports relative to white transgender people.[2,3]

Testing and Treatment

How can these patients be treated appropriately if they face these challenges? For example, the unemployed cannot afford care, the unhoused cannot access care, the incarcerated rarely have opportunities to seek care, etc. The intersectional identities of transgender patients have prevented them from receiving proper HIV testing and treatment; as a result, there are few studies that have been done on HIV testing and treatment in transgender patients.

HIV testing is also host to significant bias. For example, testing is performed less often on transgender women due to a bias that only transgender men need to be tested.[5] This feature of testing makes transgender women more susceptible to long-term effects of untreated HIV. A challenge regarding HIV treatment is that pre-exposure prophylaxis (PrEP) is used less often due to patients not wanting others to see them taking PrEP.[5] Also, because of the adverse side effects from PrEP and/or post-exposure prophylaxis (PEP), transgender patients often become non-adherent, and are reluctant to visit a healthcare professional again in case others see them receiving care for HIV.[5]

LGBTQIA+-Specific HIV Clinics

There has been a trend in recent years to establish specialty clinics for populations with special needs, and LGBTQIA+ patients are a population that requires unique care. LGBTQIA+ clinics are now present as part of multiple academic institutions (e.g., Johns Hopkins, Harvard, and Stanford) as well as part of certain public health care institutions (e.g., New York City Health+ Hospitals). These clinics provide safe spaces for members of the LGBTQIA+ community to see physicians, separate from the stigma, violence, and discrimination that these patients often face in other healthcare settings. These spaces often have an increased gender diversity of healthcare providers, which has been identified as being a key support mechanism for transgender patients.[5]

Because transgender patients are understudied and the above clinics are relatively new, there are no longitudinal studies of the efficacies of LGBTQIA+-specific HIV clinics compared with existing clinics via cohort or case-control studies. Given the level of medical and social attention that these clinics provide, it is likely that linkage to care is increased and loss to follow-up is decreased.

However, there are areas for improvement. These clinics are not always partnered with housing shelters or jails/prisons where transgender people are disproportionately present. Transgender patients who have difficulty with their finances or with transportation might not be able to visit these clinics if they do not offer financial assistance.[5]

Takeaways

It is easy to be dismayed by the shockingly disproportionate burden of HIV in the transgender community, but LGBTQIA+-specific clinics that have allied healthcare professionals and interdisciplinary care for HIV treatment can be a source of solace for the medical and social needs of the transgender community. To ensure that these clinics are supported and sustained, it is crucial for us as SGIM members to refer patients to these clinics and encourage healthcare workers to study the healthcare outcomes of patients who visit these clinics. These sites provide hope that transgender patients can have appropriate support and safety to be assessed/treated for HIV, be adherent with their medications, and have a safe space to seek long-term care.

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SGIM

BRINGING TELEHEALTH TO OLDER ADULTS VIA A HEALTH SYSTEM-HOUSING PARTNERSHIP

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Introduction

The COVID-19 pandemic prompted a rapid shift to telemedicine as both a replacement and adjunct to usual in-person care. However, an estimate found that 13 million older adults (approximately 38%) in the United States were not ready to participate in video visits.[1] Inexperience with technology was the primary barrier. This divide exacerbates health disparities that already exist for older adults, particularly in underserved communities. One way to address these disparities is to bring health care and technology directly into these communities. A review of existing literature suggests a paucity of direct partnerships between municipal health systems and municipal housing agencies. This article describes a partnered program between our safety-net hospital system and local housing authority to bring telemedicine and technology to older adults and highlight lessons learned for organizations considering similar work.

Program Description

Denver Health and Hospital Authority is an urban, safety-net integrated healthcare system serving more than 200,000 patients annually, with nearly 65% covered by Medicaid or uninsured. We partnered with Denver Housing Authority (DHA)—a quasi-municipal organization that administers housing vouchers and provides low-income housing to more than 26,000 individuals in the Denver Metro Area—to bring digital health education to five of their senior and disabled residential communities. Our initiative was designed using community-based participatory research (CBPR) principles, a collaborative approach that actively involves community members, organizations, and stakeholders as equal partners in project development.[2] This ensured that our intervention was tailored, promoted participation, and utilized existing resources to encourage sustainability.

The initial needs assessment survey conducted with DHA residents and leadership led to a two-pronged intervention. In response to our survey, DHA residents expressed interest in telehealth and digital health tools, as well as health topics related to chronic disease management. As a result, we developed monthly in-person workshops on health topics, including hypertension and digital health, covering how to use the online patient portal, and when to utilize video visits. These workshops were facilitated by a physician paired with a virtual health navigation team. The second aspect of our intervention addressed the technology gap, both in access and digital literacy, experienced by many older adults. We installed a Cisco Webex DX80 (a one-touch videoconferencing device) in a secure "telehealth room" at each community site to facilitate access to video visits for individuals who lacked access to their own devices.

Building Trust and Consistency

Trust is a crucial aspect of CBPR that necessitates fostering long-term relationships.[2] Our team consisted of a physician lead, a virtual care operations manager overseeing a digital health navigation team, and a DHA on-site building coordinator at each housing site, who planned and coordinated programming. By seeing these dependable "faces" of our health system in person

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each session, DHA residents and staff could see this was truly a partnership, not just a one-time community event. DHA leadership supported having on-site building coordinators serve as the point of contact and promote the workshops within each community. These coordinators were crucial bridge-builders, as residents already had trusted relationships with them and saw them as the go-to people for various issues. For example, at the beginning of a workshop on hypertension, one coordinator called out to a resident playfully, "Hey, I know you're going to want to come, I know you deal with this!" Unfortunately, staff turnover, particularly in building coordinators, created challenges in maintaining engagement. Whenever a new coordinator was hired, it took time to form a bond with the residents, and we saw attendance at workshops fall during these transition periods.

Digital Literacy: Meeting Individuals Where They Are

Teaching older adults how to navigate digital aspects of health care was one of our central goals. Many residents required assistance with using digital tools, but each differed slightly in their knowledge and comfort gap. Therefore, we conducted our workshops *in person* to provide tailored "at-the-elbow" support and individualized our attention to address specific questions. For example, one resident had difficulty creating an online portal because she had never had an online account of any kind, while another easily set up her online patient portal but struggled to use it due to her illiteracy. In the second case, our navigator was able to teach her how to navigate her portal using the pictorial icons instead of relying on text. Our experience suggests that while older adults may struggle with technology, they are often still interested in learning. One memorable moment came when a resident excitedly demonstrated the process to a friend after being shown how to access his lab results through the online patient portal.

The installation of DX-80 devices in a "telehealth room" at each DHA community aimed to increase the accessibility of virtual care to individuals who do not own their own devices. Having an "all-in-one" device that a Denver Health clinician can directly video call bypasses the need for residents to 1) have their own device and 2) be able to log onto their online patient portals to participate in a video visit. Our model resembled CVS' MinuteClinics[3] or the VA's ATLAS[4] program, with rooms fully equipped with a scale, blood pressure cuff, and pulse oximeter to take routine vitals. Residents who tried video visits via the telehealth room were surprised at the ease of connecting and quality of the visit, "just like being at the doctor's office…without the wait!" However, in implementing this model, we encountered barriers to residents easily accessing the shared space, difficulty integrating appointment scheduling with the rest of the system, and low resident motivation to receive care in this manner.

Optimizing Time and Resource Allocation

For community-based partnerships like ours, sustainability is critical yet challenging. While the program has been anecdotally successful, it has also required a significant investment from the health system, including dedicated physician time, health navigator support, and equipment installation. Although financial outcomes were not a primary consideration of the project, they are an unavoidable reality. For example, reserving a half-day of physician time for virtual visits meant that unfilled slots could be perceived as lost revenue.

One key challenge initially was the low resident turnout at health education sessions and the high number of unfilled virtual telemedicine slots. To optimize future resource allocation, we have implemented a rotating lecture schedule, in which one monthly session is broadcast to multiple sites, thereby reducing the physician's time burden associated with traveling to multiple sites monthly. We also found that integrating interventions into previously existing community events can significantly increase attendance. As one site coordinator noted, "there's nothing like Bingo to get everyone involved!"

Additionally, we transitioned to a "virtual walk-in clinic" model following each workshop. This change consolidated virtual care appointments, eliminating some administrative challenges of scheduling appointments across multiple providers and sites while ensuring that a Denver Health staff member is present to facilitate the use of the telehealth room for patients. DHA recently hired digital health navigators who use building-specific resources to support both our program and broader digital health initiatives, which uses the resources of both organizations more efficiently. We anticipate that having staff closely available early on will enable residents and coordinators to better learn how to use the technology, allowing the program to become more sustainable.

Conclusion

Technology holds great promise for addressing health disparities, but its success depends on thoughtful implementation. Our experience demonstrates that integrating health systems within local residential communities can help bridge the digital divide for older adults. By combining health education, personalized digital literacy support, and tailored telehealth access, we have developed a program that is responsive to the specific needs of DHA residents. While challenges persist regarding sustainability and engagement, our evolving partnership with DHA underscores the importance of CBPR principles such as flexibility, cultural humility, and leveraging existing

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community assets. We believe our experience can serve as a model for SGIM members seeking to expand digital access and build meaningful, long-term collaborations with underserved populations.

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MEDICAL EDUCATION

RECOGNIZING THE DISTINCT EDUCATIONAL VALUE OF STUDENT-RUN FREE CLINICS: MORE THAN A PLACE TO VOLUNTEER

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In United States' medical schools, clinical exposure during the preclinical years is more emphasized and expected today. This shift reflects the priorities of both institutions and students. Medical schools recognize that early clinical exposure helps students explore specialties and make more informed career decisions. Many students enter medical schools with prior clinical experiences and are eager to return to the bedside with a foundational knowledge base.

While medical schools have been integrating more patient-facing experiences, such as shadowing or performance-based exams (PBE), into the preclinical curriculum, many students seek extracurricular opportunities, for example, volunteering in a student-run free clinic (SRFC). SRFCs are in most medical schools, commonly featured on medical school websites, and mentioned in prospective students' secondary applications. These clinics offer preclinical students the opportunity to conduct interviews, physical exams, and discussions of their findings and plans with interprofessional teams, all while providing culturally competent care for local underserved populations. In this article, we explore the educational value of SRFCs compared with other early patient-facing experiences and discuss the implications for curricular design.

Prior studies on SRFCs suggest they provide important educational advantages. Preclinical student volunteers report greater confidence in their knowledge, skills, and preparedness for clerkships.[1,2] Students also report higher levels of self-efficacy in caring for underserved patients and connectedness to their purpose.[3,4] Further, students are more likely to continue engaging with underserved populations and pursue careers in primary care fields.[4,5]

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A student-faculty research team at the George Washington University School of Medicine and Health Sciences invited first- and second-year medical student SRFC volunteers to complete a custom survey. The survey solicited students' opinions regarding six preclinical patient-facing experiences: SRFC, clinical apprenticeship program (CAP), physical diagnosis classes (PDX) with standardized patients (SP), formative objective structured clinical examinations (FOSCE) with SP, PBE with SP, and shadowing. For each activity, there were four core questions, each of which used a 5-point Likert scale to assess the following themes:

1. Clinical knowledge/skills enhancement
2. Overall educational value
3. Alignment with medical education goals
4. Value of patient/SP interactions.

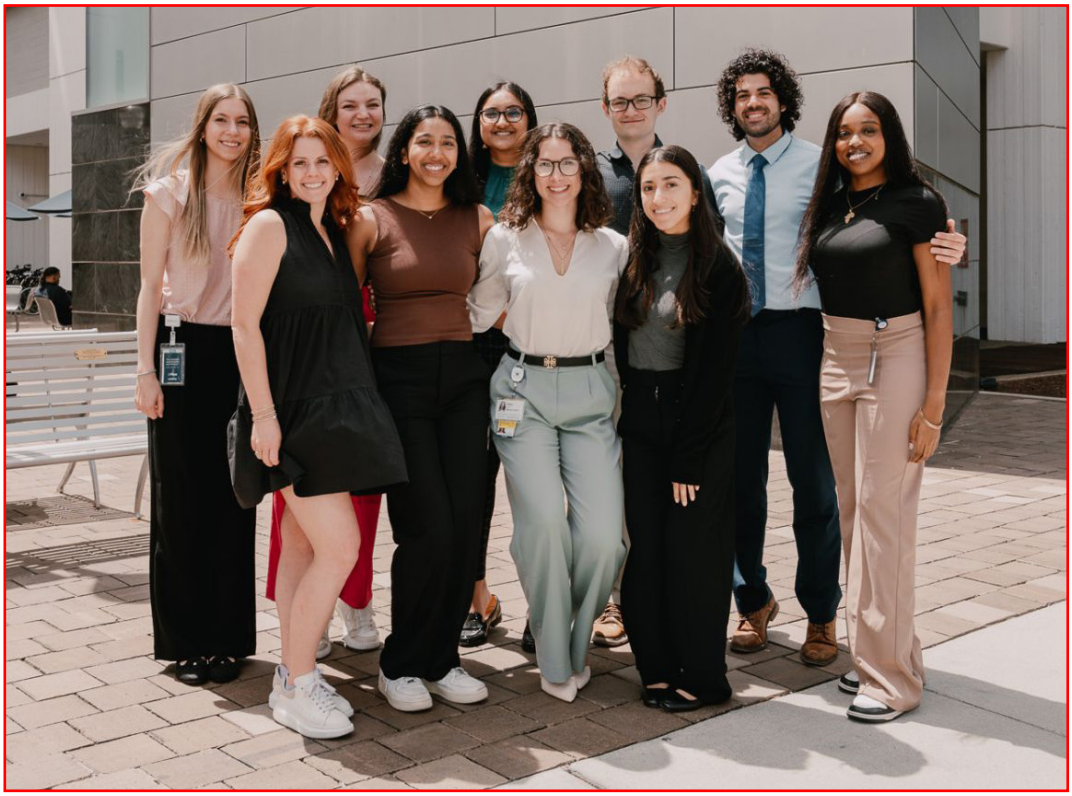
A final multiple-choice question asked participants to identify their "most rewarding" preclinical experience.

Thirty-two of 111 preclinical students (29%) completed the survey. Regarding their SRFC roles, 47% of respondents served as clinic managers, 34% served as patient navigators, and 19% served as translators. Forty-one percent of respondents completed five or more shifts at the SRFC during their first year of medical school, 13% completed four, 31% completed three, and 16% completed two or fewer.

Respondents rated SRFC favorably (defined as a 4 or 5 on the Likert scale) for knowledge and skill enhancement (56%), overall educational value (63%), alignment with educational goals (72%), and value of patient/SP interactions (72%). SRFC matched or exceeded other preclinical patient-facing experiences in favorability, except for PDX's overall educational value (69%). With regards to the "most rewarding" patient-facing experience, SRFC had the highest selection (50%), followed by shadowing (16%), FOSCE (13%), CAP (9%), PDX (6%), and PBE (6%).

Despite our study's small, single-institution sample and potential self-selection bias, the findings indicate that our students perceived SRFCs to be more educationally valuable than other preclinical patient-facing experiences.

This raises an important question for SGIM educators and leaders at medical schools: should institutions invest in SRFCs as structured, longitudinal learning environments starting in the preclinical years? Although some anticipated challenges with embedding SRFCs into the longitudinal curricula could include faculty and staff availability and operational costs, there are significant



(Student-run free clinic leadership committee at the George Washington University School of Medicine and Health Sciences.)

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positive outcomes to this institutional investment. SRFCs offer preclinical students unique learning opportunities often missing or not emphasized in the formal curriculum, allowing them to build clinical, interprofessional teamwork, and cultural competence skills.[1-3] Additionally, these clinics may foster students' clinical growth and encourage future careers in primary care.[4,5] Beyond the educational benefits, this investment may also lead to better continuity of care, improved patient outcomes, and stronger community partnerships.

We encourage SGIM members to consider these findings—and the preferences of your medical school applicants—when designing your students' preclinical curricula to meet evolving educational goals and healthcare needs. SRFCs represent a powerful opportunity to engage the next generation of physicians early, meaningfully, and in ways that prepare them for the clinical demands and social responsibilities of modern medicine.

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IMPROVING HEALTH CARE FOR OLDER ADULTS BY RECOGNIZING AND REDUCING AGEISM

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Introduction

More than one in six people in America are now 65 or older, a significant increase compared to prior decades.[1] Most clinicians, not just geriatricians, spend a significant amount of time caring for older adults. Ageism can play a role in how physicians see and treat their patients. A systematic review in 2020 showed that in 85% of the included studies, age was a determining factor in who received certain medical procedures or treatments, even after controlling for prognosis and care preferences.[2] Improving the medical care of older adults and creating a more inclusive society that promotes healthy aging demands attention to ageism.

The World Health Organization (WHO) defines ageism as the stereotypes (how we think), prejudices (how we feel), and discrimination (how we act) regarding others or ourselves based on age.[2] Ageism is pervasive in society. Per the 2019 University of Michigan National Poll on Healthy Aging, 82% of adults 50-80 years old experience ageism in their day-to-day lives.[3] This includes exposure to ageist messages in day-to-day-life (65% of older adults) and experiencing ageism in interpersonal interactions (45% of older adults).[3] About 15% of the older adults surveyed reported that others assume they do not do anything valuable or important.[3] A study published in *JAMA Network Open* in 2022 showed more than 80% of older adults reporting internalized ageism.[4]

Stereotypes involving older adults disregard the heterogeneity among this population, including that of physical capacities, cognitive function, social networks, and goals of care. Many studies looking at the impact of negative perceptions of aging show deleterious impacts on older people's health, including cardiovascular health, physical functioning, cognitive function, stress and psychiatric illness, longevity, and healthcare costs.[2]

The WHO released its 2021 Global Report on Ageism, which outlines an action framework to reduce ageism and includes specific recommendations.[2] This report emphasizes that "addressing ageism is critical for creating a more equal world in which the dignity and rights of every human being are respected and protected."[2]

Body

Efforts to improve the care of older adults demand attention to reducing ageism, which negatively impacts patient outcomes. Ageism can be divided into three categories: institutional, interpersonal, and internalized.[2] *Institutional ageism* occurs when an institution enacts actions and/or policies that are ageist.[2] Whether intentional or not, institutional ageism legitimizes the exclusion or inappropriate treatment of people based on age or age-associated assumptions. *Interpersonal ageism* is an undervaluing of an older adult's intellectual and/or physical capacities through interactions between two or more individuals.[2] *Internalized ageism* is self-directed, such as the belief held by some older individuals that they cannot or should not do something based solely on their advanced age.[2] These misguided assumptions damage individuals' self-worth and create apprehension about growing older. Acknowledging the presence of ageism is the first step to addressing it.

Five Simple Strategies to Integrate into Routine Care to Reduce Ageism

The medical community is increasingly recognizing the impact of ageism and the importance of promoting age-friendly care. The following strategies offer ways to translate need into action:

1. **Talk directly to the patient.** Ageist tendencies lead healthcare professionals to primarily address family/caregivers instead of the patient. To counter this, position the patient directly in front of you, with family/caregivers positioned aside or behind the patient. This keeps the patient at the center of the conversation, literally and figuratively. It preserves the ability of family and caregivers to cue you with vital information—collateral information as well as corrections to what patients report—without interrupting or upstaging the patient.
2. **Assess patients' functional age.** Ageism may play a role in both patients' self-imposed limitations and in healthcare professionals' underdosing or neglecting

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effective therapies. Avoid ageist-related underestimations of potential benefits and/or overestimations of the risks of interventions by assessing each patient's physiological, psychological, and social functioning. With patients' mobility a key factor in preserving function and independence, develop individualized strength-training programs that match the intensity of exercise to the patients' functional age. Real-time use of calculators and decision tools may help facilitate discussions regarding personalized risks and benefits of interventions.

3. **Explore patients' goals and priorities.** Avoid making assumptions based on age alone. Explore patients' values by asking what abilities patients deem crucial for a life worth living and what trade-offs they are willing to accept to prolong life (e.g., doctor visits, hospitalizations, side effects of treatments).
4. **Avoid elderspeak.** Use normal speech patterns when talking to older patients. Avoid elderspeak, a speech style characterized by excessively simple vocabulary and sentence structure, using the collective "we" (e.g., "We need to take a shower"), repeating phrases, and speaking excessively slowly. Elderspeak often sounds like baby talk with a singsong voice, and it includes terms of endearment like *honey or sweetie*. While not malicious in intent, this can come across as patronizing and exacerbates an unequal power dynamic. Using elderspeak worsens agitation and increases resistance to care in patients with dementia. One possible explanation for this is that elderspeak's implicit messages of incompetence conflict with patients' attempts to maintain a positive self-concept.
5. **Avoid age-biased language.** Adjust language to avoid words and phrases known to contribute to implicit and explicit bias. The American Geriatric Society (AGS) published a list of problematic words, including *elderly* and *senior citizen*, which carry connotations of frailty.[5] It offers alternatives, such as *older adults*. In broader discussions, AGS recommends avoidance of catastrophic terms like *tidal wave* and *silver tsunami*, and encourages the use of neutral terms, such as *the demographic shift in the US* or *the aging population*.[5] The hope is that encouraging bias-free language will help improve the public's understanding of what aging means and the many ways that older people contribute positively to our society.

These five simple strategies lend themselves to smooth integration into a busy clinical practice, with potential rewards for patients and clinicians.

While these five steps seem straightforward, distinguishing ageism from competent age-adjusted care presents challenges. Age matters. It must be considered because varying degrees of functional decline accompany normal physiological changes of aging (e.g., loss of muscle mass, presbycusis, and renal changes), and certain diseases are more prevalent in older adults (e.g., macular degeneration and dementia). Consequently, age-friendly care includes purposefully avoiding certain medicines in older adults, such as nonsteroidal anti-inflammatory drugs (due to increased risk of renal injury) and highly anticholinergic medications (due to increased risk of delirium). High-quality care depends on personalizing the risk-benefit ratio in every case, taking age into consideration as one variable in the equation.

Conclusion

Acknowledging and reducing explicit and implicit bias pertaining to ageism improves the ability of SGIM members to provide personalized care in an age-friendly manner. Using these five strategies helps to keep patients as the focus of the conversation about their care, avoid harmful assumptions based on age alone, and use language and speech patterns that avoid infantilizing older adults and catastrophizing aging. Policies and laws, educational initiatives, and enhanced intergenerational contact will help address ageism on a larger scale. These and other efforts aimed at reducing ageism in medicine are essential for improving the care of older adults while creating a more inclusive society that promotes healthy aging.

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