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SGIM FORUM

Society of General Internal Medicine

ANNUAL MEETING UPDATE

HIGHLIGHTS OF THE SGIM 2025 ANNUAL MEETING: CELEBRATING OUR TRANSFORMATIONAL IDEAS AND ENACTING MEANINGFUL CHANGE

Thomas Radomski, MD, MS; Dominique Cosco, MD

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On behalf of our colleagues on SGIM's 2025 Annual Meeting Planning Committee, we are delighted to offer a sneak peek into the 2025 Annual Meeting (#SGIM25) scheduled for May 14-17, 2025, at the Diplomat Beach Resort in Hollywood, Florida.

Our theme—*From Ideas to Action: Catalyzing Change in Academic General Internal Medicine*—presents an opportunity to highlight the ideas and innovative work our members and trainees have brought to fruition across all facets of general internal medicine, including clinical care, education, and research. We anticipate that attendees will be inspired by their fellow generalists' outstanding work and will leave the meeting with the skills necessary to transform their ideas into action and enact meaningful change in their health systems and local communities.

Our theme is exemplified by our two outstanding plenary speakers: Drs. Jim Withers and Mona Hanna. Dr. Withers is a Pittsburgh-based physician, pioneer in street medicine, and healthcare provider to the homeless population. Dr. Hanna is a pediatrician and public health advocate best known for uncovering the Flint, Michigan, water crisis which exposed lead contamination in the water supply. She authored an acclaimed book detailing her experiences and the importance of advocacy in public health.[1]

We are excited about several special symposia that align with this year's theme that demonstrate how we may translate ideas into action to address the changing healthcare landscape, including:

- *Recommendations on the Use of Generative Artificial Intelligence in Internal Medicine: Insights and Future Directions*
- *"Geriatricizing" the System: An Introduction to Age-Friendly Health Systems*
- *Implementing Trauma Informed Care for Diverse Populations: How Do We Actually Do It?*

We will also feature symposia that incorporate a variety of viewpoints on topics important to SGIM members, including:

- *Common Goals, Different Perspectives: Challenging Conversations Across the Aisle*
- *Ending Unequal Treatment: The Status of Health Equity*
- *Current State of Reproductive Rights: A Legal Primer and a Call to Action.*

In addition to the core programming, we highlight several new programming elements for the 2025 Annual Meeting, especially a virtual attendance option, the incorporation of a special symposium highlighting the

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BE A BETTER LEADER—MAKE A DIFFERENCE FOR THOSE AROUND YOU

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

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."[1]

In medicine, we are all leaders whether it be a formal role with a specific title or an informal role, such as leader of the healthcare team for a patient. We learn about leadership during our training and then refine our skills over our careers. In the 22 years since completion of my residency training, I served in many academic leadership positions. However, the biggest jump in leadership responsibilities arose when I became the chief of medicine at the Southeast Louisiana Veterans Healthcare System (VA) in New Orleans.

Hurricane Katrina created turmoil in the New Orleans healthcare systems. One of my biggest challenges was the unexpected leadership opportunities it afforded. Only six years out of residency, I became assistant chief of medicine at our VA. We were only a system of outpatient clinics at that time but there was a large hill to climb to open a replacement hospital. Then, 10 years out of residency, I interviewed and was selected as chief of medicine. The chief of medicine at a VA mirrors a chair of medicine at an academic medical center in many ways—one key similarity is that you lead multiple specialty sections and many different individuals.

Thrust into this unexpected opportunity, there were daily lessons to learn. Many would have been learned over an extended career before assuming a chief or chair position. I got the crash course version of expedited learning. There were many interactions and lessons learned that I have shared with my section chiefs and colleagues over the past 12 years.

I share the following top three areas that have made me a better leader during my tenure as chief of medicine:

1. **Employee Engagement.** Learn about your employees and what makes them happy (but only as much as they want to share). Each employee is different and what is critical to one employee may not be important to the next employee. Recognize that family comes first. Employees struggle to be present at work yet worry about a sick child, parent, or spouse. They

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STRENGTHENING THE FUTURE OF ACADEMIC GENERAL INTERNAL MEDICINE: SUPPORTING FELLOWSHIP PROGRAMS FOR LONG-TERM SUSTAINABILITY

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

"GIM fellows and fellowship programs are essential to the long-term sustainability and growth of academic general internal medicine. They provide the critical pipeline of skilled clinician-educators and clinician-investigators who will shape the future of GIM."

My journey into academic general internal medicine (GIM) was far from intentional.[1] I took a position at Grady Hospital with the hopes of simply being a good clinical doctor and providing care for historically marginalized patients. This job required a faculty appointment at Emory School of Medicine. Although medical school and residency had prepared me for clinical care, I realized I was unready for the skills required to succeed in academic medicine.

I realized that academic medicine offered joy and a sense of purpose that would keep me on this path. It was not just the opportunity to provide direct care and make a difference in the lives of individual patients; but academic medicine also gave me the chance to mentor future clinicians and change makers. Academic medicine also offered the potential to engage in discovery with the power to shape policy, influence medical education, improve clinical care, and impact society. After committing to all aspects of the tripartite academic mission, I sought additional training in the University of North Carolina Faculty Development Program in GIM. This two-year program, supported by the Health Resources and Services Administration (HRSA), enabled me to maintain a full-time faculty position while participating in intermittent but intense research, teaching, and leadership training.

For others, the pathway to academic medicine is more intentional, with GIM fellowship training immediately

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Q & A WITH SGIM'S CEO AND PRESIDENT ABOUT THE IMPORTANCE OF SGIM'S EXTERNAL RELATIONS IN DISRUPTIVE TIMES

Eric B. Bass, MD, MPH; Jada Bussey-Jones, MD, MACP

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Bussey-Jones (jcbusse@emory.edu) is the President of SGIM.

Since 2020, SGIM's Council has nurtured relationships with other organizations by following a framework that calls for each relationship to support one or more of our main organizational goals.[1] At the Council's retreat in December, I presented an update on our external relations and sought input on how to strengthen relations that would be most valuable in helping to address threats and opportunities in a political climate calling for disruptive changes in healthcare. After that discussion, I asked SGIM's President Dr. Jada Bussey-Jones to share her thoughts.

EB: What do you think about the current importance of SGIM's external relations?

JBJ: SGIM's relationships with other organizations are more important than ever because of the political climate that's calling for major changes in many aspects of the health system. Our voice will be stronger if we join forces with organizations that share our concerns and values. Although we may not be perfectly aligned with any other organization, it is critically important for us to collaborate with other professional societies as much as possible. Collaboration is particularly important when some groups are challenging the role of professional societies in addressing controversial issues directly or indirectly related to health care.

EB: How do external relations help address SGIM's goal of advocating for a just health system?

JBJ: We seek to partner with organizations that share interest in strengthening the primary care foundation of the health system and eliminating disparities in health care. Nearly all organizations with whom we collaborate have strategic priorities consistent with SGIM's vision for a just system of care in which all people can achieve optimal health.

One of our most important relationships is with the Primary Care Collaborative (PCC).[2] The PCC is a non-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care. SGIM has been an executive organizational member of the PCC since 2019. I have been very impressed by PCC's advocacy efforts and their commitment to incorporating SGIM's input in their efforts, generally working with members of our Health Policy Committee.

Our voice in advocating for a just health system is also enhanced by having a strong relationship with the American College of Physicians (ACP) which has a comprehensive vision for a better healthcare system.[3] Our advocacy efforts benefit from frequent communication with ACP's leadership and their strong health policy team. Similarly, we benefit from regular communication with leaders of the American Academy of Family Physicians (AAFP) which also has a strong health policy team committed to advocacy for primary care. Since becoming an organizational member of the Council of Medical Specialty Societies (CMSS) in 2021, we have had increased opportunities to collaborate with other societies on issues that plague the health system. Recently, we have sought to interact more with the Association of American Medical Colleges (AAMC) which has its own strategic plan for creating a healthier future for all.

EB: How do external relations help with the goal of fostering development of general internal medicine leaders?

JBJ: We collaborate with organizations that can help give members opportunities to enhance their career development. One of our most important partnerships is with the Society of Hospital Medicine (SHM). We recently renewed the agreement to work with SHM in running the Academic Hospitalist Academy (AHA). The Level 1 version of the AHA is designed for junior hospitalists pursuing academic careers. The Level 2 version of the AHA is designed to help mid-career academic hospitalists advance their careers and reputations. We also have a wonderful partnership with the United States Department of Veterans Affairs (VA) in offering a training program

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YALE PRIMARY CARE'S CHAMP: THE CASE FOR ADDICTION MEDICINE TRAINING TRACKS

Kenneth L. Morford, MD, FASAM

Dr. Morford (Kenneth.morford@yale.edu) is an assistant professor at Yale School of Medicine, program director of the Collaborative Behavioral Health and Addiction Medicine in Primary Care (CHAMP) program, and associate program director of the Yale Addiction Medicine Fellowship.

The current overdose and addiction crisis requires an "all hands-on deck" approach to expand effective care for individuals who use substances. As educators, it is imperative that we prepare future general internists to address substance use and related complications in a variety of settings, across a spectrum of severity, and aligned with an individual's unique treatment goals. This article describes the development of a specialty addiction medicine training track for internal medicine residents.

> **"Creating a specialty addiction medicine training track that combines outpatient and inpatient experiences can constitute a more robust approach to SUD education."**

As described in a recent SGIM Forum article, the Accreditation Council for Graduate Medical Education (ACGME) now requires all internal medicine residents to complete clinical experiences in addiction medicine.[1,2] Dr. Terasaki describes meeting these new ACGME requirements by focusing on inpatient addiction training and formalizing the educational structure of his hospital-based addiction consult team.[1]

Inpatient addiction training offers critical experiences in treating a variety of substance use disorders (SUD) and their acute complications; however, outpatient training is equally important. A decade ago, I was among the first cohort of Yale Primary Care Internal Medicine residents rotating in a newly formed outpatient addiction recovery clinic.[3] I learned how to prescribe medications for opioid and alcohol use disorders, apply motivational interviewing strategies, and provide harm reduction counseling. I was struck by how many patients were stable and thriving on evidence-based addiction treatment. This contrasted with my inpatient rotations where I admitted numerous patients presenting with complications of substance use. At the time, I was taught to stabilize the acute condition and facilitate discharge with no more than a list of outpatient resources to address their substance use. Not surprisingly, many patients were readmitted within weeks to restart the cycle.

As with other chronic conditions, SUD often requires longitudinal care. Outpatient addiction training allows residents to partner with patients over time, learn to adapt treatment plans, and manage chronic comorbidities often associated with SUD. Such experiences not only help dismantle the stigma that dehumanizes individuals with SUD as being behaviorally challenging when encountered in the hospital in crisis but also combat historically pervasive views that addiction cannot be treated.

Creating a specialty addiction medicine training track that combines outpatient and inpatient experiences can constitute a more robust approach to SUD education. Internal medicine residency programs have developed specialty training tracks in response to other public health emergencies. For example, several residency programs implemented HIV training tracks to equip physicians with specialized knowledge and skills to care for the growing population of people with HIV.[4,5] Inspired by this model and recognizing the magnitude of the current overdose and addiction crisis, the Yale Primary Care Internal Medicine Program established an addiction medicine training track in 2019. Supported by the Health Services and Resources Administration as part of a broader behavioral health training program called *Collaborative Behavioral Health and Addiction Medicine in Primary Care (CHAMP)*, it was named the CHAMP training track.

Each year, two residents are recruited post-match into the three-year CHAMP training track. The goals of CHAMP are to improve knowledge, skills, and readiness of select internal medicine residents to care for patients

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RESPONDING TO THE SACRED: MEANINGFUL MOMENTS IN THE LIVES OF OUR PATIENTS

Robert Jordan Hall, MD

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"This will be the last round, assuming the rhythm is non-shockable. Any objections?"

Silence predominated. A few heads nodded no. All eyes were fixed on the cardiac monitor, waiting intently as a mechanical CPR device pounded away on the stranger's chest.

"Pulse check."

The machine's pulsatile hum ceased; the weight of the ensuing moment almost tangible.

"No pulse. Asystole."

A quick ultrasound confirmed an akinetic heart.

"Time of death…"

So concluded nearly 90 minutes of fighting for this man's life. I knew from the beginning that his odds were not great. He suffered a cardiac arrest at home, and CPR had not been started until EMS arrived. When he got to the resuscitation bay, his lactate was greater than 20 mmol/L and pH was less than seven. After a few rounds of CPR, he somehow developed a shockable rhythm, and after a few more rounds of CPR accompanied by multiple pushes of epinephrine and shocks, his heart began to beat independently again. It didn't last though. Within 15 minutes, his heartbeat went from too fast to too slow, and blood pressure crashed despite continuous infusion of multiple vasoactive drugs. CPR started anew. We managed to get him back one more time, but a similar pattern predominated, and for the third time we started chest compressions. After several rounds without a shockable rhythm, CPR was stopped.

Even though I knew this man was unlikely to make it, the moment it was called I was overwhelmed by the significance of the moment. They say you'll never forget losing your first patient. As a medical student, how could I? The weightiness of that moment was near dissociating. My head was spinning, ears slightly ringing, scalp tingling, and arm hair raised on end. I had to take a walk while I figured out whether to cry, pray, talk to someone, or some combination of the sort.

There were several moments in medical school that the significance of a moment hit me like a wave, but almost none as heavily as this one. Almost none.

"Push! One, two, three, four, five, six, seven, eight, nine, ten."

The mom's cries diminished as she breathed a sigh of relief. After not too long the cycle started again.

"One, two, three, four…"

With every successive cycle the anticipation in the room grew until finally the moment came when mom's cries were replaced with the cries of a newly born child.

That moment too was a near out-of-body experience, as the weight of significance washed over me, provoking spontaneous tearing in my eyes and a difficulty catching my breath. It, too, had stopped time and conjured in me a feeling of both profound gravity and weightlessness.

From within the delivery room, it was almost as if I could see the future.

Beyond the smiling, tear-filled faces, there is a baby bringing joy to a mother and father as they marvel over the life they have brought into the world. There are excited siblings eagerly waiting at home. There is a baby meeting the extended family. Celebrating the holidays for the first time. A first birthday. Starting to walk. Starting to talk. Making friends in day care then grade school. Struggling with the transitions of puberty. Graduating from grade school. Figuring out how to overcome and learn from struggles and obstacles. Finding purpose in life. Making an impact on the world. Of course, all of this is more of a hope than a guarantee. But from within that room, it was the future I saw that washed over me like a wave.

From within the emergency department resuscitation bay, it was almost as if I could see the future.

The room grows silent. Machines are turned off, and a formerly animated body lays still. A spouse receives the news. Displayed in the face of the one who may have known him best is the significance of all that this man was—good and messy—mixed with the anticipation of what will no longer be. There are similar reactions as the rest of the family and friends receive the news. There are tear-filled embraces. Those he held dear reflect on and

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BUILDING THE RUNGS: USING CHANGE MANAGEMENT TO ACCELERATE ACADEMIC PROMOTIONS AT A COMMUNITY ACADEMIC HOSPITAL

Anjali A. Nigalaye, MD, MBA; Matthew A. Weissman, MD, MBA

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Introduction

Academic promotion serves as a vital pillar for fostering self-assurance, kindling passion, and earning recognition among faculty. However, faculty primarily focused on clinical practice, with additional responsibilities in education, quality improvement or administration, have frequently found themselves overlooked in climbing the academic ladder. This challenge may be exacerbated by the absence of appropriate tracks for those who may not secure grant funding or produce substantial scholarly work. Even within institutions offering suitable tracks, the complexity and obscure nature of the promotion process, coupled with a dearth of tangible incentives (e.g., compensation) have deterred many faculty. At Mount Sinai Beth Israel, we worked to change this paradigm. Our medical school had previously developed clear frameworks for promotion, with promotion linked to increased compensation. Nonetheless, we found that substantial faculty were mired in lower academic ranks, and junior faculty were largely unaware of their promotional options. In 2019, only 16% of the faculty in our department of medicine were full or associate professor, compared to 39% of internal medicine faculty nationally.[1] As leaders of a community hospital campus within a university academic health system, we declared it our mission to accelerate the rate of faculty promotion via an intentional framework of change.[2]

Light a Fire

Our academic department spent two decades as part of two different medical schools and health systems. The faculty composition included new hires and clinical staff from both institutions. Notably, senior faculty members were scarce, and turnover in both departmental and administrative leadership was frequent. Some divisions were closely integrated within the larger health system, allowing their individual faculty members to access broader research opportunities and mentorship. However, several larger divisions, like General Internal Medicine, remained hyperlocal in clinical responsibilities and teaching opportunities. Finally, the past decade had seen the departure or merger of several fellowship programs within the department, leading to further turnover among faculty. Amidst this structural flux, a notable inertia permeated around encouraging academic promotion.

Our initial strategy to overcome this inertia targeted the "low-hanging fruit"—faculty members at the assistant or associate professor rank with regional or national reputations who were clearly overdue for promotion. Many of these individuals possessed extensive *curricula vitae (CVs)* requiring minor reformatting. Obtaining their chair letters proved to be a straightforward process. With a gentle nudge, several of these "ripe" faculty members were successfully promoted.

Commit to the Cause

Building on this initial momentum, we elevated academic promotion to a central mission of the department and developed mechanisms for accountability. We appointed a dedicated associate chair of faculty affairs to spearhead the initiative. This role involved assessing current ranks, connecting with divisional leaders to identify existing mentoring processes and support mechanisms for faculty development, and determining barriers to promotion. The associate chair was also responsible for liaising with system leadership and the Appointments, Promotions and Tenure (APT) Committee to cultivate a deeper understanding of the promotions process. Progress was monitored and shared at departmental

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AN UNUSUAL CASE OF POST-OPERATIVE WEAKNESS: RECOGNIZING GUILLAIN-BARRÉ SYNDROME

Rachel Akers, MS; Sara Chitlik, BA; Michelle Sweet, MD

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A 57-year-old female with well-controlled diabetes, hypothyroidism on levothyroxine, and hypertension presented for a postoperative visit three weeks after uncomplicated lumbar surgery for chronic spondylolisthesis and herniated disc. She reported new-onset left leg weakness and buckling when standing and increased reliance on her walker due to feeling unsteady. She initially had an uneventful recovery but began experiencing these symptoms over the past week.

> **"This case adds to the growing literature that GBS can occur as a postsurgical complication and emphasizes the importance of early diagnosis by SGIM clinicians."**

The differential for new-onset motor weakness after lumbar surgery is broad, including nerve injury, root edema, cauda equina syndrome, infections, osteomyelitis, sepsis, hematoma, and hardware failure.[1] Demyelinating disorders, metabolic or electrolyte disturbances, myopathies, and polyneuropathies, although less frequent, should also be considered.

Physical exam findings on admission were notable for asymmetric motor weakness, characterized by 3/5 strength in the left iliopsoas (versus 4/5 on the right), 3/5 strength in the left tibialis anterior (versus 4/5 on the right), and 3/5 strength in the left extensor hallucis longus (versus 4/5 on the right). Strength was 5/5 bilaterally in the quadriceps and gastrocsoleus muscles. Deep tendon reflexes were normal throughout except for diminished Achilles reflexes bilaterally. Her gait was normal, and there were no signs of dysmetria. No muscle atrophy, fasciculations, or abnormal tone were observed. Sensory examination was normal, with intact light touch throughout L2-S1 dermatomes. She was afebrile, and all her vital signs were within normal limits. The surgical site was clean, dry, and intact. The remainder of her exam was within normal limits.

The distinction between the patient's motor weakness and preserved sensory function suggests that the underlying pathology primarily affects the motor pathways without involving the sensory nerves. This observation helps narrow the differential diagnosis to conditions that impact motor neurons or motor nerves rather than those that affect both motor and sensory functions.

Differentiating between peripheral and central nervous system involvement is crucial for accurate diagnosis. The focal, asymmetric motor weakness, normal reflexes (except diminished Achilles), and absence of upper motor neuron signs point to a peripheral nervous system cause. The physical exam suggests that the problem originates from peripheral nerves, nerve roots, or the neuromuscular junction rather than the brain or spinal cord. The initial diagnostic approach should focus on ruling out common etiologies of conditions post-operatively, including infection with a complete blood count (CBC), metabolic etiologies with a comprehensive metabolic panel (CMP), and surgical complications with imaging.[1]

Laboratory workup showed mild hyponatremia (135 mmol/L), an elevated random glucose level (172mg/dL), and mild normocytic anemia (hemoglobin 12.8 g/dL, mean corpuscular volume 88.2 fL). No additional abnormalities were identified on the CMP or CBC. TSH was measured as 0.193 µIU/mL, CK was 48.0 U/L, and HbA1c was 6.5%. Subsequent imaging, including MRI of the lumbar, cervical, and thoracic spine and the brain, revealed no structural abnormalities or evidence of infection.

The laboratory findings help narrow down potential causes of the patient's weakness. The low TSH level of 0.193 µIU/mL (reference range 0.35-4.94 µIU/mL) is notable given her known hypothyroidism treated with levothyroxine, suggesting over-replacement. However, she lacks typical symptoms of hyperthyroidism, making

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PROMETHEUS AND MODERN MEDICINE: ILLUMINATING HUMANITY THROUGH THE FIRE OF SUFFERING AND HOPE

Emma Fenske, DO

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I first met "Mrs. S" in the emergency department while admitting her to the general medicine service. She had fallen and struck the side of her head. Although this was her presenting complaint, her head injury eventually took a backseat to a more pressing concern: treating and identifying the cause of bacteremia in this patient with a history of a mechanical heart valve for aortic stenosis. The initial assessment spiraled into something more intricate—a reminder that in medicine, a single symptom often unravels a deeper, multifaceted story.

That week, I spent considerable time in her room. We discussed the need for a transesophageal echocardiogram, debated the balance of diuretics to manage her volume status, and revisited her treatment plan at every turn. It was not just the clinical details that kept me at her bedside; it was the connection we formed. Having worked in health care herself, she understood the language of medicine and I correspondingly felt a sense of relief in "talking shop" with her. "Water pills" became "furosemide," and the "camera down the esophagus" was easily translated into a "TEE." This shared vocabulary made communication smoother, but it also brought quiet pressure. I was not just caring for a patient; I was caring for a peer, someone who understood the intricacies of medicine from the inside. The unspoken expectation of mutual understanding hovered between us.

One morning, as the sun cast a rosy hue over the city skyline, I answered her and her family's questions. We moved from medical explanations to more personal reflections, and I noticed an exhaustion in her eyes, the weight of days spent in the hospital. Before I left, she flashed her famous smile and said, "Thank you for being so awesome." I have often dismissed such comments, perhaps because of the imposter syndrome that clings tightly during training. Though in that moment, her sincerity struck me. There was no pretense, no performance; it was a genuine expression of gratitude from someone who understood how difficult it is to be both compassionate and competent in medicine. Her words lingered with me longer than I anticipated, leaving me with an unexpected reassurance.

Later that day, I was paged to her bedside. She had developed low oxygen saturations after a brief walk to the bathroom. The acute change concerned me as she had what was previously considered slowly, but insidiously, accumulating pleural and pericardial effusions. I rushed to her side, ultrasound machine in tow, and began searching for the critical information that could explain the decline. My heart raced as I moved the probe across her chest, praying I would not find any signs of worsening fluid or a dangerous shift in her pericardial effusion. Thankfully, there was no worsening fluid accumulation and no tamponade. I explained my findings to her and her family, addressing their detailed questions. Before I left, she looked at me with concern in her eyes and asked, "I'm not going to die today, am I?" My response was immediate: "Not today. I'll see you in the morning."

But circumstances and clinical contexts in medicine, as they often do, took a turn. The next morning, I received a sign-out from the covering night team: "Worsening hypoxia, diuresed, transferred to the ICU for BiPAP." Though relieved that my earlier assurance had held true, I could not shake the growing concern that it might not continue to be the case in the coming days. Her name remained at the top of my patient list the next morning, and the next, as if I still held some unspoken responsibility to see her through. Even after she transferred to the ICU, I reviewed her chart with the same meticulous attention I had when she was under my care. I visited her bedside, held her hand, and promised to follow up, even as the ICU team took over most of her care. Her family trusted me enough to ask what questions they should bring to the doctors during rounds—a small act of faith that felt like an honor.

One morning, as I checked her chart for updates, her name and picture had been grayed out, a cold, sterile fea-

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following internal medicine residency. GIM fellowships provide one or two years of advanced training to equip fellows with the skills necessary to thrive as clinician-educators or clinician-investigators in academic general internal medicine. These programs are not accredited by the Accreditation Council for Graduate Medical Education (ACGME) yet play a key role in strengthening the pipeline of future general internal medicine faculty.

The History of GIM Fellowships

A 1966 report establishing the need for more primary care physicians prompted rapid increases in family medicine residency programs and trainees but there was slower responsiveness in internal medicine, which remained specialty driven.[2] Although fewer than 5% of teaching hospitals had distinct sections of GIM in 1966; this number expanded to 77% by 1979.[2] These GIM programs were focused on and supported by their clinical and educational missions. The first GIM fellowship programs in the United States were established in the early 1970s to address the growing need for academically trained physician leaders driven by increasing recognition that internal medicine required not only clinical competence but also skills in education, leadership, and research.

The number of GIM fellowships has continued to increase driven by expanded roles for GIM faculty in health services and translational research, education, and quality improvement. In addition to institutional based programs, there are several national programs, such as the Veterans Affairs (VA) Health Systems Research Fellowships, VA National Quality Scholars Program, and the National Clinical Scholars Program. Programs vary widely in their content and approach, but most have the goal of training general internal medicine fellows to serve as future faculty, leaders, and change makers in GIM.

Despite the recognized value of GIM fellowships, fellows face challenges. Essien et al highlighted that balancing the demands of rigorous coursework, clinical duties, research obligations, and personal time can be difficult during fellowship training.[3] This article also explored key factors that contribute to success in a GIM fellowship, including a sense of purpose and passion, mentorship, and career development strategies for securing an academic GIM position.

SGIM's Role in Supporting GIM Fellowships

I believe that SGIM can play a pivotal role in supporting the success of GIM fellows and their programs. In 1994, SGIM published a policy statement outlining recommended principles and guidelines for GIM fellowship training.[4] In 2021, SGIM refocused its attention on fellowship training with a survey developed by the research committee to assess and address concerns regarding the future of academic GIM, with a particular focus on the research workforce.[5] The survey also inquired about how SGIM can help its members maintain long-term investigator careers in academic GIM and simultaneously support research fellowship directors. The survey was distributed to current and former GIM research fellows and fellowship directors.

A task force was charged with responding to the highest priority recommendations resulting from the research committee survey. These tasks include developing or improving the following:

- A website compendium of GIM research fellowships
- An updated listserv of GIM research fellowship program directors
- A career center with job postings for GIM fellows
- A GIM Connect pathway to link program directors and fellows
- Additional training and career development opportunities at SGIM meetings.

The task force efforts will support a community around GIM research that spans career stages to strengthen the pipeline of GIM research faculty.

The Progress of the GIM Fellowship Taskforce

Nisa Maruthur, MD, MHS, was asked to chair this current committee. Other members include Janet Chu, MD, MPH, MAS; Ryan Kane, MD, MPH; Neda Laiteerapong, MD, MS; Aaron Parzuchowski, MD, MPH, MSc; and Mara Schoenberg, MD, MPH, representing current and prior GIM fellows and GIM Fellowship Program Directors. Arleen Brown, MD, PhD, represents SGIM Council and Erika Baker is the SGIM staff liaison. The task force is working to build a dedicated fellowship page on the new SGIM website[6] that will feature comprehensive information on GIM fellowships including why pursuing a GIM fellowship is a valuable option. The site will also provide up-to-date details on active GIM fellowship programs.[7] Additionally, the SGIM website will link directly to fellowship programs to ensure the content remains current.

The task force is working to enhance programming for GIM fellows at the SGIM Annual Meeting. The 2025 Annual Meeting (#SGIM25) will again feature the highly regarded fellows' pre-course. There are also plans to pilot a new "Fellows Poster Walk and Talk" initiative to highlight the work of GIM fellows and display their posters. Volunteer faculty, including members of the Fellowship Directors Interest Group, will have dedicated opportunities to engage intentionally and meaningfully with fellows at their poster presentations. To further increase engagement, the program planning committee is making a deliberate effort to avoid scheduling GIM Fellowship Program Directors and GIM Fellowship Interest Groups at the same time. The task force will

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memorialize him. Some move on quickly while others much slower. Those closest to him grapple with what it looks like to continue living without the man that had occupied a place of such significance in their life. Eventually resolution comes, the finding of a new normal, and gratitude for the good memories that linger. The reality will undoubtedly be much messier than this. But from within that room, it was the future I saw that washed over me like a wave.

As I reflect on my experiences in medicine, the word that feels most adequate to describe them is *sacred*.

Beyond the religious connotations of the word, it can be defined as something that is "highly valued and important" and "entitled to reverence and respect."[1] But why do we value the things we value? Could it be because of the meaning and significance those things represent?

> **"As I reflect on my experiences in medicine, the word that feels most adequate to describe them is *sacred*."**

Could it be that we regard as sacred those things that are imbued with meaning beyond the ordinary?

How do people respond to the sacred? Initially, we may be unsure of how to respond as we're overwhelmed by a tangled web of emotion. Some stayed silent, some bowed head or body, some removed their shoes. After the initial uncertainty clears, we may be left with a path to walk, a sense of direction, a calling. But what happens after years and years of treading sacred ground? These experiences can either move us to an abiding gratitude that continues to propel us or we can let the extraordinary turn ordinary.

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also work with the program committee to include best practices for fellows to get the most from the annual meeting.

In addition to these innovations, several other ideas are being explored for the future. One key initiative is the introduction of fellows' programming at all regional meetings, aimed at promoting networking and professional development. Another proposal is to create enhanced longitudinal programming between SGIM meetings for GIM fellows, which could include didactic sessions as well as professional and career development opportunities. This programming would provide a valuable space for a smaller group of fellows to network and grow professionally as a connected group. Importantly, SGIM continues to advocate with HRSA and other funding organizations to secure additional resources for research fellowships along with research funding in general.

In summary, GIM fellows and fellowship programs are essential to the long-term sustainability and growth of academic general internal medicine. They provide the critical pipeline of skilled clinician-educators and clinician-investigators who will shape the future of GIM. SGIM has already taken significant steps to support and strengthen these vital resources, but our commitment does not end there. SGIM will continue to build on this foundation to explore new ways to further empower GIM fellows and fellowship programs, ensuring academic general internal medicine remains robust and thriving for years to come.

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in "partnered research" that enables investigators to engage healthcare system leaders when conducting research on problems in health care.

EB: How do external relations help with the goal of promoting scholarship in person-centered and population-oriented approaches to improving health?

JBJ: We nurture relationships with professional societies and governmental agencies that can help stimulate innovative scholarly work. A prime example is the project led by SGIM members, Drs. Cristina Gonzalez and Monica Lypson, that was part of the CMSS Diagnostic Excellence Grant Program. Drs. Gonzalez and Lypson engaged SGIM members in developing an educational intervention to mitigate racial disparities in diagnostic decision making.

By strengthening our relationship with the Alliance for Academic Medicine (AAIM), we created opportunities for SGIM's educators to provide input on national policies in the continuing evolution of undergraduate and graduate medical education. Through participation in AAIM's Internal Medicine Educational Advisory Board, we have had great opportunities to interact closely with other stakeholders in internal medicine education, including the AAMC, ACP, SHM, American Board of Internal Medicine, Accreditation Council for Graduate Medical Education, and Intealth.

Our Health Policy Committee continues to be extremely active in advocating for funding of primary care research, health services research, and disparities research by the Agency for Healthcare Research and Quality, National Institutes of Health, Patient Centered Outcomes Research Institute, and the VA. In addition, SGIM's Research Committee has had a valuable role in providing input on priorities of the research funding agencies.

EB: What is your overall assessment of the state of SGIM's external relations?

JBJ: SGIM has greatly strengthened its voice by nurturing strong relationships with many professional societies and governmental agencies. These relationships will be extremely valuable as we face new threats and opportunities in a climate calling for major changes in the healthcare system.

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ture of the electronic medical record that immediately signals a patient's passing. My stomach twisted into knots, the finality of her grayed-out name hitting me with an unexpected force. This was how my second year of residency ended: not with a clear sense of accomplishment or relief, but with the loss of a patient I had grown close to.

As I began my third and final year of residency, I found myself carrying this case with me longer than anticipated. The medical facts were straightforward: bacteremia, heart valve concerns, oxygen desaturations. But it was the emotional residue—the human connection—that lingered. I had learned the technical aspects of medicine through countless cases, but it was in these quieter moments of humanism and advocacy that I felt the weight of what it means to be a physician.

In the end, even though modern medicine could not save her, I was reminded that humanism and advocacy are often the most powerful tools for physicians. Despite the outcome, I take solace in knowing that I did everything possible to make her feel seen and cared for in her final days. Medicine is often framed as a battle between life and death, between diagnosis and treatment. But there is an in-between—a space where connection, comfort, and understanding are the only things we can offer. And they are enough.

This experience reaffirmed that the true practice of medicine is more than procedures, medications, and tests—it is about recognizing the patient as a whole person. This is often the most challenging part of the profession. In many ways, I felt like Prometheus. Though, instead of stealing fire, I was stealing borrowed time to give my patient moments of hope despite knowing I could not control the outcome. I found these small moments of sacrifice are always worth it. Each time I choose to connect with a patient, to sit with them through their suffering, pain, or uncertainty, I affirm my role as both healer and human.

As I approach the end of my residency and the beginning of my career, I carry this lesson with me: even when our medical interventions fall short, we can still make a profound difference in how our patients experience their final days. In the end, this is what I will remember most.

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leadership meetings and with division chiefs and system leadership. By committing time and human capital to advancing faculty promotions, we placed this initiative at the forefront of our departmental priorities.

Give Clear Direction

In assessing the barriers to promotion, we noted a significant lack of understanding among faculty about the benefits of promotion and the application process. We also learned that most faculty members either undervalued their accomplishments or did not know how to frame their achievements in a way that felt promotion-worthy.

To address this, we prioritized providing clear direction and a simplified process. We created a localized "promotions checklist" and built a roadmap highlighting key contacts, documents, and timelines to guide applicants along their path. Collaborating with divisional leadership ensured targeted dissemination of this material to faculty members who were ready to embark on the application process. The associate chair played a pivotal role by offering personal coaching and accountability.

Appeal to the Heart

Motivating faculty beyond providing direction involved a focus on messaging and culture. The most effective strategy was hosting regular CV workshops for all departmental faculty. What was typically a solitary, "behind closed doors" chore of drafting and upkeeping one's CV was transformed into a collaborative and enjoyable group activity that crossed divisional lines. We invited faculty of all rank and divisions and encouraged them to bring their current CVs for unfiltered advice. This created a spirit of inclusivity and underscored our deep commitment to supporting the entire department. By inviting system departmental leadership, such as vice chairs and faculty development experts, to host the workshops, we reinforced the attainability of promotion and the broad support for accomplishing it.

We used videoconferencing with break-out rooms to foster a hands-on, intimate experience where faculty members could comfortably share their CVs among a small group led by a faculty affairs expert. This approach was also a tangible way to give direction—we were able to provide real-time feedback to faculty members on the readiness of their CVs while also learning about professional development activities we needed to develop to address gaps. We noted that deficiencies were often in obtaining regional reputation where faculty had not accessed the appropriate forums to share locally developed innovations. While many faculty members were recognized for teaching excellence at our site, they lacked broader reputations for their accomplishments in medical education. In these instances, we tried to circle back with faculty members after the workshop to make the necessary connections, suggest opportunities for speaking engagements, and provide departmental sponsorship for awards and wider recognition.

We found that several faculty members had met the requirements for promotion through varied outputs (such as a community outreach or regional committee involvement) but had omitted these elements from their CVs or miscategorized them due to misconceptions about these accomplishments not meeting academic standards. The direct feedback provided during the CV workshops helped faculty members recognize that they were farther along the promotions path than initially perceived and that the goal was within reach. This is a motivating technique and helped nurture internal accountability and a sense of progress.

Keep it Going

Using direct coaching, clear roadmaps, and motivational workshops we were able to help a significant number of faculty get promoted. In 2019, associate professors composed 13% of our faculty and only 3% were full professors. By 2023, this increased to 23% and 10%, respectively. Notably, a majority of promotions were faculty who identified as women.

Celebrating each win was integral to sustaining momentum—we ensured that each promoted faculty member was featured in our monthly departmental newsletter and congratulated by the system departmental chair and vice chairs. Additionally, mentorship pools of recently promoted faculty were established to foster a herd effect, thus encouraging ownership of the mission among the broader faculty.

Conclusion

We believe that through tangible and thoughtful process improvements—like climbing the rungs of a ladder—we have instilled a culture of accessible and attainable professional development within our department with a distinct priority on academic promotion. These strategies helped our faculty highlight the value of their work and served as a reminder to reflect upon and appreciate our successes and take appropriate credit. These change management strategies are beneficial in different healthcare organizations fostering many different types of change. By applying those same principles to their department, division, or project, SGIM members can improve their workplace culture and help their faculty climb to the top.

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with SUD, as well as to support individual career trajectories. This is achieved via diverse outpatient and inpatient clinical experiences, small group and didactic educational activities, teaching opportunities, and mentorship.

The core aspects of CHAMP include the following:

Clinical Experiences

Outpatient (Years 1-3):

- A longitudinal primary care panel that includes 50% of patients with SUD and other behavioral health needs
- Two half-days weekly in the Yale Primary Care Addiction Recovery Clinic and one half-day weekly at a community-based opioid treatment program during ambulatory rotations
- Elective half-days at a Transitions Clinic for recently incarcerated patients and as part of a Street Medicine team.

Inpatient (Years 2-3):

- Two-week rotation on the Yale Addiction Medicine Consult Service each year.

Educational Activities

Outpatient (Years 1-3):

- Weekly small group training in motivational interviewing and cognitive behavioral therapy through clinical supervision with a licensed clinical psychologist
- Monthly addiction medicine grand rounds, journal clubs, and research-in-progress meetings.

Teaching Opportunities

Outpatient/Inpatient (Years 1-3):

- Noon conferences on addiction medicine topics
- Small group addiction medicine workshops for medical, nursing, and physician associate students.

Mentorship

Outpatient/Inpatient (Years 1-3):

- Pairing with a faculty advisor board-certified in addiction medicine who provides guidance and support throughout training.

The CHAMP training track has generated significant interest, aiding in recruitment and offering broader benefits to the residency program. As of July 2024, six residents are enrolled in the track and six have graduated. CHAMP residents serve as addiction medicine consultants and educators, promoting culture change and enhancing the training environment to embrace compassionate care of patients with SUD. The track has also proven to be an effective pipeline to addiction medicine fellowships. Notably, four of six graduates pursued addiction medicine fellowships, and another graduate plans to pursue both addiction medicine and palliative care fellowships.

Despite these early successes, the CHAMP training track has limitations. Demand from residents to join the track or electively rotate at CHAMP training sites exceeds our current capacity. The track requires established clinical addiction treatment sites staffed by trained faculty who often have competing responsibilities. Additionally, it is dependent on time-limited grant funds, emphasizing Dr. Terasaki's call for more monetary and logistical support to sustain such addiction training programs.[1]

While these challenges may seem daunting for SGIM educators in internal medicine residency programs who are interested in replicating this model, the CHAMP training track demonstrates an opportunity to "start somewhere." Developing a training track with even a few residents can provide an addiction training infrastructure with the potential to grow and positively influence the broader program.

The CHAMP training track combines a robust outpatient addiction medicine curriculum with the inpatient-focused training reported by Dr. Terasaki,[1] equipping residents with skills to care for patients with SUD along the spectrum of severity and partner with them to achieve individualized treatment goals. By integrating a similar model into their residency programs, SGIM educators can prepare the next generation of internists to address the ongoing overdose and addiction crisis.

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will find it hard to do their job and be a concerned parent, spouse, etc. Meet regularly with your employees and help them plan a future that meets their needs. Charting a course for their future keeps them engaged and motivated with a future within your work group. Employees want to feel valued.

2. **Crisis Management.** Overcommunicate on tough decisions. Although you may not be able to share everything, the more you can share, the more trust is built; employees will be more likely to understand a decision they do not like if it is put in a larger context. Ask your employees to bring solutions to you, not just the problems. This empowers employees to seek solutions for change and encourages them to speak up. It also ensures that you work positively with the employee to address their concerns instead of cringing every time they request a meeting. It is critical to never rush a meeting with an employee that needs your time and attention. Their need is important and no matter how busy you are, most things can wait the time necessary for you to assist your employee. They will appreciate your time and will be grateful that you were there when they needed you.

3. **Resource and Praise Your Employees.** Know what your employees are doing and empower them, but don't micromanage. Provide the resources they need to do their job—if they need resources that you cannot provide, rethink the "ask" you have of that employee. Sing their praise for a job well done. They will work harder and be more engaged when they are recognized. Stand up for your employees and protect them when appropriate. Do not allow others (no matter their position) to challenge your employee's credibility, work ethic, etc., if you know otherwise—you will be appreciated by employees who know you will have their back. Be available as a mentor, but make sure you are not their only mentor. As their leader, you may have difficult decisions to make that are not in their personal best interests but are beneficial for the larger group. An external mentor might provide guidance to them on how best to handle this.

Leaders often struggle with the many challenges that come with being a leader. My leadership journey reflects the lessons I shared. Success as a leader comes from being a great leader as opposed to a good leader. Adam Grant, successful author and psychologist, notes: "Good leaders build products. Great leaders build cultures. Good leaders deliver results. Great leaders develop people. Good leaders have vision. Great leaders have values. Good leaders are role models at work. Great leaders are role models in life."[2]

SGIM has many great leaders. Do you want to join their ranks? What can you do to be a great leader?

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thyroid dysfunction less likely as the cause of her motor weakness. Low-normal sodium (135 mmol/L) is unlikely to cause significant neurological deficits. Mild normocytic anemia (hemoglobin 12.8 g/dL, MCV 88.2 fL) does not explain the acute motor symptoms. Additionally, normal CMP results and absence of elevated creatine kinase levels effectively rule out causes such as postsurgical thyroid dysfunction, postsurgical rhabdomyolysis, electrolyte imbalance, and renal dysfunction as causes of her weakness. With negative imaging findings, primary causes of postsurgical weakness such as nerve root edema, hematoma, infection, hardware failure, and disc herniations were deemed unlikely.

The diagnostic focus should shift to less common neuropathic etiologies, including inflammatory myopathies, demyelinating diseases, and nutritional deficiencies, after common entities are ruled out.[2] Some conditions on the differential diagnosis include amyotrophic lateral sclerosis, multifocal motor neuropathy, sensorimotor neuropathies, inclusion body myositis, and chronic inflammatory demyelinating polyneuropathy. When a neuropathic etiology is suspected, electromyography (EMG) and lumbar puncture are commonly performed tests to narrow the diagnosis. A psychiatric component, such as somatic symptom disorder or conversion disorder, should be considered when all organic causes have been ruled out.

A thorough clinical history of our patient revealed no risk factors for psychiatric components or vitamin deficiencies (e.g., alcoholism, anorexia nervosa, dysphagia, malabsorption/impaired digestion, and veganism/vegetarianism). With no significant findings on initial

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winners of our Regional Meeting Teaching Competitions, and a new process for selecting pre-courses developed and submitted by our SGIM members.

We are excited to pilot a virtual option for those unable to attend the in-person meeting. This option will include the ability to livestream each plenary presentation; clinical practice updates in primary care, hospital medicine, and medical education; and several special symposia. Participants will be able to submit questions in real time via Slido to maximize their participation. Mentoring opportunities will be available, and additional programming will be accessible via GIMLearn after the meeting. To ensure that our West Coast SGIM members can attend each virtual session during their regular workday, our plenary presentation will be the first virtual session of each day and will take place starting at 10:45 am EST, with all other virtual sessions scheduled afterwards.

This will be the first year we feature the winners of each SGIM region's teaching competition. In 2019, the inaugural teaching competition was held by the Mid-Atlantic Region to highlight the innovative teaching approaches of our clinician-educators and trainees.[2,3] After the pandemic, the Education Committee revived the teaching competition in conjunction with the Southern Region, and it is now a staple of each regional meeting. We will highlight this year's winners at a special symposium entitled *Rising Stars in Med Ed: A Showcase of SGIM Regional Teaching Competition Winners*. Through this symposium, we will highlight the innovative teaching methods our rising star educators use across our six SGIM regions.

This year, we had our first open call for pre-courses where submissions were reviewed and selected by the planning committee. We will offer pre-courses that have been long-standing favorites, including a pre-course focused on POCUS skills and another that is focused on the career development of our General Internal Medicine Fellows. We will also offer two new pre-courses: *Curriculum on Improving the Diagnostic Process through a Lens of Health Equity: A Train-the-Trainer Pre-Course* and *Building a Health Law, Policy and Advocacy Curriculum*.

Another highlight will be this year's advocacy focus: *Promoting Equitable Access to Care Across Our States*. New this year, a video booth will be available during the meeting so that members may provide physician testimonials to ensure that their voices inform advocacy efforts in Florida and elsewhere. Our Saturday morning plenary session will include a panel of local Florida health policy and advocacy leaders who will inspire us to enact change and overcome laws and policies in our local communities that run counter to SGIM's organizational values. We are excited to feature the findings of a research study from Georgia medical students regarding their statewide survey about the decision to practice in a state that did not expand Medicaid.[4] Please be sure to check out the upcoming March 2025 Forum to learn more about our advocacy programming.

We are planning to incorporate an array of programming dedicated to students, residents, and fellows, including a career planning panel, a curated guide to help students, residents, and fellows identify workshops and other sessions that are most pertinent to them, and new activities to enhance engagement at our poster sessions. This programming on our student, resident, and fellow programming will be featured in the April 2025 Forum.

Finally, we are grateful for the challenging work of the 38 other members of the planning committee and the leadership and vision of SGIM President Dr. Jada Bussey-Jones. We want to extend a huge thanks to the SGIM meeting staff, including Judy Dalie, Loubna Bennaoui, and Dawn Haglund. The SGIM staff are our unsung heroes who work behind the scenes to make the meeting happen.[5]

We are excited about this year's meeting (#SGIM25) and believe our theme and programming will highlight the outstanding work that academic generalists and our trainees do to advance change in their communities and beyond. On behalf of the 2025 Annual Meeting Planning Committee, we look forward to seeing you in Florida this Spring! #SGIM25

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workup and abnormal physical exam, an EMG was performed to evaluate polyneuropathy. The EMG demonstrated electrodiagnostic evidence of an acute, widespread, yet asymmetric neurogenic process with features of demyelination, including severely prolonged latencies in median motor responses and mildly prolonged latencies of other motor nerves. CSF analysis revealed an elevated protein level of 192.5 mg/dL (normal 15-40 mg/dL)[3] and a low white blood cell count of 2 cells/μL, consistent with albuminocytologic dissociation (ACD). All other features of the CSF were within normal limits.

The exam findings of peripheral motor neuropathy and the EMG and CSF studies together were consistent with an acute inflammatory demyelinating polyneuropathy (AIDP) subtype of Guillain-Barré Syndrome (GBS). While GBS has been historically characterized as a post-infectious autoimmune neuropathy, a growing body of literature identifies postsurgical GBS cases following various procedures in the spine, gastrointestinal tract, heart, brain, uterus, renal and stem cell transplantations, and allogeneic-banked freeze-dried bone grafts. This case supports the notion of GBS as a post-traumatic phenomenon, where surgery may function as a triggering event.

There is a paucity of literature analyzing patient demographics, clinical course, and recovery differences between post-infectious and postsurgical GBS. However, recent systemic reviews of postsurgical GBS cases have provided a description of four patients diagnosed with postoperative GBS following spinal surgery.[4] All patients were male, and two of the four demonstrated ACD following lumbar puncture. Intravenous immunoglobulin (IVIG) was initiated for all patients. Patients in this review presented at various stages of recovery during follow-up appointments, ranging from still requiring mechanical ventilation to only residual minor neurological deficits.[5]

The patient was treated with 0.4 g/kg IVIG after the diagnosis. Repeat neurological examinations revealed additional abnormalities, including neck flexion weakness, bilateral hand weakness, and worsening proximal and distal weakness in the bilateral lower extremities. Reflexes remained present in the upper extremities but became absent in the lower extremities. Sensory examination was intact to light touch, pinprick, temperature, and vibration in all extremities. The patient could ambulate with a walker but demonstrated an unsteady, wide-based gait.

After the second day, the patient received only 60 grams of IVIG. Consequently, the dosage was increased to 0.5 g/kg daily, aiming for 2 g/kg. Over the next two days, the patient's lower extremity strength improved significantly (though not to baseline), allowing her to ambulate with assistance from a person or walker.

Upon completion of IVIG treatment and strength improvement to 4/5 in all extremities, the patient was discharged home with plans for outpatient physical therapy, occupational therapy, and follow-up with neurology and orthopedics.

IVIG is first line for GBS, blocking antibodies that target myelin and Schwann cells. It has been shown to be as effective as plasma exchange therapy (PE) in reducing disability duration and hospitalization.[4] IVIG does not require the same expertise and specialized machinery as PE and is easier to administer promptly. Steroids are not recommended, as they inhibit the action of scavenger molecules involved in nerve regeneration.[4]

Conclusion

When SGIM providers evaluate a patient for new postsurgical weakness, demyelinating polyneuropathies like GBS should be considered early in the diagnostic process. This case adds to the growing literature that GBS can occur as a postsurgical complication and emphasizes the importance of early diagnosis by SGIM clinicians. Timely diagnosis will improve the patient's time to recovery and reduce unnecessary diagnostic costs and interventions.

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PRESIDENT'S COLUMN *(continued from page 11)*

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