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SGIM FORUM

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LEADERSHIP PROFILE/IN CONVERSATION

THE KEYS TO SGIM'S SUCCESS OVER THE PAST 50 YEARS

David Karlson, PhD

Dr. Karlson (Karlson6188@gmail.com) served as the Executive Director for the Society of General Internal Medicine (SGIM) and the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) from 1997-2015. He is currently retired and living in the Washington, DC, area.

SGIM has made great advancements since its founding 50 years ago as a 501(c)(3) non-profit organization. Yes, it may surprise some long-time members, but it's been 50 years since SGIM was established, and ACLGIM followed 22 years later. In this article, I share my perspective on why the Society has not only survived but also continues to thrive.

Many non-profit organizations struggle to adapt to necessary changes and member needs. These organizations fail for several reasons, including lack of member services, shifting environmental factors, ever-changing federal regulations, poor leadership of governing boards, loss of competent staff, and financial instability. Any one of these powerful indicators can bring down a non-profit. There is a very delicate balance between organizational growth and decline; this balance requires organizations to stay attuned to changes and address them proactively.

SGIM has successfully navigated these challenges and grown as an organization. Here are some of the key factors integral to SGIM's success:

Membership

Although membership began to decline in the 1990s, SGIM has since rebounded with record numbers of SGIM members attending the national meeting along with a growing number of students, residents, and fellows (SRF). Very few non-profit organizations have greater than 50% of their members attend their annual meeting, but this is the norm for SGIM. Our members feel a powerful sense of loyalty and often refer to feeling a part of the SGIM "Family" and call SGIM their "Academic Home." Other programs that have increased membership include the critical role of SGIM mentoring programs as well as the successful ProudToBeGIM program.

Publications

Journal of General Internal Medicine (JGIM) has grown from publishing fewer than 1,000 pages annually to more than 3,000. The quality of *JGIM* articles has increased as evidenced by the rising impact factor. SGIM Forum is very popular with SGIM members for articles that are

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easy to read and focus on topics that are relevant to members. The newly designed website pulls together these publications and resources in an easy-to-use format. As a result of these scholarly efforts, SGIM has responded to the call for better patient care.

Advocacy

SGIM's health advocacy efforts have expanded over the past 50 years. The Leadership in Health Policy Program (LEAHP) was introduced to train members in effective advocacy techniques. SGIM members have used these learned advocacy techniques in their meetings with political leaders during Hill Day events.

Training Educators and Researchers

SGIM has developed better teaching and research programs which have received enthusiastic responses from members. Examples of successful programs include the TEACH program and GIMLearn for Medical Educators, the Research committee offerings, and the new Fellowship Directory.

Finances

Members have contributed to various efforts that cannot succeed without adequate resources. A balanced budget is maintained annually to support the Society, and it has grown from less than $1 million to $4.8 million dollars. Philanthropy has been important during this time as successful fundraising efforts have benefited the organization, including the purchase of the SGIM mortgage-free home office in Alexandria, Virginia. Members contributed $700,000 to this office acquisition.

Respect

SGIM is looked to as a thought leader within the GIM community—a role forged over many years of collaboration and being at the table discussing critical issues. This respect has been earned by the countless hours and dedicated work of presidents and SGIM members through numerous publications, workgroups, committees, invited talks, advocacy efforts, and scholarly contributions in GIM.

Staff

SGIM's staff remains deeply committed to the organization's mission and goals. Collectively, key staff have served for more than 100 years, with the current CEO (Eric Bass, MD) approaching 10 years of service, Deputy CEO (Kay Ovington, CAE) with 28 years of service and Senior Director of Communications and Publications (Francine Jetton, MA, CAE) approaching 20 years of service. Additionally, five other staff members, including staff that work with the *JGIM*, have served a minimum of 10 years. SGIM acknowledges the invaluable contributions of staff we have lost, including Leslie Dunne and Sarajane Garten, who dedicated many years of service to the organization.

Serving Patients

The combined service of research, education, and advocacy are focused on improved patient care. This is reflected in the SGIM mission statement and values which is to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.

Regional Growth and Participation

There has been significant growth each year with support from the Board of Regional Leaders (BRL). Regional meetings offer opportunities for involvement by SRF and junior faculty members who may not make it to the annual meeting. Expansion of regional meeting offerings serve as a portal for new members to experience SGIM offerings.

Volunteers

SGIM is a member-driven organization. Hundreds of volunteers and committee members help articulate SGIM's enduring values supported by a newly enhanced website. SGIM members are always looking to expand the regional and annual meeting programming as well as the work of the various SGIM Committees and Commissions.

Stability in Leadership

SGIM has only had three executives/CEOs over the 50 years since it was established. Founding ACLGIM has proven essential in connecting with many leaders in GIM to create a pipeline of future academic leaders.

When I arrived at SGIM some 28 years ago, there were only four committees and JGIM. Two committees were active—Annual Meeting and Health Policy—but the future Education and Research committees were not active at that time. Today, SGIM has dozens of active committees, commissions, task forces, and interest groups. Collaborations with external medical organizations have created significant opportunities for continued SGIM success.

SGIM/ACLGIM has come a long way and more than survived powerful challenges that could have endangered its growth. We can all be proud that an impactful future lies ahead. SGIM/ACLGIM has always been committed to wisely doing the right thing!

I am thrilled to have been a small part of the ongoing success of this amazing organization and am confident that SGIM/ACLGIM will continue to advance and thrive in the future. It was a personal joy to contribute to the ongoing success of this incredible organization.

With warm regards and my love,
David Karlson, PhD

SGIM

BURNING OUR BOOKS AND DATA: *FAHRENHEIT 451* MIRRORS TODAY'S SCIENTIFIC WORLD

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

"It would be funny if it were not serious. It's not books you need, it's some of the things that once were in books."[1]

As I write this column in mid-February for the April 2025 issue of SGIM Forum, I reflect on the current uncertainty within our scientific community. Regardless of one's political leanings, SGIM members must recognize the firestorm surrounding science (i.e., the pursuit of new knowledge through the ethical application of hypothesis generation and testing or collection of observations). Observing this scientific crisis reminds me of a prescient novel from high school English class—Ray Bradbury's 1953 classic, *Fahrenheit 451*.[1]

For those unfamiliar with the novel, Guy Montag, its protagonist, is a fireman charged with burning "the books." He dares not read the books as it is illegal. But Montag starts to question the destruction of knowledge and censorship of literature. He builds his own library of books until he is reported anonymously and is forced to burn the books and his house down with a flamethrower. After killing his fire captain with the flamethrower, Montag escapes. The search begins for Montag as the Mechanical Hound built by the government is sent to track and kill him.

A SparkNotes summary describes Guy Montag:

> *"Guy Montag is a fireman who burns books in a futuristic American city. In Montag's world, firemen start fires rather than putting them out. The people in this society do not read books, enjoy nature, spend time by themselves, think independently, or have meaningful conversations. Instead, they drive very fast, watch excessive amounts of television on wall-size sets, and listen to the radio on "Seashell Radio" sets attached to their ears."*[2]

Now let's compare that SparkNotes summary of 1953 to a summary reflective of 2025:

> *"XXXX are individuals/groups that manipulate data in American systems. In XXXX's world, individuals start fires/conflicts rather than putting them out. The people in this society do not read books, enjoy nature, spend time by themselves, think independently, or have meaningful conversations. Instead, they drive very fast, watch excessive amounts of television on Samsung wall-size sets, and watch TikTok or listen to Sirius on their iPhone with AirPods attached to their ears."*

Strikingly similar!

History has shown that, in conflict, victorious armies strip the conquered people of their history, customs, and science. Libraries are burned, leaders are executed, customary celebrations are banned, restrictions on who could be where doing what are set in place. World War II is a recent example where attempts were made to eliminate entire cultures. In a quote often misattributed to Sir Winston Churchill, we get a better understanding why this occurs as "History is written by the victors."[3]

As this column goes to publication, SGIM members are expressing significant concerns regarding the restrictions placed on science. Many feel that attempts are being made to rewrite scientific history. Data has been removed from public websites and research funding has been cut in certain areas. Government agencies with a focus on science have faced staff terminations. In our divided country, there are individuals who support these efforts while others oppose them. But data are numbers that need context, and this should be apolitical. We must not allow individuals to manipulate data or scientific findings for political leverage. We should not have restrictions or the elimination of research that drives scientific knowledge and wisdom.

In the dystopian society in which *Fahrenheit 451* is set, Bradbury describes attempts to destroy books, oppress people, and control history. But why books?

"It's not books you need, it's some of the things that once were in books. …. The same infinite detail and awareness could be projected through the radios, and televisors, but are not. No, no it's not books at all you're looking for! Take it where you can find it, in old phonograph records, old motion pictures, and in old friends; look for it in nature and look for it in yourself. Books

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were only one type or receptacle where we stored a lot of things we were afraid we might forget. There is nothing magical in them at all. The magic is only in what books say, how they stitched the patches of the universe together into one garment for us."[1]

In Bradbury's novel, the books are burned, whereas science and research are the targets today. Data drives research to improve tomorrow's health care. SGIM members should continue to challenge the restrictions placed on the scientific community. We cannot sit quietly while forces seek to erase our scientific history and constrain the pursuit of knowledge.

After his lecture to Montag about why books are banned, Fire Captain Beatty (Montag's boss) states: "*We stand against the small tide of those who want to make everyone unhappy with conflicting theory and thought. We have our fingers in the dike. Hold steady. Don't let the torrent of melancholy and drear philosophy drown our world. We depend on you. I don't think you realize how important you are, we are, to our happy world as it stands now.*"[1] This description of the government's oppression of the book hoarders glorifies the "necessary work" of the firefighters as they burn books. Today, the scientific community and SGIM members need to stand against those who would burn our data. Science and our patients depend on us. The future physicians we will train need us. We need to rise above the tide.

After his house is burned, Montag must escape the Mechanical Hound. The Hound symbolizing the oppressive nature of the government, uses technology to control and punish dissenters: "*Montag manages to escape in the river and change clothes to disguise his scent. He drifts downstream into the country and follows a set of abandoned railroad tracks until he finds a group of renegade intellectuals ("the Book People"), led by a man named Granger, who welcome him. They are a part of a nationwide network of book lovers who have memorized many great works of literature and philosophy. They hope that they may be of some help to mankind in the aftermath of the war that has just been declared. Montag's role is to memorize the Book of Ecclesiastes. Enemy jets appear in the sky and completely obliterate the city with bombs. Montag and his new friends move on to search for survivors and rebuild civilization.*"[1]

SGIM members are the "Book People." We are the keepers of data. We are the helpers of humankind. We are the "intellectuals." We do not know the future of our scientific community, but we must protect the past and future data, the knowledge that will be generated and the resulting wisdom for our trainees, colleagues, and patients. If our science is obliterated, we must rebuild our medical civilization.

SGIM members must stand tall in the face of this emergency. SGIM members must tell those who try to take our data and books that "*You can't ever have my books.*"[1]

**(Note: The opinions in this column do not purport to reflect the opinions, views, or positions of SGIM or any other entity.)*

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SGIM

REFLECTING ON OUR ACHIEVEMENTS, PREPARING FOR THE ROAD AHEAD

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

"As I write this final column, I see it not just as a reflection on our accomplishments, but also as a call to action.... There is much work ahead, but together, we will continue to move forward with determination and purpose."

This is my final President's column, and it's hard to believe the year has passed so quickly. I am struck by the many innovations and successes we've achieved together. As I write this article in February 2025, I also cannot ignore how much academic medicine has been shaken to its core. The foundations of what we hold dear feel increasingly under threat, making it difficult to focus solely on our "accomplishments" when so much work remains ahead. Even in turmoil and uncertainty, Society of General Internal Medicine (SGIM) members must find a way to navigate crises while staying focused on our core responsibilities—providing patient care, advancing medical education, and driving innovation. This also means preserving and strengthening our organization to ensure its continued success.

So, I *will* take time for reflection and gratitude, even in the context of the changing landscape we will face and navigate together. I hope this reflection will not only capture the successes of the year but also offer a much-needed source of strength to bolster our resilience. There is so much to be proud of that it is impossible to capture it all in this article, but I will highlight a few key initiatives from the past year.

"Even in turmoil and uncertainty, Society of General Internal Medicine (SGIM) members must find a way to navigate crises while staying focused on our core responsibilities—providing patient care, advancing medical education, and driving innovation."

Leadership Pathway Program

In a previous Forum article,[1] I highlighted how the voluntary service and leadership of our members are both our greatest strength and biggest challenge. Like many organizations, SGIM has faced a decline in volunteer leadership. To address this, SGIM examined the pros and cons of uncontested ballots, a practice widely regarded as the standard for nonprofit organizations. After engaging in extensive communication with members through regional meetings, GIMConnect, and SGIM Forum, SGIM is piloting an uncontested slate for the Treasurer position. At the same time, SGIM is upholding our commitment to transparency by continuing to offer an open process for this and all leadership roles, including opportunities for self-nominations.

I also proposed a Leadership Pathway Program to provide clear, structured opportunities and support for those aspiring to leadership roles within SGIM and ACLGIM. This initiative received enthusiastic support from Council. A talented team led by Andrea Sikon, MD, Ryan Kane, MD, and Jillian Gann, SGIM's Director of Leadership and Mentoring Programs, has made great progress on work to improve onboarding and create transparent pathways for success within the organization.

Diversity, Equity, and Inclusion Task Force

In light of the increasing attacks on diversity programs at academic institutions, which have a direct impact on our members, learners, patients, and communities, SGIM established a Diversity, Equity, and Inclusion Task Force. SGIM acknowledges that "engaging diverse perspectives and backgrounds in classroom, clinical, laboratory, research, and community settings, enriches the educational and work experiences of our learners and colleagues. Diverse learning and clinical environments are important to provide future physician leaders with skills needed to interact, engage, and lead change across complex health systems."[2] SGIM past president, Monica Lypson, MD, MPHE, and deputy CEO, Kay Ovington, CAE, are leading this important effort to support our members and affirm our commitment to equity, which is at the heart of our mission to cultivate innovative educators, researchers, and clinicians in academic general internal medicine (GIM).

New Member Initiatives

In 2023, the SGIM Membership Committee introduced institutional membership opportunities for select institutions across each region and we have enhanced and ex-

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panded these efforts. SGIM focused on university-based institutions with low membership compared to their GIM faculty size, driving notable growth. SGIM also collaborated with Historically Black Colleges and Universities (HBCUs) to encourage faculty memberships. This work has resulted in a growing and diverse membership within SGIM.

President's Podcast

One of my proudest accomplishments has been the launch of the inaugural SGIM President's Podcast.[3] This platform has allowed SGIM to highlight influential leaders in general internal medicine across health care, public health, policy, and academia, giving a voice to those leading at the forefront of academic medicine. I have been fortunate to hear inspiring stories from leaders like Eric Bass, MD, MPH, Thomas Inui, MD, ScM, Monica Lypson, MD, MPHE, Harry Selker, MD, MSPH, and Robert Centor, MD. These leaders share powerful stories of starting and leading GIM divisions, navigating crises, working in segregated hospitals, and driving groundbreaking policies that have transformed primary care and its reimbursement models. The podcast has offered a unique opportunity to deepen our understanding of the rich history of SGIM while learning from the leadership journeys of others.

Virtual Meeting

In another exciting first, SGIM will pilot a virtual option for our Annual Meeting.[4] This decision is in response not only to concerns from members who are unable or choose not to attend the Florida meeting but also prior requests from the Environmental Health Interest Group, ensuring that key sessions are accessible to those who cannot join us in person in Florida.

Expanded GIM Fellowship Support

In addition to expanding offerings for GIM fellows at our annual meeting, the GIM Fellowship Taskforce, led by Nisa Maruthur, MD, MHS, and Erika Baker, SGIM Director of Project Management, has worked to create a new fellowship page on the SGIM website.[5] This page provides comprehensive information on GIM fellowships, explaining their value and offering up-to-date details on active fellowship programs.

Next Steps

This column highlights just a few examples of a year marked by noteworthy progress and many remarkable achievements for SGIM. When I began my presidency, I thought the most controversial aspect would be the meeting location. In hindsight, the decision to hold the meeting in Florida seems fitting, as similar advocacy challenges and threats are emerging nationwide. The theme we selected, "From Ideas to Action: Catalyzing Change in Academic General Internal Medicine," has proven to be timely.

This final column is a reflection on our accomplishments and a call to action. This includes our ongoing response to emerging issues through the efforts of our members, the Health Policy Committee, and advocacy partners Cavarocchi, Ruscio, Dennis (CRD) Associates, LLC. SGIM's advocacy and partnerships with other medical societies is strong, and we will continue to leverage collective efforts to advocate for policies that reflect our values. SGIM's core strength lies in our connections, driven by a commitment to offering our members opportunities to engage, collaborate, and share valuable resources, especially expanding programming at our annual meeting to address key issues,[4] offering regular advocacy updates, and providing educational content through GIMLearn. SGIM is dedicated to creating safe spaces for discussion and education including a new Health Policy Interest Group on GIMConnect. There is much work ahead, but SGIM will continue to move forward with determination and purpose.

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SGIM

Q & A ON THE NEW QUALITY FAMILY PLANNING GUIDELINES

Eric B. Bass, MD, MPH; Sonya Borrero, MD, MS

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Borrero (borrsp@upmc.edu) is a professor of medicine and director of CONVERGE, a research center focused on sexual and reproductive health equity, at the University of Pittsburgh.

Late in 2024, the *American Journal of Public Health* published new recommendations from the United States Office of Population Affairs (OPA) on "Providing Quality Family Planning Services in the United States."[1] Recognizing that the topic is of interest to many SGIM members when there is major controversy about reproductive health care, I asked SGIM member Dr. Sonya Borrero to share what she learned from being a co-author of the guidelines.

EB: What is the purpose of the new recommendations for providing quality family planning services?

SB: The 2024 Quality Family Planning (QFP) guidelines represent a transformative step toward achieving sexual and reproductive health equity (SRHE) in the nation. Specifically, the guidelines aim to provide comprehensive, equity-informed, evidence-based recommendations for delivering high-quality sexual and reproductive health (SRH) services. These guidelines address the social, technological, and legal changes that have occurred since the initial 2014 recommendations. They emphasize inclusivity, ensuring that all individuals, regardless of characteristics—such as sex, sexual orientation, gender identity, age, disability, or race—can have their SRH needs met across diverse clinical settings. By equipping a broad range of clinicians with necessary knowledge and tools, the guidelines seek to enhance access to person-centered SRH care, promote health equity, and improve health outcomes.

> **"The QFP guidelines emphasize that SRH is a fundamental component of health care and should not be confined to specialized clinics."**

EB: How do the new recommendations differ from the original recommendations that were published in 2014?

SB: The 2024 QFP guidelines introduce several updates and expansions compared to the 2014 recommendations, encompassing a broader vision of care that addresses systemic inequities, expands access, and integrates innovative approaches to service delivery. One major shift is that while the 2014 guidelines were primarily aimed at clinicians working within Title X settings, the 2024 guidelines are designed for a more diverse range of clinicians, including general internists, recognizing their crucial role in the continuum of SRH care.

Attending to the historical context of reproductive coercion and discrimination, the new QFP guidelines emphasize building trust with underserved communities by prioritizing transparency, inclusivity, and cultural and structural competency in SRH care. This approach aims to dismantle barriers to care and foster equitable and respectful healthcare experiences.

In addition, the scope of the 2024 guidelines has been expanded beyond the focus of the 2014 recommendations, which primarily addressed family planning services like contraception and pregnancy counseling. The new guidelines encompass a wider range of SRH services, including early pregnancy management, support for individuals and couples pursuing pregnancy or considering adoption and surrogacy, strategies for prevention of human immunodeficiency virus and sexually transmitted infections, and guidance on providing affirming and respectful care to lesbian, gay, bisexual, transgender, queer, and intersex individuals. They also highlight the importance of expanded preventive health services, addressing the intersection of SRH with mental health and other health needs. Moreover, the updated recommendations emphasize the creation of safe, trauma-informed environments for individuals who have experienced adversity. These changes reflect an evolving understanding of the interconnectedness of physical, emotional, and social well-being in SRH care.

EB: How strong was the process for developing the recommendations?

SB: The development of the 2024 QFP recommendations was grounded in a rigorous and inclusive process. OPA collaborated with a diverse array of experts and partners to ensure the guidelines were comprehensive and evidence based. An Expert Working Group, comprising professionals with extensive expertise in SRH and health

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equity, was convened to guide the process. This group identified research gaps, which led to systematic reviews and environmental scans. Subsequently, Technical Expert Panels (TEPs) evaluated the evidence and helped to formulate recommendations. Importantly, OPA engaged individuals with diverse lived experiences and potential end-users to incorporate a wide range of perspectives, ensuring the guidelines are scientifically sound and attuned to the needs of various communities. This comprehensive approach underscores the strength and credibility of the updated recommendations.

EB: What are the implications of the recommendations for general internal medicine physicians and other primary care physicians?

SB: The QFP guidelines emphasize that SRH is a fundamental component of health care and should not be confined to specialized clinics. The new guidelines underscore the shared responsibility of all healthcare providers to advance SRHE. As such, general internists, other primary care clinicians, community health workers, and specialists in fields beyond obstetrics and gynecology are all critical to expanding access to SRH services. The guidelines provide specific tools and frameworks to assist clinicians in integrating SRH care into their practice, ensuring a seamless "no wrong door" approach for patients seeking care. General internists, for example, are encouraged to screen for SRH needs using standardized tools to identify patients' reproductive health needs, preferences, and goals; engage in open, nonjudgmental conversations about contraceptive options, family-building desires, and sexual health; and coordinate care by establishing referral pathways to specialists or community resources for services beyond their scope. By adopting these practices, primary care clinicians can ensure that patients receive comprehensive, person-centered SRH care within familiar clinical settings, thereby enhancing access and promoting health equity.

EB: Any there any final thoughts you want to share about the importance of the QFP guidelines?

SB: The new QFP guidelines arrive at a critical moment in the landscape of reproductive health care in the United States. The Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision has fundamentally altered access to abortion services across many states, exacerbating disparities in reproductive health care and creating new challenges for clinicians and patients.[2] These shifts underscore the urgency of implementing comprehensive, evidence-based SRH care that addresses the full spectrum of reproductive health needs. The QFP guidelines offer a roadmap to navigate this new reality, emphasizing equity, inclusivity, and the essential nature of SRH services as part of overall health care.

EB: Given the importance of the topic, I want to close by encouraging members to attend the sessions on women's health issues at SGIM's Annual Meeting in May, including a Special Symposium on "The Current State of Reproductive Rights," an "Update in Women's Health," the "Distinguished Professor of Women's Health," and 21 workshops on specific topics in women's health, such as the following:[3]

- Addressing Women's Health Concerns from Social Media
- Debunking Urban Legends about Menopause
- Hot Flashes, Cool Solutions
- Improving Patient Comfort for Intrauterine Device Insertions
- Lactation Medicine for the General Internist
- Managing Genitourinary Syndrome of Menopause
- Navigating Weight Management and Weight Expectations Across Women's Key Life Transitions
- Peri-Pregnancy and Beyond: The Effects of Pregnancy Health Throughout the Lifespan
- Spill that T: Testosterone Use in Men and Women
- The SGIM Women's Health Core Competency Initiative
- Weight Management Through a Woman's Reproductive Lifespan
- What Internists Need to Know to Manage Early Pregnancy before the First Obstetric Visit.

I encourage members to show your support for women's health by attending one or more of these workshops. A full listing of workshops is available in the online Annual Meeting Program.[3]

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SGIM

STUDENTS, RESIDENTS, AND FELLOWS AT SGIM 2025: PLANNING AHEAD FOR OUR ANNUAL MEETING

Rebekah Weil, MD; Matthew Metzinger, MD

Dr. Weil (raweil@uabmc.edu) is an associate professor in the Division of General Internal Medicine at the University of Alabama at Birmingham. Dr. Metzinger (metzingermn@upmc.edu) is an Academic Clinician-Educator Scholars (ACES) fellow in the Division of General Internal Medicine at the University of Pittsburgh School of Medicine. They are respectively the Co-Chair and Chair of Student/Resident/Fellow Programming for the SGIM 2025 Annual Meeting Program Committee.

As the Chairs of the SGIM 2025 Annual Meeting Student/Resident/Fellow (SRF) programming planning committee, we are thrilled to welcome the many students, residents, and fellows who will attend the SGIM Annual Meeting "From Ideas to Action: Catalyzing Change in Academic General Internal Medicine." The meeting (#SGIM25) is scheduled for May 14-17, 2025, in Hollywood, Florida, and we provide a glimpse of the exciting programming designated for our SRF attendees through this article!

While attending a national meeting can be overwhelming, the 2025 Program Committee planned this meeting with the needs of students, residents, and fellows in mind. The meeting's theme is focused on creating and implementing change, and who better to change the future than our trainees? SGIM is focused on building relationships (between peer and near-peer members as well as senior and junior members) to help students, residents, and fellows achieve their future goals. The annual meeting provides opportunities for trainees to expand their clinical, leadership, research, and advocacy skills. Further, the meeting positions SGIM members to launch a meaningful and fulfilling career in general internal medicine (GIM).

Here are a few of the exciting offerings for the student, resident, and fellow community. First, a specifically designated pre-course for fellows provides a unique opportunity to network with the national community of GIM fellows. Fellows will receive feedback on their scholarship and job applications, training on transitioning to junior faculty roles, and mentorship from GIM Chiefs and former fellows. The pre-course takes place on Wednesday, May 14, 2025, 11:00 AM-5:30 PM and requires a separate $25 registration fee.[1]

Our Society is committed to mentorship, and some of the most meaningful experiences at our meeting are the formal and informal interactions with other SGIM members. Our one-on-one mentoring program matches trainees (and early career faculty) with an experienced mentor of shared interests. Mentees should come prepared with goals for the mentoring relationship and meet with their mentors at least once during the meeting. Our one-on-one mentoring program operates on a first-come, first-serve basis and registration is now open![2]

In addition to the one-on-one mentoring program, the Annual Meeting offers several formal mentoring panels. A career planning session for students, residents, and fellows highlighting the diversity of rewarding and impactful career paths within general internal medicine will be held on May 15, 2025, 1-2:00 PM. This session will intentionally facilitate peer and near-peer mentoring with a brief structured networking period. Additional mentoring panels benefiting SRF members include parenting in medicine roundtables and career panels for clinician educators and clinician investigators. A career fair will also take place throughout the conference.[3]

First-time attendees have many opportunities to engage with other SGIM members who share similar passions and interests during breakfast and lunch interest group sessions. Interest groups are formed independently by our members and may focus on clinical topics, advocacy goals, or building communities for ourselves within medicine (such as the General Internal Medicine Fellowship, Women in Academic Medicine, or the Minorities in Medicine interest groups). Interest group sessions tend to be small and interactive, offering more opportunities for forming relationships around a common goal. Feel free to bring breakfast or lunch with you to these sessions!

Poster sessions are another key offering for students, residents, and fellows. Poster sessions highlight our members' scholarship in medical education, research, quality improvement, and clinical work. Trainees often present their own scholarship in these sessions and meet others with similar academic pursuits by perusing the poster hall. Senior SGIM members relish the chance to talk with early career clinicians about their work. The SGIM 2025 Annual Meeting Program Committee plan on highlighting our trainee members/poster presentations ahead of the annual meeting, so stay tuned for more details on how to support your fellow SRF members!

ANNUAL MEETING UPDATE (continued from page 9)

A major highlight of each annual meeting is our plenary sessions that occur each morning on May 15, 16, and 17, 2025. Plenaries include Dr. James Withers' perspectives on reality-based care for unhoused patients based on his experiences caring for those on the streets of Pittsburgh, Dr. Mona Hanna's perspective as the Associate Dean for Public Health at Michigan State University on the challenges and opportunities facing our field, especially in light of her major role in uncovering the Flint, Michigan, water crisis, and a special session on equitable access to care for vulnerable patients. The plenary sessions also highlight some of the most inspirational clinical and scholarly work being presented by our members at this meeting. There is no competing programming during these sessions so that all members of our Society can have a shared learning experience.

Attendees can choose between a variety of clinical updates, workshops, poster sessions, oral presentations, and special symposia based on their individual goals for the meeting. In clinical updates, content experts provide a curated review of practice-changing new evidence within a specific subfield of general medicine, ranging from primary care to geriatric medicine to perioperative care. Oral presentations and clinical vignette sessions allow for more in-depth discussions of our members' current research or diagnostic dilemmas. In our special symposia, experts present a topic of special interest to our members.

#SGIM25 will also offer a variety of workshops aimed at improving clinical, research, leadership, educational, advocacy, and career development skills. Workshops blend didactics with small group activities and thrive with the perspectives of a diverse set of participants, including students, residents, and fellows. The SRF Programming Committee is curating a list of workshops and other programming that may be particularly applicable to the SRF community. Be on the lookout as this will be posted on SGIM social media outlets closer to the meeting! This year, for example, we highlight workshops on artificial intelligence in medical education, lobbying as a form of advocacy, and social media's role in how our patients get health information.

Finally, outside of the formal educational and mentoring program at our meeting, we are also pleased to offer Trivia Night once again on Friday, May 16, 2025, 7-9:00 PM.[4] During this popular evening event, teams compete on medical and pop-culture knowledge for bragging rights and prizes.

As the Chairs for SRF on the #SGIM25 Annual Meeting Program Committee, we are incredibly excited to welcome this contingent of the SGIM community to Hollywood, Florida. We are confident this will be a meaningful, inspiring, and fun meeting filled with mentorship, learning, and growth. In the meantime, be sure to download the #SGIM25 Online Planner[5] to learn more about the meeting's many sessions and to plan your days. We look forward to seeing you at #SGIM25!

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SGIM

LEVITY THROUGH FICTION: A LOW STAKES APPROACH OF TEACHING FAILURE IN MEDICAL EDUCATION

Christopher R. Simmons, MD, PhD

Dr. Simmons (Christopher.Simmons@uky.edu) is an associate professor in the Department of Internal Medicine and a medical educator and MD/PhD program co-director at the University of Kentucky College of Medicine.

Anyone who has tended to a garden or cared for patients has experienced the turmoil of hope and failure. There are trials and tribulations, but the plot remains predictable. Physicians invest their lives in fixing what is broken and propping up the wounded. Academic physicians also devote themselves to mentoring, teaching, advocacy, and research (to name a few). Regardless of our talents and hard work, not every story is one of success. We mourn and try to understand why, only to realize how little control we have over modern hospitals and healthcare systems throughout the stages of our careers.

Careers in academic medicine, much like good works of fiction, have components of comedy, tragedy, and dénouement. No story would be complete without a bit of luck, which, according to Seneca, "is what happens when preparation meets opportunity."[1] The goal of this column is to illustrate the utility in preparing for failure via storytelling so that we may focus on opportunities as they arise throughout our academic journeys.

"It's now or never." The young physician palmed his withering seeds of curiosity before giving them a toss into the wind. He struggled to rise against the weight of disappointment laid atop his shoulders, but readily acknowledge that his ideas failed thus far to produce fruit. His mentors had tried. He cast a glance across the sun-bleached soil and rubbed the earth between his fingers, wondering to himself when it last rained.

Despite our practice of continual self-improvement, failure shackles many of us with shame. These heavy feelings weigh us down like stones in the pockets of our white coats. We may grow stronger while carrying them, but the burden can be exhausting.

As an MD/PhD program graduate, I had high hopes for a career in research. My mistakes sprouted up during training and propagated as a junior faculty member. Life happened, and I struggled to juggle it all. Weighed down by the many stones in my pockets, I debated leaving academics for good. Too embarrassed to approach my mentors, I let my emotions slip. It was my students who bore wide-eyed witness.

His breath caught in his chest as the air split like thunder behind him. There stood his colleague lazily dangling the ax at her side as she smiled at the felled tree. "The roots were strong, but the fruit was bitter." He watched with his mouth gaping as she swung and fell another tree. Having cleared the plot, she turned toward the bright blue sky and smiled. "It sure is nice to see the sun again."

"Here, hold this for a moment." I unfettered my stories of failure and watched my students' eyes flash excitedly as they wrestled with them. Through storytelling, I turned my failures into a cause for hope. In sharing my stories of failure, I felt the weight of shame fall away, and inspired others to learn from failure.

It was years before I realized how other faculty smiled through acts of remittance and labor. Thankfully, one colleague was persistent in telling their story—they spoke of the struggle, the isolation, and the disappointment. They told me their story of cutting a loss and accepting that timing matters as much as talent. As I listened, I immersed myself in their pain and catharsis. I saw the parallels in my career and, thanks to their story of change, found a way forward. I turned my own sordid feelings of failure as a scientist into an opportunity to educate and advise future physician-scientists.

A year later, he stood in his small plot beyond the orchard. "Why am I doing this?" he asked himself, apropos of nothing. The ax swung without a second thought, and the small, fruitless tree fell. A moment later, the sound of crunching soil brought a smile to his face. Hearing his colleague's approaching footsteps, he turned to see her raise her arms and exclaim, "Think of all the sunlight you'll have!" No sooner had the words parted her lips that the first raindrops pelted their faces.

"Why speak of sunlight on a rainy day?" The physician's scowl went slack at the sight of the shovel and small jar of wildflower seeds in her hands. Inside his coat pocket, his fingers fumbled with the one seed of curiosity he had held back—the one seed that was different from the rest.

"The sun and rain are fickle, but there's no reason we can't still enjoy them" she said as she shoveled.

As an educator, I echo the findings of our colleagues in that medical students report limited exposure to failure, leading to significant distress upon witnessing

MEDICAL EDUCATION (continued from page 11)

failure in the clinical setting.[2] Misaligned expectations and underutilization of peer and mentor support only complicate matters.[3] I blame the plot of ever-advancing technology, the culture of work-until-you-drop, and the hero archetypes inappropriately cast onto physicians. While most medical students are unprepared to navigate the uncertainty of failure, they are keen to incline an ear toward our stories.

Storytelling is an underutilized method of teaching failure in an experiential, low stakes manner.[4] For me, it has become a way to help the downtrodden to see the sunshine. Sometimes, I may even embellish for the sake of entertainment. Believe it or not, even fiction is instructive when applied skillfully in the classroom.[5]

SGIM members may be in the middle of our journeys, but, for some of us, the story is just beginning. Try sharing a story of one of your failures and the life that followed with a student or colleague. Together, our stories have the power to reshape the arc of modern medicine. Good stories highlight failure as an agent of change, a plot-twist if you will. The protagonist in our story struggled to accept their failure and the perceived failures of others. With time, and a bit of experience, they came to learn not to blame themselves for the things beyond their control. Not every story is clear in the beginning, and, if we understood the story before reading it, then what would be the point of it? Take time to struggle with failure and see the opportunities it can bring. Navigating a career in academic medicine is daunting, but, through community and shared stories, we can shape the way future generations handle their own plot twists and persevere for our own good and the good of our patients.

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SGIM

PERSPECTIVES ON THE INTERNAL MEDICINE SUB-INTERNSHIP

Nabeel Akhtar, MD, MEd

Dr. Akhtar (nakhtar@pennstatehealth.psu.edu) is an assistant professor at the Penn State College of Medicine.

The Internal Medicine (IM) sub-internship (sub-I) is an important rotation for medical seniors. The rotation has historically been a clinical exposure without a standardized curriculum. However, the Alliance for Academic Internal Medicine (AAIM) has published recommendations supporting a competency-based curricular model that prioritizes higher-order core entrustable professional activities (EPAs).[1]

My IM sub-I was my most important course in medical school. After I matched into IM residency, I found myself extremely nervous about internship. I feared the intern roles and responsibilities (which overlap with the core EPAs): entering orders, writing notes, working with other team members to call a consult or to answer pages, and recognizing sick versus stable patients.[1] These responsibilities exist while the intern is expected to build medical knowledge and clinical reasoning skills and maintain personal well-being during six-day work weeks. This feeling would have been worse if not for my IM sub-I.

> **"The IM sub-I was my most memorable course during medical school, and years later, it is my utmost priority as a clinician-educator."**

As a medical student, I completed two IM sub-Is: one, at my home academic tertiary care hospital, and the other, at a local Veteran Affairs hospital. During both rotations, I tasted the richness of internship—putting in orders, documenting notes, participating in care coordination and family meetings, and, of course, holding the team pager. I felt like I was part of the medical team and not a nuisance like medical students might be perceived. After I finished clerkships and the US Medical Licensing Examination, I found my knowledge base and decision-making improving as evidenced by my oral presentations and participation in resident conferences. These rotations prepared me for the roles and responsibilities that I dreaded and offered sanctuary as I began intern orientation.

During my internship, I was thankful for the house staff and faculty during my IM sub-Is. As I endured the rigors of internship, I reflected on my sub-I rotations where the team expected me to function as an intern, thus making internship not completely foreign. For example, I was already familiar with the admission process from the Emergency Department, including what orders were needed to admit a patient, what information to document in the History and Physical, and what to relay during sign-out. This gave me confidence as I rotated among clinical services.

At the same time, I realized I struggled in other areas. I had difficulty recognizing who was sick and, consequently, triaged patients to inappropriate units. For example, I cared for a patient who developed acute-onset atrial fibrillation with rapid ventricular response. My team had left for the day, and I was dumbfounded about what to do as the nurses cautiously observed the brand-new intern with concern. I did not know what medications to give, what medication or nursing protocols were permitted on the medical ward versus the intensive care unit, or what resources I had available. The cardiology fellow on-call rescued me several minutes later. Back then, I felt unfit for practicing medicine, and I asked myself why some co-interns seemed more competent and wondered if their IM sub-I had anything to do with their skills.

I came to understand my beloved rotation had its weaknesses as I became more invested in medical education. There were no dedicated didactic sessions for future interns. The resident conferences did not always align with the interests and needs of soon-to-be interns. Access to the electronic medical records was problematic; I could not put in orders for a future date or complete the medication reconciliation on discharge. The summative evaluations did not specifically assess the same skills I thought I needed to improve. It appeared the rotation could benefit from a competency-based curriculum in which the roles and responsibilities of students and faculty, rotation objectives, and corresponding assessment tools were more defined and developed.

For years, medical educators worked to expand the traditional clinical exposure in the IM sub-I. In 2015,

PERSPECTIVE *(continued from page 13)*

the AAIM released minimum expectations of what constitutes an IM sub-I, with one component being competency-based.[1] In 2017, the AAIM recommended which core EPAs to focus on during the fourth year of medical school including the IM sub-I, and, two years later, it published the Internal Medicine Subinternship Curriculum Guide 2.0 to facilitate the development of competency-based IM sub-I curricula.[2,3] The latter two resources provided examples of education and assessment models to use. These resources aim to prepare medical students to achieve the core EPAs by the start of internship.

Since 2019, medical schools have made limited progress on reshaping the rotation. Medical educators have implemented a variety of innovative tools to teach and assess core EPAs. Unfortunately, there is still variability for this important rotation regarding structure, education, and assessment in curricula among medical schools.[4] A significant factor is the struggle IM sub-I directors have in getting protected time and resources in developing the course.[5] Sub-I directors were found to spend most of their time on administrative duties or in other courses like the IM clerkship.[5] This has restricted the growth and standardization of the rotation despite years of recommendations to reshape the IM sub-I.

I was recently appointed as the IM sub-I director at the same institution where I completed my rotations. As faculty, I am reminded of the importance of the sub-I in medical education. Medical students applying to IM residencies often seek letters of recommendation during this rotation. Their rotation grades and feedback are reported in our Medicine Departmental letters for residency program leadership to review. I had two faculty members write letters for me after my sub-I, and program directors noted my sub-I grades when I was on the interview trail. Clinically, it is one of the last opportunities for medical students to work on their competencies and core EPAs prior to graduation and internship. During orientations I lead for the rotation, sub-interns often express their goal for the rotation is to practice the core EPAs needed for internship and not necessarily to improve their medical knowledge or clinical reasoning. As medical educators look to improve the undergraduate medical education-graduate medical education transition, the IM sub-I is one of the centerpieces of this transition.

I am working with my institution to reform the IM sub-I to adhere to national recommendations. The IM sub-I is essential, and I sense that the rotation—and the fourth year of medical school—has long been overlooked and neglected in undergraduate medical education compared to the IM clerkship and pre-clinical curricula. To improve the rotation, I urge SGIM members, many of whom are stakeholders as IM sub-I directors, or part of medical school leadership, to align their curriculum with the AAIM curricular guide. SGIM members should develop a competency-based curriculum and create education and assessment tools that focus on high-yield medical concepts and higher-order EPAs. This would create a learning environment for future interns to practice and become entrusted to complete these activities, promoting safe and effective patient care during residency. There will be obstacles, notably access to resources, administrative and faculty support, and institutional policies. We must identify barriers to implementing the resources set out by AAIM and stress the importance of the IM sub-I to our medical schools and hospital administrations. Our responsibility is to ensure our medical students are ready for internship.

The IM sub-I was my most memorable course during medical school, and, years later, it remains my priority as a clinician-educator. It is a critical rotation for faculty and students, and it is time that SGIM members take action to optimize the course and adopt competency-based education.

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SGIM

PERCEPTION IS REALITY: HOW WE TALK WITH PATIENTS AFFECTS THEIR HEALTH

Scott Selinger, MD, FACP

Dr. Selinger (scott.selinger@austin.utexas.edu) is a clinical assistant professor in the Departments of Medicine and Population Health at the University of Texas at Austin Dell Medical School.

In residency, I spent hours trying to get my notes perfect and research best practices for care. I knew I could figure out the right approach to every problem. Feeding into this idea of the perfect practice was my love of the then-popular television show *House*[1] (which spanned my medical school and residency years), featuring the titular antihero internist who took on only the most complex cases and opted for diagnostic accuracy over bedside manner.

I have since learned that it does not matter if you are right, it matters that people listen to you. Today, you cannot be right if people do not listen to you. I realized my main objective as a clinician is helping people understand my thinking and clinical reasoning based on their report and exam. In doing this, they are informed to make the decision that is right for them, even if we disagree.

I accidentally started learning this concept of how important perception is in residency. For my senior grand rounds, I gave a picture-packed presentation on "The Effect of Physician Attire," redubbed by my mentor as "Why Scott Doesn't Like Wearing White Coats." He was not wrong, but I learned from the presentation and his feedback that patient-physician interactions influence memory and impressions substantially more than physician attire. Pronchik and colleagues found that more than half of the patients remembered having a good/great interaction with their ER physician; yet more than half identified them as wearing a tie when, in fact, they were not.[2]

When I first started independent clinical practice, I was so committed to evidence-based medicine that sometimes I would omit a physical examination during my patient's annual check-up. For healthier patients, it seemed most important to talk through preventive behaviors and lifestyle changes. Then, I started receiving patient feedback that "he didn't even touch me." All the time we spent talking about diet and alcohol and wearing a helmet on the bicycle, and that was what they took away? My bedside manner needed some fine-tuning.

I worked to change this by attending communications workshops for physicians and doing more role-playing than I ever intended. I slowly developed my skills in clinic, in administrative work, and, yes, even when talking with my family. I learned more about the power of suggestion and behavioral health teachings and started realizing more about the importance of making that connection.

The Four Habits Model was drilled into my head as being paramount to good outcomes[3] and includes the following:

1. *Invest in the beginning.* Introduce yourself to everyone in the room, talk about the book they brought or the hat they have on, and elicit their concerns. If they have a long list of items to address, agree on the topics most important to discuss that day.
2. *Elicit the patient's perspective.* Ask for ideas from your patient and their loved ones to help get to the "question behind the question" and clarify their expectations for your role—be it diagnosis, treatment, referral or explanation and reassurance.
3. *Demonstrate empathy.* Open yourself to your patient's emotions and build your ability to identify and share emotional connections,
4. *Invest in the ending.* Educate and involve your patient in the decisions to make sure they understand and agree with the plan as well as follow-up steps.

When I followed these four habits, this led to better patient satisfaction with their care and overall health.

Evolving from this philosophy, my most recent guiding tenet is the effect that I have on the placebo and nocebo effect, these interventions that should have no therapeutic or detrimental value but can still be perceived as positive or negative, respectively, because of the strong effect between the brain and body.[4] I realize that little of what I *do* seems to have influence, but *how* it's done matters more. How I discuss a treatment, test, or condition affects its subjective efficacy or severity. During residency, a patient was moping in a dark room about how they did not feel like they were well enough to go home on my pre-rounds. Not even a half-hour later, my upbeat attending walked in and declared "Wow! You look so much better than yesterday!" The patient's trust and belief in my attending's perception instantly made the patient reframe their personal self-assessment of their readiness for discharge and they were discharged later that day.

I spent too much time early on in my career focused on finding the right answer: the perfect method, the best

SIGN OF THE TIMES (continued from page 15)

test, the top drug. My best experiences now don't come from being right, they're in the relationships I form. Every visit can be a team-building exercise, a way to build or rebuild trust in our primary care system, or a chance to help me feel like my day is collaborating with people instead of just checking boxes and clicking the "order" button. Forging that connection is an amazing power SGIM members can hold, develop, and wield with the utmost care. SGIM members can use it to give people the power to make changes in their life and in the way they view it, to take control of how they feel. To me, it's the most important aspect of the artistry of medicine.

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SGIM

IMPROVING CARE

ELEVATING POCUS RESILIENCE: FIVE STRATEGIES TO EMPOWER CONTINUED PRACTICE

Ritu Bansal, MD; Prashant Patel, DO, FACP

Dr. Bansal (ritu.bansal@ucsf.edu) is a clinical professor and Point of Care Ultrasound (POCUS) credentialing lead in the Division of Hospital Medicine at the University of California, San Francisco (UCSF) School of Medicine, and the Associate Director of POCUS at UCSF St. Mary's Hospital's Internal Medicine Residency Program. Dr. Patel (prashant.patel@ucsf.edu) is an assistant clinical professor in the Division of Hospital Medicine at the UCSF School of Medicine.

Soon after attending a Point of Care Ultrasound (POCUS) workshop, you are thrilled to apply your newfound skills by performing a volume status exam on your dyspneic patient in the hospital. Armed with your ultrasound probe, you stride into the room to augment your physical exam with POCUS. However, your screen flashes "equipment error" as your patient is sitting in bed munching on breakfast cereal. Overcoming the dreaded software hard-stop, you begin scanning. However, the scanned images do not resemble any of the pristine images that you saw during the workshop or acquired on standardized patients. Time passes, your probe is hot enough to catch fire, and your patient's perplexed expression matches yours. You leave the room with some short video clips, feeling clueless. Discouraged at the outcome, you ponder "What's next?"

While this can be frustrating and disheartening, most issues with POCUS image acquisition and interpretation can be resolved. Whether you are starting your POCUS journey or are an experienced user it is certain that POCUS can be filled with excitement, challenges, and, sometimes, frustration. Like other skills, it is prone to stagnation and disengagement, eventually leading to decline in both knowledge and skills.[1] If concerns and frustrations have crossed your mind, the following five important strategies will assist you in making your POCUS journey a rewarding adventure:

1. Master Your Equipment
2. A Two-Way Street
3. Scanning with a Purpose
4. POCUS Is a Team Sport
5. Unleash Your Creativity.

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With a strategic mindset and approach, the following sections will explore the significant ways to help refine your technique, overcome common pitfalls, and keep your POCUS skills moving in the right direction.

Master Your Equipment

Be proactive in your probe management. Do not leave your probe's fate to chance; if there are limited machines in the hospital, be sure to claim one early. Ensure it is charged and verify its seamless connection to your screen. Arm yourself with an ample supply of gel, because "gel is your friend." Don't forget to enter the room equipped with towels and wipes—your patients will thank you later.

Be prepared to troubleshoot your way out. A loose connection or gel seeping into the lightening port is often the issue. Restart your device, update your software, and check for error messages. Disconnecting from Wi-Fi often will allow you to scan without storing images and remove ongoing error messages from the device.

A Two-Way Street

Build rapport early. Forge a partnership with your patient through transparent communication. Articulate your intentions with the scope of your POCUS exam clearly. Generously share your screen and thought process as you proceed with your scanning. This engenders trust and forms a unique bond with your patient.[2]

Strategically position your patient. If your patient is seated, and cardiac views are not imperative, commence with lung views and the jugular venous distension (JVD) scan. If you need your patient supine, inquire what time they will be getting back into their hospital bed and offer to return later. Optimal positioning can make an enormous difference in image quality.

Scanning with a Purpose

Goal-driven scanning will focus your efforts. Set specific objectives for each scan but be open to the unexpected. If the right ventricular size remains elusive, use surrogates. A clearly visible Tricuspid Annular Plane Systolic Excursion (TAPSE) can add valuable data points to your clinical problem solving. If you are having difficulty obtaining a particular view, you can still gather the information needed with alternate views.

Scan the "normal" and the "easy" patients. Scanning the patient who just had an ultrasound or Transthoracic Echocardiography (TTE) to cross reference your findings can improve your image interpretation. Patients with thin body habitus may provide an opportunity to acquire a beautiful view of the aorta. If your patient is undergoing a formal ultrasound or TTE, seek permission from the technician to watch and learn their image acquisition techniques. As you continuously enrich your library of normal images, abnormal findings will begin to unveil themselves effortlessly.

POCUS Is a Team Sport

Know who your POCUS allies are. The lack of formal POCUS training and supervision are among the top barriers to POCUS mastery.[3] Knowing your POCUS experts and peers at your institution or professional societies, such as the Society of General Internal Medicine (SGIM) POCUS interest group, is a tremendous advantage. Seek help with image acquisition or interpretation challenges by saving your clips and request troubleshooting and optimization support asynchronously via e-mail.

Sharing with a team is fun. Be an active participant in the POCUS world. When you capture a remarkable image, present it at an image review meeting at your institution or graduate medical education conference. If POCUS vastly changed your initial diagnosis or expedited care, consider publishing your case.

Unleash Your Creativity

Craft your own POCUS mission. Create short- and long-term goals for yourself to prevent stagnation by providing personal purpose and direction. If you perform clinical procedures, expanding your horizons by adding POCUS-guided lumbar punctures to your skillset could be your next frontier. If you feel limited in your volume assessment by relying solely on your inferior vena cava (IVC) measurements, add the venous excess ultrasound (VExUS) score to assess the severity of venous congestion in distal veins to guide your fluid management.

Think beyond traditional boundaries. In the spirit of creativity, employ POCUS in novel yet safe ways. When faced with the enigma of a blood clot versus stone versus tumor as noted on the computed tomography (CT) of the bladder, unleash your POCUS prowess. Bladder clots tend to be mobile in dynamic ultrasound, stones tend to cast shadows, and tumors often exhibit vascular features on Doppler.

With these strategies to prevent skill stagnation and deterioration, SGIM members are not only POCUS practitioners but also collaborators, knowledge-sharers, and innovators! Before you contemplate stashing away your probe, remember the countless discoveries and victories waiting to be unlocked in your POCUS journey.

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1500 King Street, Suite 303, Alexandria, VA 22314
202-887-5150 (tel) / 202-887-5405 (fax)
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