The Society of General Internal Medicine (SGIM) has announced its 2020 award and grant recipients. SGIM is proud and pleased to announce the recipients by category.

### Recognition Awards

**The Robert J. Glaser Award**— Presented to Mark Linzer, MD, (Hennepin Healthcare), for outstanding contributions to research, education, or both, in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

**Herbert W. Nickens Award**— Presented to Raegan W. Durant, MD, MPH, (University of Alabama, Birmingham School of Medicine), for a demonstrated commitment to cultural diversity in medicine.

**Elnora M. Rhodes Service Award**— Presented to Amy S. Gottlieb, MD, (University of Massachusetts Medical School, Baystate), for outstanding services to SGIM and its mission of promoting patient care, research, and education in primary care medicine.

**ACLGIM Chiefs Recognition Award**— Presented to Andrea L. Sikon, MD, (Cleveland Clinic). This award is given annually to the general internal medicine Division Chief who most represents excellence in division leadership.

**ACLGIM UNLTD (Unified Leadership Training in Diversity) Award**— Recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM. Its 2020 recipients are Utibe R. Essien, MD, MPH, (University of Pittsburgh), Joni S. Williams, MD, MPH, (Medical College of Wisconsin), and Brandon Allport-Altillo, MD, MPH, (University of Texas at Austin Dell Medical School).

**The ACLGIM Leadership Award** is given to a member of the ACLGIM who is within the first 10 years of faculty appointment. It recognizes skills in leadership in any number of areas of academic medicine, including clinical, educational, research or administrative efforts. The 2020 recipient of this award is Shana Ratner, MD, (University of North Carolina at Chapel Hill School of Medicine).

**The Quality and Practice Innovation Award**— Recognizes general internists and their organization that have successfully developed and implemented innovative role model systems of practice improvement in ambulatory and/or inpatient clinical practice. The 2020 award was presented to Mitesh Patel, MBA, MD, MS, (University of Pennsylvania Health System).

### Research Awards

**John M. Eisenberg National Award for Career Achievement in Research**— Presented to Eve A. Kerr, MD, MPH, (VA Ann Arbor Healthcare System), in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the continued on page 6
This has been a year of tumultuous and painful change. Headlines, social media, and other platforms constantly remind us of the societal drive towards a “new normal.” During this tumultuous time, I receive the metaphorical gavel as incoming Editor-in-Chief of SGIM Forum from Joseph Conigliaro, MD, MPH, with deep gratitude and sense of duty to amplify the diverse and powerful voices of our communities.

As I reflect on past works published in the Forum, I realized we’ve had this conversation before: SGIM Past-President Giselle Corbie-Smith, MD, MSc, articulated in her first President’s column in May 2018’s Forum how “social, economic, technological, and environmental change” are driving us towards a “new normal.” Many of these factors are still present, but now magnified by the clashes of a pandemic, a disinfodemic (or misinformation), anti-racism movements, and more.

For our communities as general internists, settling for the status quo is exactly what physician advocates, educators, and innovators just don’t do. Jean Kutner, MD, MSPH, our current SGIM president, reminds us that our community’s vision is to create a just system of care to promote optimal health for our patients. We are famously passionate and effective at what we do—striving to be better and do better for our patients and for each other. When our communities face adversity, especially our patients, we speak up, we adapt, and in doing so, we inspire those around us to do the same.

In this issue, we recognize our 2020 SGIM awardees, traditionally recognized also at the Annual Meeting. The Awards Subcommittee of the Education Committee offers us perspectives on growth into GIM clinician-educator careers through profiles of this year’s Clinician-Educator Award recipients. Additional articles offer glimpses into how our daily routines, professionally and personally, have been inexorably altered due to regional and global events. Ganith, et al., explore rapid adaptations to teaching virtual visit competencies to trainees, and Erickson writes about his own experience as a medical student dealing with new uncertainties around taking the USMLE. Eric Bass, SGIM’s CEO, responds to learners’ concerns about the “new normal” for them in the SGIM community.
The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—all SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.

O

ver the course of several months this spring, SGIM Council approved three statements: first, the “SGIM Position Statement on the Internist’s Role in Social Determinants of Health,” second, “A Message on Racial Injustice From SGIM Executive Leadership and Staff,” and quickly followed by “Ensuring Equity Amid the COVID-19 Pandemic: A Society of General Internal Medicine Statement to Members.” These statements represent the effort and perspectives of SGIM members, elected leadership, committees, and staff. While the documents were developed separately, they address interrelated concepts and are synergistic. Much of the health disparities seen in the pandemic have roots in social determinants of health (SDOH) as well as in long-standing biases in the delivery of health care.

Focus on these issues is integral to SGIM as its vision is one of a just system of care in which all people can achieve optimal health. This commitment precedes the attention brought to health disparities through the significant differential impact of COVID-19 on communities of color. It also precedes the attention brought to systemic racism by the brutal and shocking deaths of George Floyd, Breonna Taylor, Ahmaud Arbery, and Rayshard Brooks. In fact, the vision and plan for the SDOH statement long predated any of these current events. The combination of the pandemic and these highly visible examples has highlighted what many SGIM members have been working on and addressing throughout their careers. This expertise is reflected in the programming of SGIM 2020, which offers a breadth of relevant virtual plenaries, special symposia and abstract presentations.

While these three complementary statements are powerful, their impact will only be as forceful as what we, as a professional society, and as individual members, do. Our actions will speak louder than our words.

Our members regularly witness the direct effects that systematic racism has on our country’s healthcare systems and populations. The SGIM statements not only name the problems but also, more importantly, serve as calls to action. We can no longer be blind to the existence and impact of these issues in every patient we see, in our institutions and organizations, and in the communities in which we live and provide care. We must take ownership. SGIM is taking this challenge seriously.

---

**IF NOT NOW, WHEN?**

Jean S. Kutner, MD, MSPH, President, SGIM

---

PRESIDENT’S COLUMN

---

Our members regularly witness the direct effects that systematic racism has on our country’s healthcare systems and populations. The SGIM statements not only name the problems but also, more importantly, serve as calls to action. We can no longer be blind to the existence and impact of these issues in every patient we see, in our institutions and organizations, and in the communities in which we live and provide care. We must take ownership. SGIM is taking this challenge seriously.
Our mission is to cultivate innovative educators, researchers, and clinicians in academic GIM leading the way to better health for everyone. Now more than ever we must focus attention on the major organization goal of fostering the development of GIM leaders in academic and other settings.

Before the COVID-19 pandemic, SGIM’s leadership was acting upon recommendations made in April 2019 by the Career Development Oversight Workgroup, led by Mitch Feldman. The workgroup called for SGIM to adopt a uniform definition of what it means to be a core SGIM career development program, and only include as core programs ones that: a) extend beyond a single day; b) have continuity with learners; c) require reflection; and d) follow principles of good curriculum development. The workgroup also recommended: recruiting a new staff member to serve as Director of Education; developing a comprehensive set of career development programs covering foundational knowledge and skills; conducting periodic formal evaluation of the career development programs to determine their contribution to our mission; asking all career development programs to conduct a formal self-evaluation; creating a common evaluation tool that each program can use; and developing a centralized process for organizing and tracking mentoring activities.

Our new director of education, Dawn Haglund, was hired in late 2019 and she was immersed in leading action on the workgroup’s recommendations when COVID-19 emerged to disrupt plans for our national meeting. Since most of our career development programs include activities held at the national meeting, the loss of the meeting required reassessment of the programs. Last year, we asked SGIM’s Health Equity Commission to help develop a framework for incorporating health equity and diversity issues into our career development programs. Recent incidents of racial injustice remind us that such work is extraordinarily important. We plan to proceed with that work, reaffirming our steadfast commitment to raise up a diverse new generation of leaders in GIM committed to advancing health equity. The Society’s recently released position statement on the internist’s role in addressing social determinants of health is very timely in this regard. New ideas are likely to emerge as program leaders reflect on the recommendations for taking action in our spheres of influence, as educators, researchers, practicing physicians, health system leaders, and advocates.

We expect leaders of the programs to use the next year to re-imagine how to achieve their learning objectives, without so much dependence on an in-person national meeting. We envision finding new ways to facilitate the interactions and networking that are such important factors in the success of the programs. We also will be encouraging programs to consider options for connecting with members through the Society’s regional meetings, which will be held virtually in the upcoming year. Despite the financial hit from losing the national meeting, the Council has agreed to invest in a learning management system that will strengthen our ability to support all career development programs and educational activities. Thus, it will be a busy year as we re-imagine how to foster the development of GIM leaders.

References
MEET THE 2020 SGIM CLINICIAN-EDUCATOR AWARD RECIPIENTS!

Alia Chisty, MS, MD; Carla Spagnoletti, MD, MS; Daniella Zipkin, MD

Dr. Chisty (achisty@pennstatehealth.psu.edu) is an associate professor at Penn State Milton S. Hershey Medical Center, Penn State College of Medicine and a member of the SGIM Education Committee. Dr. Spagnoletti (spagcl@upmc.edu) is a professor at University of Pittsburgh School of Medicine, director of the Academic Clinician-Educator Scholars (ACES) Fellowship in General Internal Medicine and the Master’s and Certificate Programs in Medical Education, and chair of the SGIM Education Committee. Dr. Zipkin (Daniella.zipkin@duke.edu) is an associate professor at Duke University School of Medicine, associate program director for ambulatory care in the internal medicine residency program, vice chief of education in the division of general internal medicine, and a member of the SGIM Education Committee.

The Awards Subcommittee of the Education Committee is pleased to highlight this past years’ SGIM Education Award Winners! Here we share Q & A with each winner during which we explored the inspirations, triumphs, and challenges that contributed to their impressive achievements.

Paul Haidet, MD, MPH—Career Achievement Award for Medical Education

What inspired you to pursue a career in medical education?
One of my core beliefs is that great educators create an experience through which the students transform. This is a colossal task! No longer does the educator “tell” the learner the content, but he/she needs to create the conditions that allow the highest proportion of learners to discover something that will evolve their abilities. In 1967, Jimi Hendrix’s debut album, Are You Experienced, had the following quote: “Be forewarned. Most experiences make you a bit older. This one makes you wider.” We are trying to create an education experience that doesn’t make you older but makes you wider – that is the coolest thing ever and keeps me in the game!

To date, what is a career accomplishment that you are most proud of?
For me, I think less in terms of accomplishments and more in terms of engagement. Over the last 15 years, I have been most engaged with the arts in medicine. From my work in jazz and medicine, I believe that physicians can learn from jazz musicians and that improvisation is the “seventh competency.” Fostering things like adaptive expertise are all about educating people to be good improvisers. I am constantly thinking about how to do this with doctors.

Can you describe one of your biggest professional challenges and how you approached it?
Even though I was asked to lead two organizations, the Academy of Communication in Health Care (ACH) and the Society of Directors of Research in Medical Education (SDRME), leadership is not usually in my plans nor is it something that I would naturally seek out. Instead, what interests me in my daily work is the myriad of ways that leadership can go down. What we usually promote as ideal leadership qualities in medicine are sometime characteristics I don’t identify with. Instead of hierarchical and top-down leadership qualities, I am more interested in features of distributive leadership. Because of my style, traditional leadership roles feel like a constant challenge for me.

What advice would you give to a junior clinician educator who is looking to pursue a similar career?
In retrospect, the most important thing I learned in fellowship was not the content but rather how to engage in scholarly activity, collaborate with others in collecting data about a question, and organize my thoughts. That was super important training. My biggest advice to junior clinician educators is to find a mentor, do a fellowship if you can, and, in your first job, find the time to think in a scholarly way with a mentor about what you are doing, whether it is clinical practice, education, or both. If you approach your professional development in a scholarly manner, you will be constructing experiences that maximize the chances that you are discovering or creating something new and valuable. You will have evolved.

Rachel Bonnema, MD, MS—Mid-Career Medical Education Mentorship Award

What inspired you to pursue a career in medical education?
Medical education wasn’t on my radar as a student but during my residency at Pitt I had such admiration for my core educator faculty that I decided to pattern my career pathway off those folks. I didn’t realize at the time the breadth of opportunity that exists for clinician educators (CEs)! As a mentor, I help my trainees realize that a CE career isn’t just one pathway—we can focus on teaching, education research, curriculum development, and/or administration, and can work with various levels of learners. For those interested in becoming CEs, I help them delineate which path complements them the most.

continued on page 14
A SPECIAL THANK YOU
Eric I. Rosenberg, MD, MSPH, FACP, and Benjamin B. Taylor, MD, MPH,
Chairs of the SGIM 2020 Annual Meeting Program Committee

The past six months have introduced substantial changes into all of our professional and personal lives and unfortunately led to SGIM not being able to host the eagerly anticipated 2020 Annual Meeting in Birmingham. As chair and co-chair of the SGIM Program Committee, we were honored to contribute to the planning of the Annual Meeting. In place of a traditional retrospective article on the meeting, we wish to express our sincere thanks to the members of the 2020 Annual Meeting Program Committee, submission reviewers, and SGIM leadership for their innovative ideas, dedication, and steadfast focus on the meeting during a remarkable year. We encourage members to take full advantage of annual meeting content now available through SGIM20 On-Demand (https://connect.sgim.org/on-demand/home).

We can’t wait to see what’s in store for SGIM’s 2021 Annual Meeting!

References

FROM THE SOCIETY: PART I (continued from page 1)

way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator of the Year—Presented to Zirui Song, MD, PhD, (Harvard Medical School), for early career achievements and overall body of work that has made a national impact on generalist research.

Mid-Career Research Mentorship Award—Presented to Geetanjali Chander, MD, MPH, (Johns Hopkins University School of Medicine), in recognition of mentoring activities as a general internal medicine investigator.

Best Published Research Paper of the Year—Presented to John Mafi, MD, MPH, (University of California Los Angeles David Geffen School of Medicine), for his 2019 publication “Evaluation of an Intervention to Reduce Low-Value Preoperative Care for Patients Undergoing Cataract Surgery at a Safety-Net Health System.” This award is offered to help members gain recognition for their papers that have made significant contributions to generalist research.

Founders’ Grant—Presented to David S. Burstein, MD, (Northwestern University Feinberg School of Medicine). The SGIM Founders Award provides $10,000 support to junior investigators who exhibit significant potential for a successful research career and who need a “jump start” to establish a strong research funding base.

Mary O’Flaherty Horn Scholarship—Presented to Tyra Fainstad, MD, (University of Washington School of Medicine). This three-year career development grant is awarded to an outstanding junior medical school faculty member in general internal medicine.

Clinician-Educator Awards
National Award for Career Achievements in Medical Education—Presented to Paul M. Haidet, MD, MPH, (Pennsylvania State University College of Medicine), for a lifetime of contributions to medical education.

Frederick L. Brancati Mentorship & Leadership Award—Presented to Paul D. O’Rourke, Jr., MD, MPH, (Johns Hopkins University School of Medicine). The Brancati Award honors an individual at the junior faculty level who inspires and mentors trainees to pursue general internal medicine and lead the transformation of health care through innovations in research, education, and practice.

National Award for Scholarship in Medical Education—Presented to Kathleen Hanley, MD, (New York University School of Medicine), for her individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

Mid-Career Mentorship in Education Award—Presented to Rachel Bonnema, MD, MS, (University of Texas Southwestern Medical Center). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician educators.

SGIM
I have a confession to make—I have never been particularly interested in virtual visits. To me, the electronic medical record (EMR) was a lurking presence during clinical encounters that demanded my attention and derailed me during important moments of communication. The idea of adding even more technology to the clinician-patient relationship seemed daunting. Also, I was reluctant to embrace any technology that seemed to implicitly undermine the relevance of the physical exam, suggesting that healing by the “laying on of hands,” is merely a formality.

Enter the COVID-19 pandemic. Suddenly, the entirety of my outpatient clinical schedule consisted of virtual medicine patients—I had to learn how to do it well. Now.

To add insult to injury, I also had to be teacher and role model to the learners in my residency program on the skills of virtual medicine. And I had to do that virtually, too.

With some urgency, my colleagues and I invented our curriculum, and found very few sessions which taught learners the skills necessary for successful virtual medicine encounters, such as building rapport, tolerating clinical ambiguity, and making clinical decisions in the absence of physical exam findings. Utilizing the principles of adult learning theory, concepts of active and passive learning, and strategies for fostering learner independence, we developed a new case-based curriculum that leverages digital learning platforms and small-group work to teach learners essential skills in virtual medicine. In this article, we describe our new case-based virtual medicine curriculum.

Virtual Medicine Curriculum
The Center of Outpatient Education (COE) was developed in order to train future healthcare professionals to work successfully in interprofessional teams. Trainees within the COE include residents and students from the following fields: Medicine, Nurse Practitioner, Nursing, Pharmacy, Psychology, and Social Work.

Beginning in April 2020, the initial parts of the curriculum (Part 1 and Part 2) were taught in individual one-hour sessions using a VA-based telephone (audio only) conference system—subsequent sessions (Part 3) were conducted using Zoom. Trainees were asked to activate their webcams and microphones to facilitate robust interaction.

Part 1: The Fundamentals (One Hour)
In the first session, learners and faculty consider the differences between office-based and virtual outpatient medicine. Discussion focuses on appropriate selection of patients, virtual engagement with care providers, and managing technical difficulties. Learners are led through a discussion of faculty providers’ anecdotal “Top Ten” strategies for developing virtual rapport with patients. Additionally, faculty emphasizes the importance of creating a professional virtual environment through attention to clinical attire, lighting, and background.

Part 2: Advanced Skills in Virtual Medicine (One Hour)
During the second session, learners meet in small groups to discuss a series of case-based scenarios. These scenarios, which are adapted from Reisman and Brown’s article, highlight challenging aspects of virtual clinical practice, such as interviewing patients with dysarthria, navigating requests for opioid medications, and obtaining clinical information from caregivers. Learners discuss strategies for taking detailed medical histories, attending to non-verbal cues, and assessing for understanding in a virtual setting. They also develop strategies for avoiding diagnostic error and managing clinical uncertainty. Faculty facilitators help learners identify virtual best practices.

Part 3: Chronic Disease Management and Virtual Medicine (2-3 hours)
Subsequent meetings focus on chronic medical conditions (diabetes, hyperlipidemia, hypertension, depression) and explicitly highlight the similarities and differences in
“I’m scared to go to the hospital but I’m scared to stay at home.”

These words are uttered in between labored breaths by my elderly COVID-19 patient. Over the telephone, she tells me she has been feeling progressively more ill. Yet, she is worried about getting sicker or infecting others by going to the already overburdened hospital, citing the NYC Department of Health and Mental Hygiene’s mandate to “Stay Home, New Yorkers.”

Our office staff assists her in enrolling in the patient portal and walking her through the process of initiating a video visit. I am then able to see my patient “face-to-face” and assess her respirations. I help her download a pulse oximeter smart phone app; her daughter texts me with updates. A nurse from our clinic calls the patient frequently to check in. During one of our video visits, we are able to conference in the patient’s rheumatologist, who, in real time, provides expertise on titrating her immunosuppressing rheumatoid arthritis medications in the setting of an active COVID infection.

While the common goal of primary care providers has always been to keep patients out of the hospital, flexibility, creativity, and interdisciplinary teamwork are required when the goal now entails keeping patients out of the office as well. During this period, there has been an amazing expansion of remote primary care in ways that, even in as recently as early 2020, many providers and patients were resistant to trying or did not think were possible. However, the idea of providing care in a “geographically unbound system” is certainly not a new one. A 2019 New England Journal of Medicine Case Study in Social Medicine describes a pregnant migrant farmworker who receives fragmented medical care as she moves from farm to farm.1 The authors utilize technology to attempt to bridge these gaps in her care, including text-message check-ins and video visits by “bridge” case managers not tied to a geographic location. In this way, when we begin to think of providing care that is not bound to a traditional medical office, the possibilities for patient outreach, as well as for the role of the primary care provider, become vast.

We are currently experiencing such an expansion in our roles as primary care providers. We are forced to think outside the box, such as hosting weekly video check-ins with a patient with schizoaffective disorder to ensure that she is not decompensating in the setting of social isolation. In some ways, we are also changing how we practice medicine. We are attempting to adhere to evidence-based approaches in a space where there is still little to no formal guidelines on best practices. In a cultural shift, we are prescribing empiric antibiotics for dysuria and evaluating patients’ volume statuses through a Smartphone screen. There is an increased sense of urgency—not to mention a government mandate—to keep patients out of the hospital and in their homes and to provide safe and effective care from miles away. We are not screening for cancer, administering vaccines, or checking A1Cs. Even semi-urgent issues cannot be prioritized. It is not safe for our elderly patient with postmenopausal vaginal bleeding to leave her home for an ultrasound. We cannot send our COVID+ patient with abdominal pain for a CT scan, as this would require the scanner to be shut down for hours while it is cleaned.
Our medical office staff has also taken on new and invaluable roles, rapidly enrolling our established patients onto the portal and troubleshooting any technical difficulties so that patients can engage in video visits. To make sure our most vulnerable patients are being contacted during the pandemic, we used population health data to generate a list of our highest risk patients. A team of medical students called these patients to ask about COVID symptoms, social concerns such as food insecurity, and medication refills, and to gauge interest in a televisit. Patients who had been resistant to telehealth are now enrolled and successfully completing video visits from the safety of their own home.

Therefore, if this idea of providing remote care is not a new one, and our goal as primary care providers has always been to keep patients out of the hospital, why do things feel so different now? On the inpatient floors, our colleagues constantly ask: “Where are all the non-COVID patients?” Our sentiments were echoed in an April 2020 New York Times article entitled “Where Have All the Heart Attacks Gone?” As discussed in the article, some of the reduced admission rates may have to do with cancelled elective procedures. Expansion of telemedicine may also account for some, but would not necessarily account for the acutely ill. Are people staying at home and suffering, or worse, dying, rather than coming to the hospital? Is social distancing—less eating out, less alcohol, less physical exertion—removing many of the acute triggers for, say, an acute myocardial infarction or congestive heart failure exacerbation?

Perhaps outpatient physicians are doubling their efforts to keep patients at home. For example, a patient at our clinic who self-catheterizes is frequently sent to the emergency department (ED) to treat multi-drug resistant urinary tract infections. However, during the COVID pandemic, we worked to set up home antibiotic infusions for this patient. Similarly, a woman with type I diabetes, admitted a few months ago for diabetic ketoacidosis, confessed in a telephone call that she had run out of insulin and felt similar to how she did before her prior admission. Instead of sending her to the ED, we were able to arrange for the patient to receive IV fluids in the office. Stat labs were drawn and the patient was able to be seen by endocrinology the same day, with daily monitoring via telephone thereafter.

So, why aren’t we always doing things like this? Why are our EDs and hospitals usually full even when there is not a pandemic? We believe there are many reasons for this. General resistance to telemedicine, on both the part of the patient and the provider, has long been an issue. There is also likely concern about keeping patients in unmonitored settings, or fears that we are simply delaying patients from getting the appropriate tests or treatment. Many providers may not know how to set up, for example, home infusions, especially in areas that aren’t as resource-rich as New York City. Time, an already limited resource in the primary care setting, is certainly a factor; the process of setting up antibiotic infusions for our aforementioned patient took the better part of an afternoon. Coupled with concern that the patient may decompensate, this may not always be a feasible option.

We must maintain this current emphasis on keeping patients at home even as the pandemic subsides. But to do so, the following factors will need to be addressed first:

1. Currently there are many Smartphone apps for home vital monitoring, but they vary in accuracy. Before we can safely and reliably use them to guide at-home treatment, there needs to be more data on their use, and perhaps even safety trials and/or the development of healthcare app standards.
2. We need an expansion of accessibility to home medical equipment such as pulse oximeters, blood measure cuffs, and diabetic testing supplies, even for people without uncontrolled medical problems. While expensive, the ability to reduce in-person office and ED visits and forestall decompensation should make this program financially self-sustaining.
3. Should Smartphones themselves be considered necessary medical equipment? Should phone plans be covered by insurance so that patients can participate in telehealth? Should providers also be universally given technology so that their patients can reach them when it is safer for both provider and patient to remain at home?
4. We need to reduce disparities in telehealth accessibility through better spoken language and American Sign Language (ASL) interpretation resources.
5. The process of prescribing home blood draws and infusions should become streamlined and easier for the provider to access. Navigating multiple agencies makes ordering home services a daunting task with potential significant cost for the patient.

We have all become more creative primary care providers because of this pandemic. As we look to the future, we must work to advance these accomplishments while remaining cognizant that it is precisely the most vulnerable of our population who are most likely to fall through the gaps of a geographically unbound healthcare delivery system. That way, we will be best prepared for the next pandemic—and also for the endemic diseases that we face every day.

References

continued on page 16
balancing work and family poses a myriad of challenges—never made more apparent than by the COVID-19 pandemic. New professional duties for physicians include learning and implementing skills in telemedicine, video conferencing, PPE safety and ever-changing COVID-19 playbooks. Family life now entails social distancing necessitating education in the home (“crisis schooling”). How do we find enough hours in the day to manage an endless list of responsibilities while living, working, and teaching in quarantine under one roof? The answer lies in translating our physician skills as leaders, teammates, educators, and innovators to our youngest generation of learners—our children.

Our process began with the feedback of our children regarding the impact of social distancing on their learning. Perceived benefits included one-on-one attention and frequent breaks. Pitfalls included limited social interaction, frequent distractions, motivation and structure. Utilizing this information, combined with our personal parenting experiences, we sought to build and present a framework of tools to optimize success in managing the parenting experiences, we sought to build and present a framework of tools to optimize success in managing the home learning experience.

As a result, our process implementation focused first on how best to accomplish tasks. Adhering to the core leadership principle “preparation is the key to success” is crucial to facilitating the home learning experience. Through trial and error, we found that reviewing the lesson plan the week or night prior can help prioritize children’s activities in a way that accommodates parental work schedules. For those whose lesson contents are made available in the morning, a free-play strategy for the children was employed while the day’s outline could be mapped by the parent(s). Strategic planning may be needed to account for differences in sibling ages and complexity of tasks, such as teaching older children while younger ones nap/play. Creating relative predictability within the daily schedule including frequency and duration of breaks proved essential.

“What happens if I get sick or exposed?” “What about if both parents need to work?” The COVID-19 pandemic requires preparation planning around such realities. Quarantine and dual-physician families pose a unique challenge to lesson preparation and execution. Shared family calendars for meetings and activities help ensure that all family members are aware of the schedule. Distance education provides a unique opportunity to employ parent and student networks with technology. Social media and conferencing platforms exist to engage students in group learning. We can enlist other parents, students, or extended family members to take turns delivering or hosting virtual lessons. For those with older children, asking for assistance in educational tasks may ease parental burden while cultivating a new skill set in the child. Medical students and other organizations around the country have offered to assist families in need, creating another avenue for assistance. Lastly, online resources may help in developing a self-guided curriculum at home—including podcasts, audio books, online curricula, reading with family via video, etc. Regardless of what resources may be available, the framing structure depends upon the individual family. The lesson for us, as doctors, came in assuring there were multiple contingency plans and a team-based approach to account for a variety of pandemic-related scenarios.

“I don’t remember 7th grade math!” “What do I do with my toddler?” Becoming a teacher overnight certainly isn’t easy. Yet, for a large part of our lives, we were learners and, at some point, teachers (read: medical school, residency). Recalling those skills and applying them to our current situations has never been more relevant. Learning styles amongst children may differ, and planning should account for strategies to target those particular needs. Early school-aged and preschool children, for example, learn particularly well experientially. Sensory bins, puzzles and other active learning may work best to reinforce learning. We must also be cognizant of teaching to different levels of learners and needs. Older children can be used to employ a “buddy

continued on page 11
up” or “train the trainer” system to help educate younger siblings. For closer-aged siblings, consider synchronous subject education with targeted learner-level questions—not unlike medicine rounds. Where appropriate, micro-techniques, such as the “one-minute preceptor” and Socratic questioning, can be used to assess understanding and allow for feedback.3,4 The teaching strategies we employ in child pedagogy certainly can draw from our experiences in adult andragogy.

“My kid just isn’t motivated.” “This is boring.” Motivation is hard enough as an adult, imagine what our children are thinking when they are suddenly tasked to do schoolwork in their playrooms, wearing pajamas with a bevy of snacks at their fingertips! Planning and educational strategies are doomed without appropriate engagement. Learning at home is novel for our children and should push us to innovate accordingly. “Picking up” the students from their room in a cardboard school bus every morning may help maintain some semblance of a daily routine. “Strewing” is an example of subliminal self-motivation—items are left strategically out as invitations for children to discover previously forgotten toys, books, and concepts. Routine activities like cooking can be pivoted to help with math, reading, teamwork, and comprehension skills. Despite travel restrictions, online resources can be utilized to put together virtual trips to the zoo, amusement parks, internationally and even space. Knowing how your children learn will guide what experiences will mesh best with their strengths and interests. The same knowledge aids us as parents to be advocates for our children when they do return to schools.

“How do other parents do this?” “I need a break.” “Juggling work, school and family is exhausting.” Many of us are accustomed to discussions around wellness within the realm of our careers. During the COVID-19 pandemic our children are also facing new stressors and their mental and physical well-being is paramount. Modeling emotional intelligence, resilience, and flexibility are key. Our children are not exempt to having bad days like anyone else. The onus falls on us as parents and teachers to recognize these challenges and make adjustments. Celebrate the small wins in our days. If need be, allow schooling times to vary on a day-to-day basis to allow for adequate sleep and physical activity. Don’t allow small setbacks to derail the work you have done. Find things that your children and you can enjoy together. Integrate your work into their day by making cards for patients and frontline workers. Read, take walks, cook, craft, watch television, ride a bike. Take a break. Decompress. Breathe. Home education and family success is dependent upon your collective happiness.

Adding crisis schooling to the delicate balance of career and family doesn’t have to be the “straw that breaks the camel’s back”. We are physicians with a multitude of tools at our disposal to ensure success and happiness for our families (see above table for an overview). Through this experience, some of our most salient takeaways parallel those we see daily in medical education:

1. Preparation truly is the key to success
2. Allow for flexibility
3. Know your learners (children)
4. Utilize resources and techniques for learner (child) engagement
on the morning of Saturday, May 16, 2020, I woke up at 6:00 AM, tried to calm my mind with a ritualistic cup of coffee, and packed snacks for a long day. I left at 7:20 AM and turned around five minutes later, realizing that I forgot to take my wallet. Again, I left at 7:35 AM with wallet in hand and arrived at my testing center 50 miles away a half hour before my 9:00 AM United States Medical Licensing Exam (USMLE) Step 1 appointment, as instructed. The parking lot was empty. Nonetheless, I tried the door to the testing center—it was locked. No one was inside.

The USMLE Step 1 in its current form is arguably the most important test a medical student will take. While intended to be pass/fail for licensing, it reports performance as a 3-digit score, which is the most common factor used by residency programs to select applicants for interviews. Thus, it can impact where a person will complete residency, which specialty to practice, and whether they will be able to practice medicine at all. This emphasis has created a “Step 1 climate” that impacts pre-clinical learning and student wellness thereby putting an extra financial burden on students. Because of this, it was announced earlier this year that the Step 1 exam would change to pass/fail reporting. However, the COVID-19 pandemic has introduced new challenges for current test takers.

When I arrived to find an empty testing center, I was upset, but not entirely surprised. For the last two months, I had heard of my fellow medical trainees experiencing cancellation of their exams and difficulty with the rescheduling process. Prometric, the testing vendor for the USMLE, announced on March 17 that its testing centers in the United States and Canada would be closed until May 1. Students scheduled to take the exam during that time were forced to reschedule to a later date when they would be able to take their exam. Students needing accommodations had a particularly difficult time since they had to reschedule by phone—during times of high cancellations, Prometric had turned off its phones.

Throughout the spring, I watched with apprehension for word about the status of my exam appointment. Since my third-year clerkships weren’t scheduled to begin until June, I had originally scheduled my exam for May 14 with the hope that I could travel and see family before beginning clerkships. On April 23, it was announced that while certain locations would resume testing on May 1, many cancellations would be inevitable in order to adhere to social distancing at the testing centers. A large number of these cancellations were announced by e-mail on April 27. While I did not receive an e-mail that day, I grew worried that I would be one of the many who did not receive a cancellation notice and would only find out the exam was cancelled upon arrival at the testing center.

There was still an issue of which exact locations would be opening, and when. While the USMLE is considered an essential program, the opening of each site is based on a number of factors including local, state, and federal regulations. At the time, there was no updated list of when each site was supposed to open. Just three days after avoiding the mass cancellation, I, too, received notice that my exam was cancelled due to my center still being closed that day. I immediately checked for open spots and found none available in my state or in surrounding states for the next three months.

Despite preparing myself for the possibility, it felt like I was approaching the end of a marathon only to be told that the finish line was being moved back but not told how far. I was worn out, but needed to keep the information fresh because I didn’t know if I would take the exam in a week or a month or a year. My school adjusted its policy so that students could begin the next phase of training without having completed the exam; but, we were at risk of study burnout and worse performance on the exam the longer the delay.

On top of this stress was COVID-19 itself. I began my dedicated study period as my state began its stay-at-home order. I studied flash cards as more cases were announced, more studies published, and more people died. I did practice questions as hospitals became overcapacity and medical professionals begged for more personal protective equipment. I took notes while I worried about my family and if they’d be able to stay safe. Many of my fellow medical students had more worries, some amplified by the killing of George Floyd on May 25 and the subsequent uprisings.

I continued to watch the Prometric website for openings and just four days after the mass cancellation and over 24 hours after my cancellation, many spots suddenly became available late on a Friday afternoon. It seemed too good to be true. After more than an hour of waiting due to high traffic to the site, I was finally able to reschedule my appointment. I managed to get a date only a week later than my original date, but it was in my home state of Minnesota since those sites had been confirmed to open May 1 whereas the sites in Illinois where I attend medical school had not. While I knew I shouldn’t travel states away during a pandemic, it was what I was going to have to do to take the exam.

continued on page 16
This struck me personally on June 4 as our leadership team was deciding how to support students, trainees, faculty, and staff who wanted to participate in the June 5 “White Coats for Black Lives” demonstration. As a clinician, I found myself at a loss for words as I saw patients in my general internal medicine practice that afternoon, with half of my patients that afternoon happening to be black. Not wanting to make any presumptions and attempting to be sensitive to current events, I found myself asking “how are you doing?” while simultaneously sensing the inadequacy of this question. As a leader and as a clinician, I realize that I must identify what I can do from where I sit both professionally and personally to address these issues. Dan Heath, in his book *Upstream*, identifies three barriers to action:

1. problem blindness (I don’t see the problem or it seems inevitable);
2. lack of ownership (It isn’t my problem to solve); and
3. tunneling (I can’t deal with that right now).

This problem should not be inevitable. It is the responsibility of each of us to solve. To quote Hillel, “if not now, when?”

The SGIM statements could not be timelier. Our members regularly witness the direct effects that systemic racism has on our country’s healthcare systems and populations. The SGIM statements not only name the problems but also, more importantly, serve as calls to action. We can no longer be blind to the existence and impact of these issues in every patient we see, in our institutions and organizations, and in the communities in which we live and provide care. While it may not be entirely up to physicians and the medical community to solve these complex problems, we cannot ignore the important role that we as a society and as individual physicians have in addressing these issues, as clinicians, as leaders, as educators, and as investigators. We must take ownership. Being intentional within our scope of influence begins with self-awareness. We must make sure that we, and our institutions and organizations, aren’t inadvertently perpetuating the very things that we are railing against. SGIM is taking this challenge seriously.

In addition to heeding and creating action plans related to the recommendations endorsed in the three statements earlier referenced, SGIM is taking a purposeful approach to diversity and inclusion in all that it does. It is our responsibility to each other, to the field, and to the people and communities that we serve to act.

**References**

5. SGIM20 On-Demand Program Guide. SGIM. https://connect.sgim.org/on-demand/program-program-guide.

**References**

To date, what is a career accomplishment that you are most proud of? I’m proud that I challenge myself to try new things, develop new skills, and build new programs. For me, that has required me to embrace change. Change furthers your career and expands your opportunities. Change has allowed me to work with a wide range of learners, to develop expertise on a variety of topics, and to develop strong professional connections.

Can you describe one of your biggest professional challenges and how you approached it?
I like routine and knowing the “right” thing to do, so I’ve had to work hard to challenge myself to expand my boundaries and to embrace change. For instance, a couple years ago I was feeling stifled in my career and had to reflect on my professional goals and motivations. I had to work my way to a solution, by recreating what got me into medical education: by observing leaders who I admire, identifying their traits, and figuring out how I could enhance those in myself. In particular, I observed that many leaders evolve their interests over time, often by reaching beyond their own institutions, and sometimes by changing jobs in order to support this evolution. They also approach fear of change head on and work through adversity. I realized that I needed to be audacious in order to meet my professional goals. Now, I am more effective with helping mentees through their own challenges, having struggled through change in my own career.

What advice would you give to a junior clinician educator (or researcher) who is looking to pursue a similar career?
Say “yes!” The concept of “saying no” is widely touted in the mentoring world and it’s certainly the right thing to do sometimes. But some of the richest, albeit unexpected, experiences I’ve had were because I said yes. When someone presents me with an opportunity, I ask myself, “Can I learn something valuable from this person?” and “Is this opportunity likely to expand a skill set that I desire?” I encourage my own mentees to pause before saying no, even when an opportunity feels like a stretch. I remind them that with that stretch often comes growth. I try to find out what is keeping them from saying yes and help them figure out if those barriers can be overcome. As a result, sometimes their initial “no” becomes an obvious “yes!”

Kathleen Hanley, MD—Scholarship in Medical Education Award What inspired you to pursue a career in medical education?
I was lucky enough to have inspirational teachers, particularly in medical school and residency. Teaching seemed natural—it never occurred to me to NOT incorporate some teaching when I went through medical school. Ultimately for me, it came down to taking care of patients. I hope that my teaching is always in the service of patient care. I learned from one of my mentors (and SGIM past President), Mack Lipkin, that as a teacher you can have a multiplicative effect on others!

Building scholarship into your career is about being a part of a group. You start asking interesting questions, talk to people you work with, and the next thing you know it becomes a study. Staying accountable to my colleagues keeps projects moving forward.

To date, what is a career accomplishment that you are most proud of?
I am lucky to have been taking care of patients at the same place for 25 years. Sometimes, I care for extended families. That they bring their families to me, and put their trust in me, is incredibly gratifying. I feel I’ve helped people in really meaningful ways— to live the way they want to live, die the way they want to die.

One patient in particular that I met over 20 years ago was grappling with opioid and alcohol use disorders. She’d had multiple overdoses. Her other chronic conditions were out of control. She inspired me to start prescribing buprenorphine. She wanted me to treat her, so we made a deal: if she would take her medication, I would get my buprenorphine waiver. Now, her BP is controlled, she doesn’t miss appointments, and she’s only had one drug-related admission in 5 years. I feel like she wouldn’t be alive if we weren’t working together on this problem.

I’m proud to have built experiences for medical students and residents where they could hear patient stories and see this type of transformation. I want them to see that the struggle with substance abuse is not fruitless—patients can get better!

Can you describe one of your biggest professional challenges and how you approached it?
I like a lot of things! Patient care, teaching, research, other projects... Fitting things in and still being there for my patients is challenging. There is not enough time in the day to do all the things I want to do. It’s a true clinician-educator challenge, we have a hybrid job! I’m always going to be feeling like I’m pulled in many directions since things don’t fit neatly into a 9-to-5 workday.

What advice would you give to a junior clinician educator who is looking to pursue a similar career?
Take advantage of teaching and research opportunities that are presented to you. At the beginning of your career, it’s good to say yes! Don’t worry about doing too much—try out different things and figure out what you like.

Find your people—find a group of collaborators and colleagues to work with who care about the same things that you do. Reach out to the people you admire and who are doing the work you want to do. Don’t be afraid to have a conversation!
Our routines have shifted and there is no going back. And why would we? Our economies and institutions adapt and grow. So do we. We are a community of change—that is, a community that drives change. The powerful voices of internists and doctors globally will influence what we preserve in our health and social systems in our profoundly altered environments.

I am inspired by those voices—your voices—who drive us towards what we, our communities, and our patients need. In solidarity with past and present leadership and SGIM members’ voices, I welcome a new, constantly evolving, and better “normal” that this community will continue to shape in its creation.

Managing them in the virtual setting as opposed to the clinic. In contrast to Parts 1 and 2 of the curriculum, which are conducted over the VA telephone conferencing system, all of these sessions are held over Zoom. The faculty facilitator uses the first 10 minutes to introduce the case, outline the session format, and discuss group expectations. Learners are instructed to work together on an “unfolding” case, in which a clinician and patient navigate an outpatient visit, a follow-up telephone visit, and a video visit occurring during the COVID-19 pandemic. The cases are written to encourage robust discussion regarding management strategies (i.e., there are no right answers). However, the learners must work as a team to review appropriate guidelines and weigh the risks and benefits of various therapeutic options. The role of the faculty, in these sessions, is to highlight take-home points in virtual management, rather than to provide direction. Learners independently come to consensus regarding their recommendations and present them when the facilitator reenters the virtual meeting.

The “unfolding” cases encourage the learners to consider clinical decision-making in data-limited scenarios. For example, clinicians who engage in virtual medicine must consider the impact that physical exam findings (which are unavailable) might have on their diagnoses. Similarly, social or environmental circumstances (such as the COVID-19 pandemic) might limit a patient’s ability to complete laboratory testing necessary for treatment monitoring. These scenarios challenge learners to consider how evidence-based guidelines can be best tailored to the individual patient and their current situation.

**Lessons Learned**

To successfully practice virtual medicine, outpatient clinicians need to develop an evolved set of skills. This includes clinical skills unique to the virtual environment (gained through an evolving case-based approach with explicit attention to differences in the virtual environment and how to navigate them) and an emphasis on leadership/teamwork/communication (gained through independent small group work/accountability).

We have found that our virtual curriculum helps to foster those skills through the utilization of a developmental model where there is more independent small-group work and less faculty involvement as learners progress through the program. A focus of learning is for trainees to navigate the virtual learning environment, developing rapport with their colleagues, clearly communicating their opinions, and coming to consensus with their team. The virtual platform allows faculty to enter and exit the learning environment easily, fostering group cohesiveness, leadership, and autonomy among learners.

To date, this curriculum has been well-received by learners, who report satisfaction with the content as well as the small group activities. In the future, we plan to investigate how patient outcomes may be influenced by participation in this course.

Teaching virtual medicine through virtual platforms requires clear goals, creativity, and dedicated faculty. While practicing virtually is not always easy or preferred, utilizing a developmental case-based curriculum can help learners recognize the most beneficial components of virtual practice. Ideally, by providing not only content/clinical skills, but fostering and reinforcing skills in teamwork, leadership, and effective communication, virtual learning empowers trainees to optimize their experiences with this modality of practice.

**References**

I did not keep that exam appointment in Minnesota for long. I worried that I would drive all of that way and risk spreading the virus, only show up to the testing center and not be able to take the exam that day. If that was going to happen to me, I’d rather have it in Illinois close to where I live, as it nearly did.

Eventually, Illinois testing centers appeared as openings on the Prometric website. I didn’t truly trust that they were opening until I had assurance in writing from my medical school dean who had been in touch with the owner of a nearby location and was told that they were definitely going to begin testing. Eager to get the exam done, I switched my date to May 16 at that location. I called the location and confirmed the appointment three days prior. I did not receive the confirmation phone call from them the day before my exam that they had told me to expect.

At 9:00 AM on May 16, when I was supposed to be starting my exam, I e-mailed my dean from the parking lot of the empty Prometric location to ask what I should do. I heard from her within minutes. She said that she tried to reach the owner with no luck but was going to keep trying and told me to wait. I waited there with an internal medicine resident who had called to confirm his Step 3 appointment the previous day and had driven from Indiana the night before to take the exam. Neither of us confirmed the time of the appointment when we had called.

Within the hour, my dean was able to reach the owner who then contacted me. It turns out there was a scheduling error—one calendar had exams at 9:00 AM and another had exams at noon that day. Because they were busy training a new employee the previous day, they didn’t double check the schedule. Guess which calendar they saw. He was going to get an employee there as soon as he could. We were still going to be able to take our exams that day.

I tried to calm my mind and prepare myself to take the exam. I laughed, reflecting on how I had thought nearly forgetting my wallet was my last hurdle before taking the exam. Soon, an apologetic employee arrived and let us in. I began my exam at 10:30 AM.

References

SIGN OF THE TIMES (continued from page 9)