

PERSPECTIVE: PART I

COVID EQUITY AND VACCINATIONS

Monica E. Peek, MD, MPH, MS

Dr. Peek (mpeek@medicine.bsd.uchicago.edu) is an associate professor of medicine at the University of Chicago and the associate director (and director of research) at the MacLean Center of Clinical Medical Ethics. She serves on Chicago's Racial Equity Rapid Response (RERR) Task Force to address COVID disparities.

Racial minorities have, as with most diseases, suffered disproportionately during the COVID-19 pandemic. Yet, it is *racism*, rather than race, that mediates the bulk of poor health outcomes for racial minorities, including COVID disparities. The chronic effects of social disadvantage and discrimination affect the hypothalamic-pituitary-adrenal (HPA) axis, autonomic regulatory pathways, epigenetics, and other pathophysiological mechanisms that increase risk for cardiovascular disease, diabetes, and other chronic diseases that lead to poor COVID outcomes. Social genetic research has shown that racial discrimination accounts for 50% of the black/white difference in acute viral inflammatory responses. Within the United States, counties with higher proportions of African Americans have higher numbers of COVID-19 cases and deaths; such counties have more crowded living conditions and lower social distancing scores, higher unemployment, and lower rates of health insurance. Structural racism and residential segregation have forced a disproportionate number of racial/ethnic minorities into low-income neighborhoods that are more physically crowded and have fewer resources. People travel farther for supplies and testing, and often rely on public transportation to do so.

As such, racial disparities in COVID are largely due to structural racism. As new treatments and vaccines become available, one way to minimize the stigma and increase the acceptability among racial/ethnic minorities is to avoid saying that “racial/ethnic minorities are being prioritized.” To many people of color in the United States, those words may come across as meaning prioritization for experimentation or unknown harms. Rather, we should acknowledge that what we are prioritizing

are the *mechanisms* (e.g., structural inequities) that put people at risk, which are more common in racial/ethnic populations. That shifts the conversation to people with individual risks because of their occupation (e.g. essential workers) or medical burden, or groups of people at risk because of where they live (e.g., congregant living, buildings with multi-generational living or poor ventilation), rather than people with brown or black skin.¹

The National Academy of Medicine’s recommendations for phased COVID vaccine delivery are based on risk groups (e.g., high-risk healthcare workers, older adults in congregant living facilities) with a cross-cutting consideration for equity based on the Social Vulnerability Index of the Centers for Disease Control and Prevention (CDC).² The CDC defines social vulnerability as the resilience of communities (the ability to survive and thrive) when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks; socially vulnerable populations include “those who have special needs, such as, but not limited to, people without vehicles, people with disabilities, older adults, and people with limited English proficiency.” Racialized minority status is included as a variable in the SVI. Thus, by factoring in *how* people and communities become at risk for diseases like COVID, we can more accurately address these risks in an evidence-based and less-stigmatizing way.

Immunizations offer our best hope for stemming the COVID pandemic, but there has been significant concern about ‘vaccine hesitancy’ in light of findings from a national survey by Kreps, et al, about COVID vaccine acceptability.³ They found that Blacks, the uninsured, people with a personal contact who had COVID, and

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FROM THE EDITOR

PHYSICIANS' IDENTITY FORMATION

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
Editor in Chief, *SGIM Forum*

At a panel session, I once introduced myself as an American-born Asian (Chinese) woman, whose pronouns are she/her, married, previously divorced, a wife, non-mother (so far, by choice), and a daughter of immigrants. I'm also an emigrant, having ventured elsewhere some years after my training. Last year's events unearthed another aspect of identity that emerged into prominence for physicians in particular: political identity. While professional identity formation as a physician has long been the subject of intense study, medical education program design, and continued developmental efforts, political identity has been given far less attention.

Consider, for example, study findings published last October that estimated physician voter registration in California, New York, and Texas, among some of the most populous U.S. states, at 14% less than that of the general population.¹ Yet, there is no question that political identity has also become entangled with professional identity, as physicians—many among SGIM ranks—engaged in a variety of ways in the democratic process not just in 2020 but well before. One might also say there is no longer any room to “fear seeming political while practicing medicine,” as the study above suggested.

As 2021 continues, we demonstrate our values through our actions, much like our upcoming annual meeting theme of “Transforming Values into Action.” We bring our whole selves, including our intersectional identities, to the table and reinforce our values and actions through community and belonging. In this issue of *Forum*, articles offer a variety of perspectives from our community's common identity as general internists and members of SGIM. Jean Kutner, SGIM president, shares her own SGIM journey and sage advice from long-time leaders in the Society on getting engaged. Eric Bass, SGIM CEO, teams up with Schwartz and Staiger, chairs of the Leadership in Health Policy Program, to provide a vital update on a new primary care coalition in partnership with other professional organizations. Kwolek, et al, and Shrivastava and Bennett, offer two articles from the Women and Medicine Commission, introducing their new Workgroup on Parenting initiative launched in November 2020 and offering a program director's leadership view on policies to promote a family-friendly residency environment.

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SGIM VOLUNTEER LEADERSHIP: PAYING IT FORWARD

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

SGIM has been my professional home since I joined as a first-year general internal medicine research fellow, at the insistence of my fellowship director. Little did I know at that point the significant role that SGIM would play in my professional and personal development.



Throughout my 26 years as a member, one of the aspects of SGIM that I have valued most is the commitment and engagement of its members—this has struck me even more during this presidential year. Despite the even greater-than-usual demands we have all faced during the pandemic, or maybe because of it, SGIM members have risen to the occasion. I am impressed by the engagement, responsiveness, thoughtfulness and commitment of SGIM's member volunteers, particularly those in leadership positions. We all have multiple demands on our attention and could choose any number of ways to spend our most precious resource, our time and energy. So, why do so many busy people choose to volunteer to serve in leadership roles for SGIM? What drives their actions? I know my own reasons. I was curious about the driving forces for my colleagues. As a result, I reached out to fellow SGIM Council members and the Chairs and Co-chairs of the

SGIM Councils and Commissions with the following two questions:

1. Among all the things that you could do with your time, why choose to dedicate time and energy to serving in a leadership role for SGIM?
2. What advice do you have for SGIM members who may have interest in pursuing leadership roles within SGIM?

Responses were highly consistent, and they resonated with my own experience and perspective. These SGIM volunteer leaders talked about the rewards of contributing as an involved SGIM member. The respondents identified professional growth and development, connecting and collaborating with colleagues from across the country who share common goals, intellectual stimulation and camaraderie as the most common reasons that they found fulfillment in actively engaging

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SGIM Forum

Editor In Chief

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Editor.SocietyGIMForum@gmail.com

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Megan McNamara, MD, MS
Megan.Mcnamara@va.gov
Somnath Mookherjee, MD
smookh@u.washington.edu
Susana Morales, MD
srm2001@med.cornell.edu

Avital O'Glasser, MD, FACP, FHM
avitaloglasser@gmail.com
Tanu Pandey, MD, MPH
tanumd@gmail.com
Shobha Rao, MD
shobha_rao@rush.edu
Jorge Rodriguez, MD
jarodriguez1@partners.org
Gaetan Sgro, MD
gaetan.sgro@va.gov
Elisa Sottile, MD, FACP
Elisa.Sottile@jax.ufl.edu
David Walsh, MD
dawalsh@augusta.edu

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Q & A WITH SGIM'S CEO AND CHAIRS OF THE LEADERSHIP IN HEALTH POLICY PROGRAM: COALITION ADVOCACY FOR A NEW PARADIGM FOR PRIMARY CARE FINANCING

Eric B. Bass, MD, MPH; Mark D. Schwartz, MD; Thomas Staiger, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Schwartz (Mark.Schwartz@nyulangone.org) and Dr. Staiger (staiger@uw.edu) are the chairs of SGIM's Leadership in Health Policy Program.

Why does SGIM need to find a way to leverage and build a unified primary care coalition?

Unless we find a way to speak with one, louder voice, backed up by patient stories, we are destined to lance at windmills seeking smaller, incremental wins at the margins, while our hospitals and procedural colleagues drive the medical industrial complex away from a higher-value, primary care based health system. As explained in a recent perspective article, the fee-for-service payment system is incompatible with person-centered primary care.¹ The article cites the astounding fact that less than 5% of all Medicare spending in 2015 went for primary care services, even when defined broadly.

What is SGIM doing to help build a strong primary care coalition?

As indicated in the January Q & A column in the *Forum*,² SGIM has been nurturing its relationships with other primary care organizations by becoming an executive member of the Primary Care Collaborative and by reaching out to leaders of other professional societies. Through such efforts, SGIM had the opportunity to participate in a coalition formed specifically to address the need for a new paradigm for primary care financing. The coalition was convened by the Larry A. Green Center, and includes the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Board of Internal Medicine, American Board of Family Medicine, American Board of Pediatrics, and SGIM. The executive directors of the seven organizations have been meeting regularly since August, and recently came to consensus on a unified statement calling for “investment in health as the new paradigm for financing primary care as a public good.”³

What are the shared principles of primary care that guided development of the statement on a new paradigm for primary care financing?

The coalition based its approach on the shared principles

of primary care that were developed in 2017 with input from more than 350 stakeholders representing diverse aspects of the healthcare system.^{3,4} The principles affirm the importance of primary care that is: 1) person and family centered; 2) continuous; 3) comprehensive and equitable; 4) team-based and collaborative; 5) coordinated and integrated; 6) accessible; and 7) high-value.

What are the main features of the proposed new paradigm for financing primary care as a public good?

The new Invest in Health paradigm would “invest in primary care functions that promote optimal health for all members of society. With that investment, primary care physicians and their teams would be enabled to coordinate care locally, collaborate with community organizations and public health departments, and address known social drivers of health.”³ In the new paradigm, payment would be connected to preventive care and upstream social drivers of health, not just the downstream consequences of acute and chronic conditions. Payment would also be relationship-centered to support connections between patients, physicians, other members of the clinical care team, and the community. The paradigm also envisions primary care as a pathway to better health at the population level with primary care leveraging community-based resources in response to local needs. For more details about the proposed paradigm, see the full statement that includes a table comparing the Invest in Health paradigm with the current cost-based paradigm.³

Who are we calling to action?

The coalition calls on the federal government to work collaboratively with primary care organizations to: 1) apply a streamlined learning process for implementing new models of primary care financing that reflect the new Invest in Health paradigm; 2) eliminate regulatory structures and policies that bind us to the current paradigm; 3) operationalize the new paradigm in all primary care payment

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programs based on evidence of what works in testing new models; and 4) increase investment in safety net programs, public health agencies, and community-based services.³ The coalition calls on private and public sector payers to commit to changing the paradigm within the next two years, and it calls on other healthcare stakeholders to join us in efforts to change the paradigm. The coalition also calls on members of our organizations to help advocate for these changes.

We certainly hope that SGIM's members will help to amplify this unified call to action!

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As of mid-December 2020, the first waves of COVID-19 vaccinations in the United States have only just begun. Peek offers a critical commentary on equitable vaccine access for the most vulnerable communities suffering from poor outcomes COVID-19 due to structural racism. Reflecting on an earlier stage of the pandemic, Kutscher and Kladney compare COVID-19 test counseling benefits during the pandemic to those of HIV test counselling during the AIDS epidemic. From the front

lines, Holliday shares her emotional journey of caring for a dying COVID-19 patient as a resident and facilitating his family's final good-byes remotely.

We experience every encounter in our professional and personal lives through the prismatic facets of our identities. Yet, each of those facets is not necessarily immutable. Despite the uniqueness of every individual physician, we can clearly work collectively, collaboratively, and respectively—and we have—towards common

goals founded on common, strong values. Let's keep doing what we do best as physicians, our shared professional identity, and do so together.

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those who believed that the pandemic would actually worsen were less likely to report accepting a COVID vaccine. Given the existing profile of COVID disparities, these findings are particularly worrisome.

Yet, in a related *JAMA Commentary*, Opel, et al, reminded us that true vaccine hesitancy occurs when people are reluctant to get vaccinated *despite an available vaccine*, whose safety and efficacy profiles are known, and that has been approved for use.⁴ This is quite different than the hypothetical scenarios in Kreps'

study, in which vaccine acceptability varied substantially based on factors such as effectiveness, durability, and adverse events. Thus, part of the reluctance among study participants may have been due to a lack of sufficient information about the vaccines to make an affirmative decision.

As of late December 2020, two COVID vaccines reported to have 95% efficacy and no serious adverse effects other than a possible severe allergic reaction. An efficacy of 90% (vs. 50% or 70%) was associated with an increase in vaccine accep-

tance in the Kreps study, as was a lower rate of adverse events. Vaccine recommendations by the CDC and the World Health Organization (WHO) were associated with higher rates of reported vaccine acceptance, as were recommendations by Joe Biden (v. Donald Trump).

Then President Biden's first action was to create a COVID-19 Task Force comprised of scientists, clinicians, health policy experts, government experts, and public health professionals. This group, co-led by

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WOMEN AND MEDICINE COMMISSION'S WORKGROUP ON PARENTING: A NEW INITIATIVE

Deborah Kwolek, MD; Beth Lewis, MD, MPH; Elisha L. Brownfield, MD; Sneha Shrivastava, MD;
Megan McNamara, MD; Anna Volerman, MD; Kerri Palamara, MD

All authors are members of the SGIM Women and Medicine Commission's Workgroup on Parenting.

The Workgroup on Parenting's monthly evening event—the "Nighttime Parenting in Medicine Café"—is open to all and is held on the third Thursday of the month from 7:30 to 9:00 pm EST by Zoom. For more information on the Workgroup on Parenting please visit: <https://www.sгим.org/communities/task-forces/women-and-medicine>

Parenting is a highly rewarding, long-term, and high-stakes commitment. For physicians, parenting demands can have a negative effect on career trajectory and prospects for academic promotion, even in the best of times. Academic physician-parents need support from their institutions, chiefs, co-workers, and professional societies to fulfill their demanding dual roles. In response, the SGIM's Women and Medicine Commission (WAMC) formed a Workgroup on Parenting in 2020 to begin a parenting initiative.

In the past, women physicians received little encouragement to have children. Beth Lewis, MD, writes, "When my mother was admitted to medical school in the 1950s, there were few women in medicine, and she was told that she shouldn't ever have children. She returned to work within a week or two of giving birth to each of her children, and it was tough. The message was clear: in order to succeed as a physician, work needed to come first. In the workplace she was expected to act and perform as though her children did not exist."

Although attitudes improved since our parents' generation, clinic charting, answering e-mails, and completing academic work can stretch long into the night after homework, carpools, and baths for children are completed.

The COVID-19 pandemic cast large numbers of physician-parents into crisis mode and upended any semblance of balance. Abrupt and radical changes in schooling routines, the acute inability to obtain reliable child care, and the pervasive fear of infecting our families with an infectious disease are stressors that are unprecedented in their precipitous onset and universal reach. The ability of physician-parents to keep up with clinical responsibilities, research, scholarly endeavors, educational work, and administrative duties has become nearly impossible to manage. Ongoing chaos caused many parents, especially women, to cut back work hours, or leave work altogether.

The WAMC's support for parenting initiative has the following three major goals:

1. To increase SGIM programming around parenting issues including monthly meetings throughout the year to equip physician-parents for success;
2. To form a community for networking and to provide a safe space for members to vent, troubleshoot, share experiences, and feel supported;
3. To work with leaders throughout SGIM to increase their support for parents at their institutions, and to identify concrete strategies for helping physician-parents to succeed.

Building Community through Monthly Meetings and Networking

The Workgroup on Parenting launched monthly meetings for SGIM members and guests in November 2020. The "Nighttime Parenting in Medicine Café" invites physician-parents to meet virtually and discuss solutions with invited speakers. The meetings are designed to be entertaining, useful, and encouraging. Zoom-bombing children, pets, and family members are welcome.

In its first meeting, "Parenting During the COVID Pandemic with Thanksgiving," Dr. Kerri Palamara shared strategies and insights on dealing with parenting stresses during the pandemic from her work as director of the Massachusetts General Hospital Center for Physician Well-Being. After icebreakers to orient and connect the group, Dr. Palamara articulated and validated the many stressors physician-parents are experiencing today, ranging from exposure concerns, extreme workloads at home and at work, challenges with home and remote schooling, dynamic and new work environments, moral dilemmas, abundant worry (parental, financial, medical, career, etc), professional development delays, fatigue, and social isolation.

To manage these stressors, Dr. Palamara focused on three skills: 1) identifying feelings and needs using principles of nonviolent communication, 2) sharing your emotional whiteboard with others from the work of Nataly

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Kogan, and 3) self-compassion using the principles developed by Kristin Neff and colleagues. Workshop participants had the opportunity to practice these principles together in small groups using real-life experiences and to debrief as a large group to reflect on the experience and lessons learned.

In December, “Work-Life Imbalance” was presented by Dr. Deborah Kwolek. Participants reflected that the work-life balance is forever in flux and can be an unrealistic ideal. Participants were encouraged to ask themselves: How do you define success? Who do you allow to judge you? Can you set yourself free from your own criticism? Will you love yourself and be happy?

When lives seem balanced, babies, illnesses, deaths, natural disasters, or global pandemics upset the equilibrium. Participants were given advice for navigating difficult times: Don’t forget the aces in your back pocket: an MD degree, grit, intelligence, work ethic, and contacts. Stand up and fight for what is right. Pick your battles. Strategize. Be bold. Seek wise counsel. Advocate for yourself in a way that also benefits others. If you blaze a trail, others will benefit.

When we are under extreme stress, we switch to survival mode and lower expectations temporarily if needed. Remember that even if you fall, you can get back up again. Get support from colleagues and mentors and stay positive- remember that your career is a life-long endeavor.

Video recordings of the monthly presentations will be available online for those who cannot attend the gatherings. Future topics will include negotiating, self care, scheduling strategies, and managing work and home.

Annual Meeting Programming

The Workgroup on Parenting will host a special symposium and workshop at the Annual Meeting in addition to the parenting panel and usual WAMC programming.

A Special Symposium, “We are family: parenting challenges and

institutional responses for academic physicians during COVID and beyond,” will involve a lively discussion of parenting challenges, solutions and potential action steps from a Department of Medicine chairwoman, a chief of General Internal Medicine, an associate program director (APD), and the director of a physician-wellness program. Childcare issues, schooling issues, and emotional issues will be addressed with possible solutions, including extensions of deadlines related to research and other obligations, virtual visits, work-life boundaries, flexibility in scheduling, and fairness among faculty with differing scheduling needs. The need for institutional and cultural changes to support faculty and residents who are parents will be affirmed.

A Workshop, “Thriving, rather than just Surviving: Parenting and Medicine during the COVID-19 Pandemic,” will identify participants’ parenting-related challenges, provide a safe space for discussion, and encourage peer/near-peer support to help identify solutions. Participants will be given strategies for healthy work-life integration that they can propose to their departmental/organizational leadership. This workshop will form the basis for an expansion of the ongoing parenting network within the Workgroup on Parenting. Participants will be encouraged to exchange contact information to support their peers/near-peers after the workshop individually, or join the WAMC Workgroup on Parenting program.

Working with Leaders in GIM to Effect Positive Changes for Physician-Parents

For physician-parents to thrive, they require the support of effective leaders. The WAMC Workgroup on Parenting seeks to equip leaders with practical strategies gleaned from medical and business resources¹⁻³ as well as from the experiences of our members. Suggestions include the following:

- Connect physician parents to, or foster the creation of, social support networks
- Share available mental health and stress-reduction resources and encourage their use
- Work with benefit specialists to address issues such as leave, childcare, and coverage for medical expenses in case of illness
- Right-size job expectations providing flexibility of work
- Ensure all leaders are on the same page with issues such as expectations of the team and the exceptional impact of this crisis on physician parents
- Provide certainty and clarity, wherever possible
- Assess physician stress, identifying and addressing specific drivers of stress at the organizational level
- Recognize that everyone’s situation is different
- Approach physicians with empathy and compassion

Conclusions and Next Steps

The Workgroup on Parenting welcomes all parents to join our initiative. We will share personal experiences when parenting challenges are felt acutely during and after the COVID crisis. We are particularly supportive of residents and junior faculty and hope to engage and retain members who feel overwhelmed with the pressures of academic medicine. We will foster re-entry for members who have left medicine or SGIM and would like to return.

We will advocate for physician wellness, and fight against chronic stress and burnout. We will also work to reverse trends in which learners (residents and medical students) and junior faculty may be discouraged from pursuing advanced careers in medicine, such as subspecialty, academic, or leadership roles, due to parenting responsibilities or their desire to become parents.

Knowing that positive changes will need to be supported by the top

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CREATING A FAMILY-FRIENDLY RESIDENCY ENVIRONMENT AS A PROGRAM DIRECTOR

Sneha Shrivastava, MD; Wendy L. Bennett, MD, MPH

Dr. Shrivastava (sshrivastava1@northwell.edu) is a general internal medicine fellow at Northwell Health and an assistant professor in the Department of Medicine at Donald and Barbara Zucker School of Medicine. Dr. Bennett (wendy.bennett@jhmi.edu) is an associate professor in the Division of General Internal Medicine at The Johns Hopkins University School of Medicine.

Despite progress in work-life integration at academic medical centers and hospitals, healthcare professionals continue to face parenting-related challenges while striving to succeed in their professional lives. These challenges became even more visible during the COVID-19 pandemic, as parents struggled to remain professionally productive in the setting of reduced school and child-care support.¹ Although many healthcare professionals face parenting-related challenges, residents are disproportionately affected because of long work hours and reduced flexibility with their schedules.

To better understand parenting challenges and solutions during residency, Dr. Shrivastava interviewed Dr. Willett (lwillett@uabmc.edu), a professor of medicine and vice-chair for education, who has served as a program director at Tinsley Harrison Internal Medicine Residency Training Program, University of Alabama at Birmingham for eight years. She is a clinician-educator dedicated to medical education, focusing on issues related to women residents and career decisions regarding pregnancy, the impact on resident duty hour changes, and innovative curricular design and evaluation.

Throughout this interview, we highlight her experience supporting residents with parenting during their residency training, specifically during the recent COVID-19 pandemic, and identify ways that academic medical organizations and SGIM can support residents' parenting roles.

What are your thoughts on parenting during residency?

Parenting is an absolute joy, yet it is a challenge because of the enormous responsibility. Trainees have less control over their schedules, which makes parenting even more challenging. Despite this, if trainees want to have children, they should not delay it because of their training. The decision to be a parent should be driven by personal desires, priorities, relationships, and resources.

Can you describe your experience with supporting residents during pregnancy or the postpartum period and the challenges you faced?

I sit down with every resident who is pregnant or planning a pregnancy and go over the American Board of

Internal Medicine (ABIM) and the local UAB policies. I want them to have all the information to confidentially and privately make the best decision for themselves and their family.

I assure all of my residents that the program will be flexible and supportive. We adjust their schedules with appropriate advance notice. We never want someone to be on the night shift or the intensive care unit during the third trimester or immediate postpartum period. Postpartum, we usually bring them back to an ambulatory month with weekends off or a rotation with no night calls.

One of my residents was assigned to the emergency department (ED) when his wife was expecting a baby. We adjusted his shifts in advance for his paternity leave. As a surprise, the baby came a month early, and with the support of the ED, we were able to re-adjust his schedule without problems. Another one of my residents is on an ABIM research pathway, which is two years of categorical internal medicine residency and then fellowship. Due to this track's requirements, she worried she would need to use all her vacation for her parental leave so that she wouldn't have to extend her residency training time. Fortunately, the ABIM had recently clarified their Deficits in Required Training Time Policy.³ I did not know if this policy would apply to this unique training track, so I reached out to the ABIM about her situation. They supported me to apply the policy, and she was able to take both parental leave and her planned vacations. I am thankful for ABIM's support in recognizing that through competency-based assessment, we can allow her to have the important time to be both a mother and a trainee.

Can you give an example of what challenges you face with residents who are parents? Did they have any difficulties managing their parenting and training responsibilities during the COVID-19 pandemic?

Residency programs have a closed coverage system, meaning there are no "extra" people who are not residents to provide clinical coverage when someone is out on medical leave. The biggest challenge is to have a schedule that works and feels fair for all involved. In our program, residents are generous and support each other,

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covering their peers for parenting emergencies. We did not have any significant COVID-19 pandemic related parenting issues. One of my residents has school-age children, and I am sure the pandemic is difficult for her. We talked with her, checked in often, and asked if she needed any accommodations from the program. Since her husband was able to work from home, she did not require changes made to her schedule. But, programs need to be intentional when scheduling residents with parenting needs. Schedule changes are not always possible, but one should always try.

What changes would you like to see locally, regionally, or nationally so that you can better support your residents who are already parents and who want to be parents?

I am delighted to see the ABIM's policies become more transparent about the flexibility allowed for parental leave without extending training time. Many female trainees are primarily concerned about not extending their training.² I would love if there were an effective and equitable way for residents to take paid prolonged leave if they had any medical complications or by choice. It also would be great to find solutions for residents who extend their training without jeopardizing their fellowship aspirations.

We need to make a shift from viewing maternity leave as a burden. We also need to include men in our parental leave policies. We all need to break the stigma of not accepting female trainees in our programs because they might have children and need prolonged clinical coverage. This disparity in how male and female residents are treated regarding parenting needs should change, and parental leave policies should apply to all genders.

There also needs to be a greater awareness of the fertility issues that female physicians face; countless physicians have struggled with infer-

tility because they delayed starting their families until after training. That is probably what saddens me the most—children are wonderful! Residents who want families should not feel they need to put their family on hold for their careers, delay childbearing, and, therefore, risk infertility. There are opportunities for growing families and careers simultaneously.

In what ways do you think SGIM can support residents who are parents or in the process of becoming parents?

SGIM can support residents by providing awareness and support to their members since many of their members are also internal medicine faculty in training programs. For example, if more SGIM members know about the flexible ABIM policy, they could share this information with trainees. Junior faculty need to hear from senior faculty that it is acceptable to have children, to put their families first, not feel intense pressure to always prioritize work early in career. In 2020, most institutions want well-rounded, happy, and successful faculty who can stay in academics, balancing their careers and family.

Do you have any final words of wisdom for residents, program directors, or senior leadership at other programs across the country?

We have offered to pair trainees who are pregnant with junior faculty or senior residents, who recently had children, like a “pregnancy or parenting mentor.” These mentors can help answer questions, such as taking time off for pediatric visits and finding daycare and nanny organizations that can be trusted. There is plenty of information on the internet and social media platforms, but we can easily create these resources locally and provide trusted mentors.

Importantly, we need a culture change in medical training—trainees should feel comfortable and support-

ed to have children when it is right for them based on their priorities and resources. Residency programs need to have the culture, structure, and policies to be most supportive and helpful since people in Internal Medicine make excellent parents. Children are an essential part of many of our lives.

Supporting residents' aspirations to have children is equally important as nurturing their professional ambitions for their overall success and wellbeing. Residency programs, institutional leadership, and national organizations can increase awareness, provide updated information, and increase training flexibility to create a supportive system for the residents. Educational leaders and residents can refer to the full list of ABIM's special policies⁴ and can contact ABIM's academic affairs department via their customer service contact number for any additional inquiries.

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A CALL FOR COVID-19 TEST COUNSELORS

Eric Kutscher, MD; Mat Kladney, MD

Dr. Kutscher (eric.kutscher@nyulangone.org) is a resident physician in primary care internal medicine at NYU Langone Health. Dr. Kladney (mathew.kladney@nyulangone.org) is a clinical assistant professor of internal medicine at NYU Langone Health practicing at Bellevue Hospital.

In the first month of the pandemic, I spent countless hours answering phone calls on a free COVID-19 hotline in New York City.¹ Most callers would describe symptoms or scenarios leading to their call and would ask to be tested for COVID-19. They would share how they were scared, had heard mixed messages about COVID-19 from friends and social media accounts, and were unable to reach their primary care doctors. They had endless questions about what social distancing meant, how the virus could be transmitted, and the best ways to stay safe. Though the limited availability of tests in New York City at the time made it impossible to offer tests to most callers, many of the over 90,000 callers hung up getting what they actually needed—personally tailored information on how to stay safe during a pandemic.

Using an individual's motivation for testing as a means to educate and counsel on behavior change is not a new strategy—I had used it previously as an HIV test counselor prior to medical school. Test counseling was started in the early days of the AIDS epidemic, where no cure was available and fear, stigma, and homophobia interfered with accurate public health messaging. Even after the advent of HAART, test counseling remained the standard of care until the recent rise of pre-exposure prophylaxis. Counseling was valued for its role in helping individuals understand disease transmission, assess individual risk, and anticipate the impact of a positive test result. In using non-medical professionals who were trained only to perform test counseling, patients can have a more relatable provider and physicians can have more time to address medical management for their patients.

The early days of HIV/AIDS are quite similar to the early days of the COVID-19 pandemic. With the availability of a viral test without a cure on the horizon, a diagnosis can feel devastating for some who receive it. Politicization of the viruses has made access to accurate information too often inaccessible. Stigma plays a role, as some wrongly say that a patient “deserved” the disease for failing to follow recommendations for abstinence (from sex or IV drug use for HIV, and from social

interactions for COVID-19). For both viruses, public health guidance is transitioning to a harm-reduction approach. With HIV/AIDS, we had the rise of safer sex; with COVID-19, we have the rise of safer socializing.²

With a record number of tests performed daily, we must transition away from testing as a means to purely monitor viral spread, and towards testing as a means to share evidence-based information on how to remain safe during a pandemic. We must make COVID-19 test counseling the standard of care.

To make test counseling work, we must empower people to make informed decisions about individual risk based on their individualized risk profile and behavior. With almost 30 years of HIV test counseling, we know strategies that tend to work. The World Health Organization calls these *the 5 Cs*: consent, confidentiality, counseling, correct test results, connection/linkage to care. Each of these steps has a role in COVID-19 test counseling.

Consent and confidentiality require currently missing legal protections. We have learned from HIV that people avoid getting tested if they are fearful of what a test result means or how it may be used against them.³ With fewer people tested, the chance of inadvertent transmission increases, and public health is threatened. Thus, testing must always be optional, with laws barring employers from obligating tests for work or firing someone based on a test result, barring insurance companies from using COVID-19 tests to determine life insurance policies, etc. Positive test results are reported to local health departments for tracking and tracing, but as with HIV, it must be illegal for the health department to share information with any other branch of government, including law enforcement or immigration agencies. An individual's COVID-19 status must remain their own personal health information. All COVID-19 tests must come with transparent and explicit disclosures as to with whom the results will be shared.

Counseling for COVID-19 must occur in a non-judgmental manner where individuals are given

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space to discuss their understanding of COVID-19, its transmission, and what they do to keep safe. This “individual risk assessment” allows for behavior change and empowerment. We must understand that home quarantine is a privilege and help those who need to leave the home and interact with others may do so in the safest way possible. We must adapt our messaging to meet our patients’ needs, using motivational interviewing to help them strategize ways to make their daily routines safer. For some, this may mean strategizing how to reduce exposure at a work place or where to take “mask breaks” during the day. For others, it may entail brainstorming how to increase air circulation or rearrange beds in a mixed generation household. Individuals know their lives best—in serving as a resource, we can help our patients make tangible plans and enact behavior change.

Before patients undergo testing, the type of test performed, its limitations, and its implications must be discussed. This is particularly true for patients who request antibody testing, where there remains limited understanding of if an antibody test result has any clinical meaning. If patients misunderstand or misuse test results, we may do them a disservice by accidentally increasing risk-taking behaviors. For instance, a person with a negative COVID-19 PCR test may assume he/she is not infectious and visit family, despite actually having been within the window period for the test. A person with a positive COVID-19 antibody test may use this as a license to gather, without recognizing that he/she may still serve as a vector for disease transmission. With HIV, a negative test result despite risky behavior has been shown to increase inadvertently future risky behavior.⁴ Counseling about how an individual plans to use their test result is necessary to avoid unintended consequences of our medical interventions.

Immediate connection to a healthcare provider for those who test positive is an important step, as studies for HIV show a steep drop off in care-seeking behavior with each increased barrier in establishing care.⁵ Anticipatory guidance and support for those who test positive—including access to a pulse oximeter—can help patients know when to seek medical attention, and how to disclose their status to others if they feel it is necessary. We can provide our patients with tailored resources, such as NYC Health + Hospitals’ take care packages distributed to COVID-19 infected patients to assist in making quarantine feasible, or free hotel rooms for those who are unable to isolate from others.

Clearly COVID-19 test counseling must come with contagion precautions and may require the use of phone or video to allow information sharing and connection without increased risk of transmission. This can allow for remote counseling for patients in more rural areas with limited access to health care, who may eventually be able to self-swab but receive test counseling while awaiting mail-in results.

Similar to HIV test counselors, COVID-19 test counselors can be recruited from nonmedical backgrounds and trained by medical professionals. We can recruit test counselors from communities most hard hit by COVID-19 to ensure they are able to provide culturally and socially applicable advice to those at highest risk. Hiring counselors from disenfranchised groups can also help address some of the socioeconomic disparities exacerbated through the pandemic. General internists can be available to manage the team of counselors, results, connect with those who test positive, and address any urgent medical needs. Eventually, these test counselors can be involved in the rollout of the vaccine for COVID-19.

COVID-19 testing is as essential now as ever to improve epidemiological data, allow for contact tracing,

and best combat the pandemic. Universal COVID-19 test counseling can enhance access to care and acute information alongside a test result. In conducting personalized risk assessments, we can transform testing into a public health intervention focused on behavior change and safer socializing to decrease the spread of COVID-19. For our patients, knowing their status is important; understanding its implications essential.

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THROUGH THE MASK, FACE SHIELD, AND IPAD

Alison M. Holliday, MD, MPH

Dr. Holliday (aholliday@partners.org) is an Internal Medicine PGY-2 at Brigham and Women's Hospital and a clinical fellow in medicine at Harvard Medical School, Boston, Massachusetts.

Under normal circumstances, I meet family members at the bedside of a patient. Meeting with and supporting family members give meaning to my days. This is especially true during times when I have little control over the patient's trajectory; yet, what I can do is ease family members' suffering. Due to COVID, however, there were new rules about family members visiting—no family member could visit unless the patient was within days of death.

My patient was in the cardiac critical care unit where he had been struggling with COVID-19 for over a week on a ventilator. I knew that he was going to die in this hospital based on how his labs looked progressively worse.

As the medical intern on the team, it was still my job to ease the family members' suffering, and now I had to do so over the phone. I called them daily—there must have been eight people in the patient's wife's household every time I called—daughters, sons-in-law, grandkids. I pictured them sitting together every day anxiously awaiting my phone call. I sensed the patient's wife's fear during my calls, the tremor in her voice. The thought that my phone call could bring fear to people I wanted to help troubled me. I wanted to reach out and hold all of their hands through the phone. Instead, I had to focus on my job to update them, to somehow convey how sick he really was so they did not have to wonder or be misled. "He's still very sick," I would say with sorrow, and then I would describe the day's events. I would hang up, wondering if my phone calls adequately conveyed the severity of the situation. Did they *really* understand what I meant when I explained his need for increased medication to maintain blood pressure? Eventually, I had to tell them—over a phone, with zero facial expression, zero hand holding, and without them seeing the tears in my eyes—that their loved one was dying.

Most people do not want to die in a hospital, and most people do not want to die alone. Determined not to let this patient die alone, the day after relaying that horrible news, I obtained permission for one person to visit the patient while he was still alive. We were not sure whether he was going to die "within days," per the visi-

tor policy, which is why I had to obtain permission. The fact that I had to obtain permission for someone to visit my extremely ill patient on a ventilator haunts me. But finally, I thought, I have done something to help ease this family's suffering. Yet, when I told the family, I sensed that I had caused increased stress among them. "Only one person can say goodbye?" the patient's wife said quietly. The decision of choosing just one person was too difficult to bear.

Instead, we decided on a Zoom call amongst family members so that everyone could say goodbye together. Within hours, our compassionate palliative care team set it up. I promised the family I would be on the call to help support them, so I anxiously put on the gown over my scrubs, then gloves, then mask, then face shield to enter the patient's room and hold the iPad. The family I had spoken with so many times over the phone would now "see" me for the first time, looking extraterrestrial through an iPad screen.

Before I entered the room, I glanced at the patient's "about me" page taped to the door. Someone had worked with families to create "face sheets" on patients that included photos of them dancing with loved ones, facts about their favorite artists, or funny stories regarding their 60-year marriage. These helped fill the void, in some ways, of the patients' loved ones not being at the bedside sharing memories with us. I was not sure whether to be thankful for or upset by the face sheets. Recognizing the patients on ventilators as more human reminded me of why I was there but also made me feel angry. I was angry that these patients—these humans who surely made an impact in so many loved ones' lives—were dying with just their nurse, a handful of other medical professionals, and me by their side.

Still, I tried extra hard to pay attention to the face sheet this time before entering the room, to try to imagine what this patient's wife of 60 years could be feeling as she approached these final moments with her husband over Zoom. I took a deep breath and entered the room to hold the iPad. The family members with whom I had spoken daily, plus others, were on the Zoom call. I said hello

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through the mask and face shield, and I held the iPad to face their loved one as he lay there motionless on a ventilator. One by one, his loved ones said goodbye to him. My face became damp with tears, loosening the grip that my mask had against my face. My mind wandered to this patient's roommate, also suffering from COVID, also on a ventilator and very sedated. Could he hear this discussion?

I held my patient's hand the whole time through my glove. Normally when I hold a patient's

hands, I appreciate the wrinkles, thinking about the life those hands have lived, the hands those hands have touched. Holding the hand through my glove meant that I could only appreciate a pulse as he lay motionless.

After about one hour of good-byes, we wrapped up the Zoom call. "Thank you, doctor," the wife said, with seemingly genuine gratitude. "You're welcome," I replied quietly, not understanding what I was saying you're welcome for. The Zoom call felt wildly inadequate, and I did not

know what else to say. I wanted so badly to ease the family members' suffering. I wanted so badly to hug them. I wanted to and I needed to, for my own coping. I said goodbye through the mask, face shield, and iPad. I exited the room, removed the protective equipment, tucked back into our physician workroom, and cried alone. As the next wave of COVID devastates our country and visitor policies remain strict, I wonder how we can do better both for our patients' families and for our colleagues.

SGIM

COMMISSION UPDATE (continued from page 7)

levels of GIM, we hope to earn the buy-in of the chairs, chiefs, PDs and other leaders who are part of SGIM.

Corresponding author:
Deborah Kwolek, MD
(dkwolek@mgh.harvard.edu).

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SGIM

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with SGIM. In addition, respondents discussed the critical importance that SGIM played in their professional success and expressed a strong desire to “pay it forward.” One leader remarked “it’s hard to find a similar return on investment for my time elsewhere.” Another stated, “because I have received so much, I wanted to give back and help build the future of SGIM so that it could continue to serve others.” Finally, these leaders talked about identification with and a desire to further the SGIM mission—one leader remarked that “SGIM reflects my interests and values better than any other physician organizations” and another expressing appreciation for the “moral clarity of SGIM.”

SGIM is an organization for and of its members and is effective because of the passion and participation of its members; its ongoing achievements and contributions require active member engagement. SGIM members therefore drive its success and growth.

One of the many positive features of SGIM is that it is large enough for there to be a diversity of interests and activities, and not so large that it is overwhelming. There are opportunities for every SGIM member to become involved across a range of expertise and time commitment. In response to my second question, volunteer leaders offered the following advice for SGIM members who may be interested in pursuing leadership roles within SGIM:

- Jump in!
- Share your passion, both for a topic area and for the organization.
- Start somewhere. Get involved at any level. Volunteering for one role will open avenues for other roles, including leadership positions. Suggestions for places to start included:
 - Interest groups—start as a member and become a leader

- Regional meetings—regional leadership roles can lead to national roles
- Abstract reviewing or mentoring—to demonstrate your interest and contribute to advancing SGIM’s mission
- Committees or Commissions—participation as a member enhances understanding of SGIM and can lead to and inform future leadership roles
- Make yourself and your interests known within SGIM:
 - Introduce yourself to the interest group, committee or commission chair
 - Participate actively in the GIM Connect conversations
 - Submit an article to SGIM Forum, in consultation with the *Forum* Editor
 - Develop and communicate a clear idea and message about what is unique about you and how it will further or enhance the work of the group that you are interested in leading
 - Be persistent
 - Find key allies to promote and sponsor you within SGIM
- Talk to people who have served in roles in which you are interested. Learn about their experience and how it might be applicable to you. Seek advice from colleagues who can help you consider which roles may be the best fit for you.
- When you accept an assignment, complete it well and on time.
- The more experience you have with participating in SGIM at various levels, the more equipped you will be to lead. Through participation and investment in the organization, you start learning more about what the organization stands for and how it operates.
- Don’t let imposter syndrome get in the way of serving.

Every member adds a valuable perspective.

There was a consistent theme that the more people became involved with SGIM, the more they felt a part of the community and the more opportunities became available.

As I reflect on my own SGIM journey, I completely agree with my colleagues. Whether the professional growth and development or the personal connections and longstanding friendships made through SGIM, I have benefitted and received more from SGIM than I have given. As was stated by one of the respondents to my query, in SGIM “I have found my people.” The passion, commitment, engagement, and enthusiasm of its members make SGIM the special organization that it is. Active involvement in SGIM has provided some of my most fulfilling professional experiences. Many people, including me, refer to SGIM as their professional “home.” What makes it that are the people—the members and staff and their commitment and dedication to advancing our shared mission.

I encourage all SGIM members to become actively involved. To quote another current SGIM volunteer leader, “our field, our patients, our learners and society need you, your energy and passion.” There are opportunities for SGIM members of all interests and seniority. Wondering how to get involved? Talk with colleagues, mentors, or any current SGIM leader. The SGIM volunteer call for committees and commissions is open until February 26, 2020.¹

So, do it today—volunteer! Start on your pathway to SGIM volunteer leadership now.

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SGIM

SGIM's Dr. Marcella Nunez-Smith, will help restore public trust that it is scientists and other health professionals who are making decisions about COVID vaccine policy and implementation. Many states have their own certifying boards in place to re-evaluate data from the highly politicized FDA to assure the public about the safety of the vaccines.

Yet, in order to truly make inroads into racial/ethnic communities, we must acknowledge and address the sociopolitical factors that have led to vaccine hesitancy within these populations—historical and current institutional mistrust. Trust is not a compartmentalized construct; erosion in one institution (e.g., criminal justice) can affect trust in another institution (e.g. healthcare); institutional trust (e.g., health care) can affect interpersonal trust (e.g., trust in physicians) and vice-versa.⁵ In this incredibly tumultuous time of racialized state violence (e.g., police brutality) and racial reckoning, pandemic, and economic devastation, racial/ethnic minorities have suffered disproportionately in many aspects of their lived experience. Much of this could have been prevented, minimized, or relieved by governmental institutions, but the response, under the Trump administration, was woefully insufficient.

President Biden, as noted, has already taken steps to shore up the erosion of public trust in our public health and medical institutions. More action will be needed, such as the protection of essential workers with PPE and paid sick leave, the provision of temporary housing for COVID positive persons living in high-risk conditions for disease spread, and other measures that directly impact the ability of populations most affected by structural racism to reduce the risk, morbidity and mortality from COVID-19 within their communities. This is what will be needed to rebuild trust with the governmental institutions and medical agencies looking to deliver COVID-19 vaccines to high-risk populations.

President Biden will also need to show that he is ready to combat white nationalism. The terror that results from knowing that white nationalists are freely roaming the country—killing black and brown residents while wearing police uniforms, and executing coup d'état attempts at the encouragement of then-president Trump—has undermined trust in government in a deep, substantial, and long-term way for many racial/ethnic minorities. One of my clinic patients told me, “If the government is trying to outright kill you in the street, why not do so with a so-called vaccine?” President Biden is going to have to show a zero-tolerance policy for white terrorists in the United States, currently listed as the largest threat in the country. We have long tolerated white violence in the United States, but this must end if we are to unite the country, seek peace, and regain trust in our most fundamental institutions, especially by the most marginalized.

This election has proven that millions of Americans are ready. We have seen grassroots organizations working hard all over this country as people “say yes!” to democracy and to government. We will need to leverage that type of organizational operation in high-risk communities, with trusted, high-profile leaders who are armed with information, science and facts. Vaccine delivery may not happen inside of hospital walls for some racial/ethnic minority populations, but it can happen in *collaboration* with healthcare and public health organizations. General internists will be critical links for this collaborative work.

General internists will also be critical in the “ground game” of vaccine implementation. Never has the trusted space of the patient/provider relationship been more important to making life-saving decisions that can bring this country back from the brink of disaster. Physicians have, perhaps temporarily, returned to the status of heroes in the public space because of our efforts during

the pandemic. We must leverage that public trust and good will now, particularly among those whose trust has been so badly broken, in every patient encounter—every clinic visit, every hospitalization, every on-call conversation. And we must lead by example.

We have a long hill to climb in order to get to COVID-19 herd immunity for the most high-risk populations and for the country as a whole. But we currently have the tools, the people, and the motivation in place. We have never had more to lose or more to gain.

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Society of General Internal Medicine
Society of General Internal Medicine
1500 King Street, Suite 303, Alexandria, VA 22314
202-887-5150 (tel) / 202-887-5405 (fax)
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A windmill in Leiden, The Netherlands, that serves as a windmill museum.
Molen de Valk

Read next month's theme issue of *Forum* on Climate Change and Health.
See *Forum* Author Instructions online for artwork and photo submissions.