# SGIM *Forum*
## Society of General Internal Medicine

**IMPROVING CARE: PART I**

# MITIGATING SALIENT BIASES IN AMBULATORY MEDICINE DURING THE COVID-19 PANDEMIC

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## Introduction

COVID-19 has changed the way clinical teams care for patients in the ambulatory setting. Without awareness and intention, especially in times of high stress and high cognitive load, biases start to fill in gaps and holes formed by the COVID-19 pandemic. It is important for clinicians to recognize and eliminate these personal biases resulting in disparate communication practices and influencing the assumptions of physical and technological accessibility and safety. Utilizing the World Health Organization's characterization of intersectoral factors influencing health equity-oriented progress,[1] described here is our developed B-I-A-S checklist (see table) to be used when assessing patients, especially during this unique time of the COVID-19 pandemic, to mitigate personal biases through awareness, systematic thinking, and openness.

## B—Black

*A 36-year-old Black man declines the COVID-19 vaccine citing how his previous symptoms were incorrectly dismissed as not being COVID-19 by an emergency room physician.*

Racial disparities in hospitalization and mortality during COVID-19 are thought to be the direct and indirect result of major factors such as socioeconomic inequities, racial discrimination, and systemic racism. In addition to these larger systemic issues, individual clinician biases also negatively impact the care of minoritized populations, especially Black patients during this pandemic. Early in the pandemic, reports surfaced that questioned if Black patients were more likely to be turned away from the emergency department when seeking treatment for their COVID-19 symptoms, which would be consistent with prior studies on disparate care provided to Black patients.

There are several contributors as to why these reported differences exist. Implicit racial bias towards Black patients has been linked to poorer patient-centered communication indicators, such as more clinician-dominated dialogue and negative tone with patients, that can adversely affect medical treatment and decision making. Concurrently, greater patient perceived bias in care results in higher patient mistrust and lower confidence in the clinician. This has implications for seeking care and following medical advice in the treatment and prevention of COVID-19 spread. Understanding the negative impact of these biases, clinicians must take extra steps to neutralize these biases in patient communication.

Given the insidious impact of racial bias in health care, much attention has been paid to decreasing

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## SOCIETY OF GENERAL INTERNAL MEDICINE

# WHAT CAN BTS TELL US ABOUT COMPASSION FATIGUE?

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
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At the end of September, BTS, the famous K-pop group, visited the United Nations as newly appointed South Korean special presidential envoys. At first glance, this seemed like just another celebrity spotlight, capitalizing on influencer culture—a phenomenon that can be grossly distorted into platforms for profit, misinformation dissemination, or civil disruption. BTS backed the United Nations Sustainable Development Goals (SDGs),[1] which include issues of health and well-being, gender equality, climate action, peace and justice, hunger, and a dozen more SDGs.

I'm no K-pop stan and certainly don't condone the many hardships of the industry for idols and idol hopefuls. However, the message and brand of BTS is arguably one distinguishing feature that makes them so popular, relatable, and, I believe, on-point when addressing contemporary issues relating to social justice, equity, diversity, inclusion, and anti-racism. The BTS brand advocates for love for others and for oneself, and as envoys, they bear a message of hope for a better future.

In our post-truth present, that message is a welcome breeze of fresh optimism and inspiration in a stagnant bog of denialism and hate. Empathy and compassion fatigue among healthcare workers are verging on epidemic as fights against multiple fronts beat down physical, mental, and even spiritual defenses. Toxic positivity is not the answer, but some hope and recognition that we are not alone in our battles, and that the current generation is not "COVID's lost generation" but the "welcome generation,"[2] can help pave a way towards forging our shared future together.

The UN called the world to action to "transform our world" through the 17 SDGs.[1] We contribute our part through our work within and outside of SGIM. Let's hope efforts towards the SDGs, amplified by BTS's messages of love, compassion, and hope, are as infectious as their hard-hitting beats and dance moves.

## References

1. United Nations. 17 goals to transform our world. https://www.un.org/sustainabledevelopment/. Accessed October 15, 2021.
2. President Moon Jae-in & BTS at the Sustainable Development Goals Moment. Published September 20, 2021. https://youtu.be/jzptPcPLCnA. Conducted September 20, 2021. Accessed October 15, 2021.
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# NOVEMBER: AN IMPORTANT TIME OF THE YEAR

Monica L. Lypson, MD, MHPE, FACP, President, SGIM

*Every November, as well as at various times throughout the year depending on your locale, we must all recommit to performing our civic duty to vote. We do this alongside SGIM which continues to use its Advocacy Agenda as a tool to cultivate a 'system of care in which all people can achieve optimal health.*

For me, November is always a time that brings fond childhood memories to the forefront. It is during this time that I recall my parents opening our family home, a three-flat brownstone as a voting location one day a year for over the course of a decade. I vividly remember the days leading up to election day, when the large metal machines were delivered to our basement. I still remember the smell and feel of the heavy red privacy curtains. When election day arrived, I stared out the window into our front yard at the long line of strangers excited to cast their election ballots. This was Chicago, and those canvasing for alderman were told to stay away and off the grass! These early experiences taught me the value of the vote.

These memories compel me to ask that we all declare November as an important time to consider our individual civic duty and cast our ballots—even in non-presidential election years. City, county, state, and national elections are held each November and throughout the year—although often without the large-scale media gaze that occurs during a presidential election; they are equally important.

Due to the pandemic, we all were left unable to fully celebrate and reflect on the historic importance of the Women's Vote Centennial. However, it did not go unnoticed. Many novel voting methods emerged amid the 2020 presidential election to address fears related to the pandemic resulting in a generational record voting turnout.[1] One of those strategies was the development and rapid-fire expansion of efforts within health care to ensure patients were registered to vote. Healthcare workers, including myself, continue to discuss voting registration with our patients, to ensure they can advocate for themselves and their healthcare needs.[2, 3] We all must work together to ensure everyone is able to exercise suffrage, despite the multiple state-level attempts to limit and question the security of our elections.[4]

# Q & A WITH SGIM'S CEO AND THE CEO OF THE AMERICAN BOARD OF INTERNAL MEDICINE (ABIM) ABOUT THE DISSEMINATION OF MISINFORMATION

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### Why did the ABIM issue a statement on the dissemination of misinformation?

BARON: According to the Surgeon General of the United States, "health misinformation is a serious threat to public health."[1] On July 29, 2021, the Federation of State Medical Boards (FSMB) released a statement that "physicians who generate and spread COVID-19 vaccine misinformation or disinformation are risking disciplinary action by state medical boards, including the suspension or revocation of their medical license."[2] Their statement was issued in response to the growing dissemination of COVID-19 vaccine misinformation and disinformation by physicians in social media.[2] According to the Centers for Disease Control and Prevention (CDC), misinformation is defined as "false information shared by people who do not intend to mislead others," while disinformation is defined as "false information deliberately created and disseminated with malicious intent."[3]

ABIM leadership agrees with the FSMB that physicians possess a high degree of public trust that gives them a powerful platform for communicating with the public. As indicated in the FSMB statement, physicians have "an ethical and professional responsibility to practice medicine in the best interests of their patients and must share information that is factual, scientifically grounded and consensus-driven for the betterment of public health."[2] As indicated in the joint statement from the American Board of Family Medicine (ABFM), ABIM, and American Board of Pediatrics (ABP), "spreading misinformation or falsehoods to the public during a time of a public health emergency goes against everything our boards and our community of board certified physicians stand for."[4]

### What are the key points of the statement released by the ABFM, ABIM, and ABP on September 9, 2021?

BARON: The ABIM fully supports the FSMB statement and wants board certified physicians to know that such unethical and unprofessional conduct may prompt the board to take action against a physician's certifica-tion.[4] In the midst of this awful pandemic, board-certified physicians have a responsibility to give people the most accurate and timely information available. When overwhelming evidence indicates that vaccines against COVID-19 are safe and effective, it is unacceptable to denigrate vaccinations.

### How will ABIM distinguish between dissemination of misinformation and expression of a dissenting point of view?

BARON: We recognize that medical history is full of stories about physicians who challenged a prevailing point of view. Our statement is not intended to prohibit discussion of legitimate questions about the evolving evidence on COVID-19. However, we expect board-certified physicians to refrain from disseminating information that is factually incorrect (misinformation). No physician should disseminate information grossly inconsistent with reasonable interpretation of available evidence. If a physician wants to express a dissenting point of view, it should be done in a context that explains the reason for dissent relative to an accurate depiction of the relevant evidence.

### What should SGIM members do to overcome misinformation about the COVID-19 vaccines?

BASS: First, we encourage members to listen carefully to their patients' questions and concerns about the COVID-19 vaccines, recognizing that they may be reacting to unreliable sources of information. Second, we urge members to engage with the communities they serve to build trust in the advice we give as physicians, as discussed by SGIM's Past President, Dr. Jean Kutner, in the webinar she gave in June 2020 on "Dispelling Disinformation in the Time of COVID."[5] Third, we recommend that members explore opportunities to help their colleagues and trainees strengthen skills in addressing misinformation with their patients. At SGIM's last Annual Meeting, for example, an excellent work-

# SCREENING FOR AND MANAGING DEPRESSION: A COLLABORATIVE PRIMARY CARE PHYSICIAN PERSPECTIVE

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Although depression is one of the most common mental health disorders in the United States (U.S.) only 8.6 million (65.5%) received mental health treatment among the 13.1 million U.S. adults with serious mental illness in 2019.[2] Additionally, 70 percent of people who die of suicide visit a doctor in the month before their death and about 40% see a doctor within one week of their death. Many practices, including ours, have adopted the nine-item Patient Health Questionnaire (PHQ -9) as an easy, validated, evidence- based tool for screening patients who might have depression. Despite the implementation of validated screening tools for depression such as the PHQ-9 questionnaire, it is our opinion that reliance on these tools as the "end all, be all" of depression screening—without genuine discussion and inquiry—could lead to over- and underdiagnosis, particularly among vulnerable populations.

To be clear, the validity of the questionnaire across multiple populations is not, in our opinion, the main issue. The problem comes when we (1) stop using the questionnaire as a *tool* to aid in a diagnosis, but instead use it as our *only* diagnostic tool; and (2) assume that it has been validated across all patient types and populations. To that end, we deeply caution national quality reporting metrics and healthcare systems from relying on the PHQ-9 as the quintessential tool for which it was never designed to be.

In our clinic, the PHQ-9, a self-administered patient questionnaire, is administered in the exam room while the patient waits to see their doctor. This setup offers a quiet, private setting for patients, but may have under recognized shortcomings. Was this questionnaire designed for the patients we serve at our safety net clinic?

A screening questionnaire completed with all "no answers" marked should serve as a red flag for patients with limited English proficiency or low health literacy, those with cultural and/or individual concerns related to stigma about mental health, patients whose caregivers respond on their behalf because the patient has a chronic disability, or simply forgot their glasses, with limited vision, etc. Myriad other scenarios are possible, all of which could lead to false negatives causing possible depression to go undiagnosed. Further, because depression plays into a patient's ability to manage other chronic conditions, the impact of underdiagnoses can have broad implications for the mental and physical well-being of affected patients.

PHQ-9 scores may also be elevated, for example, among those with conditions such as chronic pain affecting their desire to participate in fun activities, or among those experiencing social distress related to homelessness, severe grief from loss of a child, food insecurity and social isolation, or domestic violence. The PHQ-9 questionnaire could lead to 'false positives' for major depression in our most vulnerable populations —people who seem depressed in their answers to the questions, but who are really just dealing with life's many challenges.

## Algorithmic Treatment based on PHQ-9

Primary care settings, national reporting metrics, and health systems use the PHQ-9 as their main quality measure for managing depression. Patients with positive scores are put into categories of mild, moderate, or severe depression based on their total score. Once a patient screens positive, their score is then monitored at each vis-

# HOSPITALISTS ARE INDISPENSABLE IN HEALTHCARE SYSTEM COVID-19 RESPONSES

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The COVID-19 pandemic placed incredible stress on the entire U.S. healthcare system—the need to care for patients hospitalized with a novel infectious disease, displacing elective surgical patients, and keeping "regular" medical patients' home—creating workforce and capacity mismatches. Limited personal protective equipment at the outset of the pandemic also necessitated changes in how clinicians were deployed. Although hospitalists across the country have long been involved in addressing healthcare systems challenges, COVID-19 suddenly placed them at the fore of a rapidly evolving pandemic response, including being tasked with developing workforce plans involving clinicians both within and outside of hospital medicine. We aim to describe what we learned from engaging with hospitalists nationwide.

Given the persistent strains on the acute care system, we believe the hospitalist operational and clinical skillset is instrumental to the agile and continuous development of hospital workforce plans. We propose a conceptual framework illustrating the relationships among skillset, innovation, and system constraints that should be considered when anticipating needs for workforce planning, deployment, and adaptation.

The Hospital Medicine Reengineering Network (HOMERuN), a collaborative research network of academic hospitalists, quickly mobilized at the outset of the pandemic to focus on dissemination of knowledge and learnings regarding effective pandemic responses. Several workgroups were formed, including groups focused on discharge criteria, physician and advanced practice provider wellness and support, medical education, clinical pathways, and workforce adaptations among others. Our workgroup, composed of 11 hospitalists from eight U.S. academic medical centers, surveyed colleagues nationwide to learn what inpatient workforce adaptations were being implemented and compiled surge plans and training manuals disseminated to non-hospitalist clinicians newly working in the inpatient setting. Follow-up focus groups and surveys also permitted tracking of staffing changes and operational practices as cases surged and receded. Virtual meetings, newsletters, and publications were used to share findings with hospitalists registered with HOMERuN.[1]

Through this work, we saw some commonalities in responses to the first wave of patients, such as patient cohorting and hospitalist supervision of specialists and advanced care providers who were newly working in an inpatient general medicine clinical setting. Although there were similar workforce adaptations deployed by hospitals across the country, we saw however even greater evidence of the need for unique planning in each health system. Contextual differences in factors including clinical staff availability, regulations around involvement of learners in COVID-19 care, and the physical environment across hospitals limited the wholesale application of uniform effective solutions from one institution to another without significant local adaptation.

Regardless of the adaptations put in place by a given institution, we observed that hospitalists were integral to making operational decisions, serving as leaders of workgroups, and overseeing daily communication and collaboration across complex health system networks. These observations reinforced the importance of hospitalists and their skillsets, balancing dual roles as front-line clinicians and operational leaders. Systems knowledge and systems process improvement have always been central to hospitalist work.[2-4] Hospitalists were uniquely positioned to lead the response to COVID-19 due to a deeply embedded understanding of the inpatient clinical context, navigating the inpatient setting to deliver care efficiently and safely to patients, accessing and utilizing system-wide resources, engaging in real-time, rapid process improvement, collaborating across clinical roles, and navigating communication channels.

The importance of well-established contextual knowledge in a time of rapid change was also apparent. Having a pre-existing, deeply rooted understanding of the system mitigated the uncertainty inherent in delivering clinical care to a surge of patients with a novel disease. In addition to process knowledge, hospitalists are among a small group of clinicians who interact frequently with almost all

other inpatient services and have rich local networks. Hospitalists are often asked to create order and workflows that bridge multiple disciplines, and coordinate care in complex social and clinical situations. In rapidly evolving, high uncertainty situations, relationships provide the basis for effective communication, sense-making, and learning.[5] Hospitalists uniquely possess the relational networks and operational knowledge in the inpatient setting to be most effective under the conditions of unprecedented hospital capacity strain.

The rapidity of dynamic change tested hospitalist ability to effectively navigate systems change. Participants discussed the challenge of continued changes on a workforce experiencing burnout. With the first surges, workforce planning relied on goodwill that was hard to maintain over time. Hospitalists' abilities to navigate complex systems and their skill in utilizing networks again enabled them to mitigate and overcome barriers. Hospitalists leveraged local, regional, and national networks to share information and solve local problems, with HOMERuN was an example.

With both the unique skillset of the hospitalist and the system in which hospitalists work in mind, we propose a conceptual framework for hospital medicine workforce planning, deployment, and adaptation that elucidates the iterative relationship between adaptation and context in the setting of system constraints (see figure). This framework illustrates that the hospitalists' expertise lies in the overlap of skills in both the clinical and operational domains, including patient safety, quality improvement, multidisciplinary communication and collaboration, and systems navigation. This dynamic interplay between clinical and operational expertise is the basis for the innovations necessary for meeting the demands of high-capacity scenarios. Communication and collaboration within clinical and operational domains, which are inherent in the hospitalist skill set,
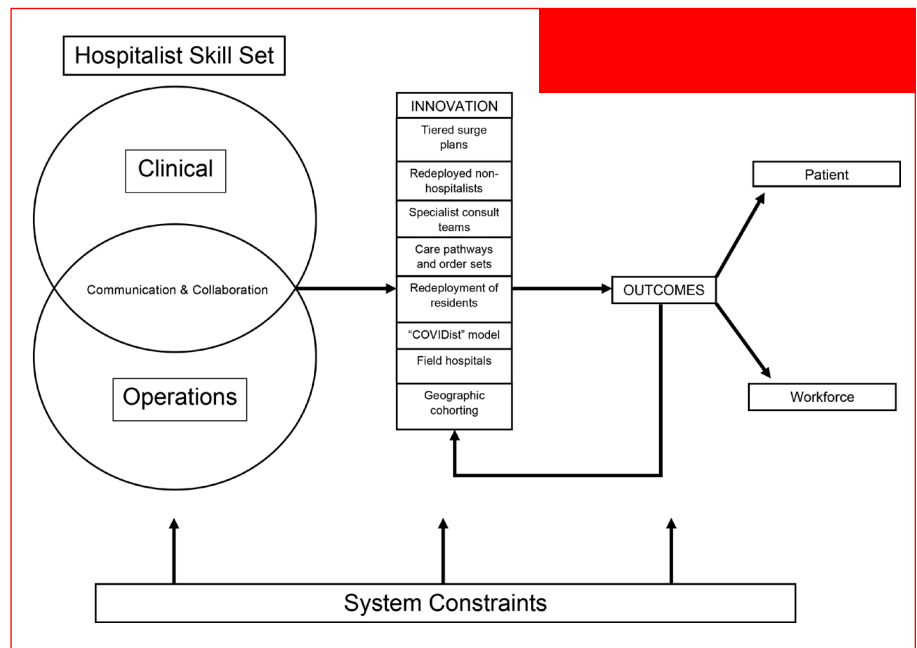


enables innovations to be attempted. These responses are shaped by local systems constraints, such as number of available hospital beds and ratios of other clinical staff. The outcomes that emerge from these new ways of organizing our clinical work, at both the patient and workforce levels, in turn shape future innovations.

Additionally, this framework provides examples of innovations, including the adaptations made in response to surges of patients, both COVID-19 patients and non-COVID-19 surgical, procedural, and medical patients. Our colleagues nationwide have described system/resource constraints including insufficient beds or ICU capacity, shortages in nursing and other ancillary staff like respiratory therapists, and a lack of redundancy in provider staffing. Navigating these system constraints to deploy adaptations that maximize patient outcomes (e.g., being discharged from the acute care setting as early as safely possible and reducing return to the hospital) and minimize workforce burnout was a challenge common across hospitals. Adaptations continue to be necessary as hospitals contend with both the evolving nature of the COVID-19 pandemic and pre-existing hospital capacity strain, particularly at academic medical centers.

Learning to adapt in dynamic environments is applicable beyond the COVID-19 pandemic. Hospitalists have an indispensable generalist clinical and operational expertise and skillset that enhances communication and collaboration and provides the necessary foundation for innovation across healthcare settings and situations. Our framework explicitly illustrates hospitalists' skillsets, showing how hospitalists can effectively lead and navigate rapid systems change.

**Disclaimer:** The views expressed do not represent the position of the Department of Veterans Affairs or other organizations affiliated with the authors.

# ACADEMIC HOSPITALIST BURNOUT DURING THE COVID-19 PANDEMIC

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Even prior to the COVID-19 pandemic, physicians expressed dissatisfaction with their workload and experienced burnout and mental health issues. A 2016 survey of academic general internal medicine physicians—including about 600 hospitalists and outpatient physicians—found that 67% reported high stress, 38% were "burned out," and 50% felt they had "low control" over their work. With the outbreak of COVID-19 pandemic, longer hours caring for sick patients, adapting to new practice structures and guidelines to cut down on transmission, and shortages of necessary medical equipment added increased stress to hospitalists. A recent Washington Post/Kaiser Family Foundation survey of 1,327 front-line healthcare workers in the United States during the COVID-19 pandemic revealed that an overwhelming 55% of front-line healthcare workers reported burnout (defined as mental and physical exhaustion from chronic workplace stress), with the highest rate (69%) among the youngest staff—those aged 18 to 29.

The COVID-19 pandemic poses unique long-term stressors and risks to physicians' physical, mental, spiritual, and emotional well-being. Leaders and front-line clinicians need to proactively protect the well-being of themselves and their colleagues to avoid adverse outcomes for clinicians and adverse effects on patient care quality. To better enable physicians to maintain personal well-being and resilience throughout the pandemic, our institution leaders aimed to monitor physician and especially hospitalist well-being.

To date, few studies have been published of successful interventions specifically to improve academic hospitalists' well-being.[1] Masters, et al, formed the UCLA Hospitalist Wellness Committee and with the creation of the Hospitalist Well-being survey offered an opportunity to pause, reflect, and intervene. The committee was a quality improvement project with the aim to support physicians through uncertainty and identify ways to help hospitalists thrive and the Hospitalist Well-being survey was a qualitative study to address and understand how the continued changes across the spectrum of health care affect the lives of individual hospitalists.

The aim of our study was to determine the prevalence of academic hospitalist burnout during the pandemic and then develop and evaluate an intervention in our division to improve emotional well-being and stress management during COVID-19.

## Needs Assessment

Using a survey, hospitalists at Loyola University Medical Center were asked to complete a survey job satisfaction, opportunities for professional growth, indicators of burnout and well-being, and their experience throughout the COVID-19 pandemic. Subjective well-being (SWB) refers to one's own cognitive and affective evaluations of their life and is most often measured as happiness and/or life satisfaction.[2] Various instruments to measure well-being are available, with a tendency internationally to use numerical scales, such as one that ranges from 0 to 10 (10 being the most positive well-being).[3] Using this scale, the survey asked hospitalists to think back to pre-COVID-19 time and rate their overall well-being level on a scale of 1 to 10 when they were at work prior to COVID-19 and during COVID-19.

The response rate was 65% (n=21/32)—82% of respondents rated their subjective well-being greater than 7 out of 10 before COVID-19; during the pandemic, only 45.5% reported well-being greater than seven. Further, 57% of respondents reported that they "were satisfied with the opportunities for professional growth" and 76.2% reported that they "had opportunities to apply their talents and expertise." However, 71.4% reported that they "were forced to weigh the clinical workload against their desire to have some other academic or administrative activities" and 52.4% felt that they "had an unsafe patient census during COVID-19, and that the workload negatively affected their patients'

care and their trainees' educational learning." Finally, 77.28% of the hospitalists rated their stress level at work during COVID-19 more than seven.

### Opportunities for Improving Hospitalist Well-being

Survey responses inspired dialogue within the group that helped identify core values and key opportunities for intervention. The division director met monthly with the hospital medicine leadership team and used the survey results to identify two areas for intervention:

1. Structural and process redesign
2. Daily noon huddles.

*Structural and Process Redesign*
The division director implemented a rotation of workers from high-stress services (COVID-19) to lower-stress services (non-COVID-19), flexibility in scheduling by allowing hospitalists to have autonomy in selecting how many days they could work in the COVID unit and trading shifts with others to cover those days off. As elective surgeries were cancelled, we dissolved our surgical co-management service to better accommodate our hospitals' needs and used cardiovascular surgery advanced practice providers (e.g., physician assistants and nurse practitioners) who released from their clinical duties to help with inpatient care. In the event of surge, our primary care doctors were willing on a volunteer basis to cover academic positions so hospitalists can focus on inpatient needs.

*Daily Noon Huddles*
Hospitalist leadership incorporated daily weekdays noon huddles via WebEx to ensure excellent patient care. Each 30-45-minute huddle, conducted by our division director, provided updates on the status of COVID-19 patients under investigation (PUI) and confirmed cases, updates in management of COVID-19 patients, boosting morale with updates on some small victories (e.g., a negative test, a patient with a good outcome) and create an open forum for communication and participation from hospitalists in decision making. Hospitalists introduced ways to navigate protocols and care pathways which eventually helped the group to make real-time changes. The regular daily huddle with our hospitalist team allowed our group to connect with colleagues at a personal level. Our director has made sure to set aside defined time for staff to discuss and reflect on their experiences. Doing so, has allowed our hospitalists to feel heard and acknowledge the difficulties faced in their clinical duties. When hospitalists were asked in a second survey to assess the daily huddles, 72.73% of the group felt that the daily noon huddle initiated by our division during COVID-19 helped with emotional well-being and stress management.

### Lessons Learned

With a brief survey, we were able to open a dialogue and proceed with two simple interventions that seemed to improve well-being for our hospitalist group. Burnout during the COVID-19 pandemic is present at higher than pre-COVID-19 era rates among healthcare professionals. Physicians, such as hospitalists, who provide front-line care are at an even greater risk. Management of these demands with increased support for physicians and identification of areas that yield more control to the provider over his or her work can prevent burnout and foster engagement. Engaged, healthy physicians are best able to deliver compassionate care, which leads to value for patients, providers, and the health system as a whole.

### References

1. Masters C, Lazarus M, Afsarmanesh N, et al. Pursuit of happiness: Creation of an academic hospitalist wellness committee and well-being survey. *Am J Hosp Med*. 2018 Apr;2(2):2018.008.
2. Diener E. Subjective well-being. The science of happiness and a proposal for a national index. *Am Psychol*. 2000;55(1):34-43.
3. Diener E, Inglehart R, Tay L. Theory and validity of life satisfaction scales. *Soc Indicators Res*. 2013; 112:497-52.

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### References

1. Linker A KS, Astik G, Keniston A, et al. Bracing for the wave: A multi-institutional survey analysis of inpatient workforce adaptations in the first phase of COVID-19. *J Gen Intern Med*. 2021 May 28;1-6. doi: 10.1007/s11606-021-06697-6. Online ahead of print.
2. Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. *N Engl J Med*. 1996;335(7):514-517.
3. Wachter RM, Goldman L. Zero to 50,000—The 20th anniversary of the Hospitalist. *N Engl J Med*. 2016;375(11):1009-1011.
4. The core competencies in hospital medicine: A framework for curriculum development by the Society of Hospital Medicine. *J Hosp Med*. 2006;1:2-95.
5. Leykum LK, O'Leary K. Annals for hospitalists inpatient notes—Sensemaking: Fostering a shared understanding in clinical teams. *Ann Intern Med*. 2017;167(4):Ho2-ho3.

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# THE SHARED RAFT

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*The following essay was one of the top three Arts and Humanities submissions
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Sociologist Arthur Frank's book *The Wounded Storyteller* describes serious illness as a loss of the "destination and map" that had previously guided the ill person's life.[1] Ill people have to learn how to "think differently" as their lives have been totally upended. Their "new normal" could be very challenging if faced alone. This mix of isolation and fear was precisely how it felt when I was suddenly forced to face a new reality brought on by an unwelcomed microscopic organism during Spring 2020. My life screeched to a stop, thrown by strong gravitational forces, caused by uncertainty and the fear of death. This stopping-in-my-tracks moment made me reflect on the way my patients felt soon after having been the recipients of a terminal diagnosis.

Back in the early days of the COVID-19 pandemic, it felt lonely and scary as I scrambled between my life as a doctor in a hospital in upstate New York, a mother of two children, and a daughter living far from her beloved elderly father. I remember those days as being marked by a vast cloud of surrealism, interrupted by showers of confusion and inadequacy. An initial sense of denial felt somehow familiar, making me think again of this common defense mechanism used by patients assaulted by a newly diagnosed devastating illness.

Frank also writes "the fatigue, uncertainty, sometimes pain and fear have always called for stories to repair the damage produced by illness"[1], especially after a terminal diagnosis has been disclosed. Patients' narratives under those circumstances tend to be chaotic and usually resemble someone experiencing a shipwreck in the middle of a storm. When I think of Frank's term *narrative wreckage*, Daniel Richter's dramatic painting *Tarifa* comes to mind.[2] The painting depicts a group of people hunkered low on an orange dinghy just large enough to bear their weight as a black sea threatens to engulf them all at any moment. I always found this painting a perfect metaphor for what many seriously ill patients endure. Somehow, I also think it depicts the inescapable feeling of uncertainty that many of us experienced during the early months of the pandemic.

During Spring 2020, the chaotic narrative was palpable in every story told by my coworkers, neighbors, and loved ones. The air was one of impending doom everywhere I turned. This new reality started to suddenly feel inescapable. The mandatory lockdowns and quarantines created a sense of entrapment. Inside the hospital, the use of tight masks coupled with a constant sensation of imminent danger made the air too thin and difficult to breathe. Along with my own physical and mental discomfort, I witnessed the relentless suffering by the most vulnerable and seriously ill. Images of patients of all ages, forced to remain in isolation and unable to have their loved ones by their side during their final days, became morally damaging. I constantly stepped on eggshells of fear, anger, anxiety and despair. This felt many times like a drip of poison endlessly running through my veins, a feeling that I envisioned my patients receiving chemotherapy have experienced.

The concept of time as I knew it was also transformed. Suddenly, I was confronted with no future, similar to what patients have described to me after given their terminal diagnosis. Like them, I could only plan for my day-to-day because of not knowing what to expect next or when this nightmare would end. Oddly enough, this somehow started to feel liberating. The usual time constraints, expectations, and deadlines were no longer a priority. This new collective timelessness and forced life-pause presented opportunities for reflection. My never before experienced phenomenon ended up displacing the unpleasantness of the initial months and lifted some of the pandemic's original burden. I started to cherish the extra time to reflect on the goodness in everyone and be grateful for all the good as well as the bad. I discovered the beauty within the pain. I embraced kindness and was even more driven to care for others and for myself with compassion. This tectonic shift in time and space helped me to let go and ride the waves of grief, something I had previously witnessed with family members and patients did as they contemplated the end of their life journeys.

This whole awakening propelled me to establish a new routine. I began to meditate, read more poetry, and do reflective writing. Last fall, I enrolled in Columbia University's Narrative Medicine Program to further study the intersection of humanities and Medicine. I also went for regular walks in a nature preserve near my home. And finally, after years of pondering, I decided to put a hold in my practice and embark on a Fellowship in

# RESILIENCE PERSONIFIED

Sangeetha Isaac, MD

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A typical day in the life of this 47-year-old man started with a morning walk with his dog, a healthy breakfast, and then a busy day at work at a company that he had passionately built over the past decade. "There's nothing like being your own boss," he said with a smile, and continued, "And coming back to my loving wife and kids completed my day."

Now, my patient, this same 47-year-old man, has been in the hospital with COVID-19 for four months. *Four months of admission for COVID-19?* This patient has had multiple COVID-19 complications, one after the other: respiratory failure requiring intubation, pulmonary fibrosis, deep vein thrombosis, pulmonary embolism, atrial fibrillation, lacunar stroke—all of which I was familiar with from reviewing his medical records when I assumed his care in the medical team.

When I first entered his room, I was struck mostly by how optimistic he was, despite what he has gone through. "This man has a different kind of strength," I thought. *Resilience personified.* He was polite, grateful, and warm. I pulled up a chair and sat next to his bed.

"Hi, Mr. J, how are you today?" I started.

"I am great doc, have nothing to complain [about]. Y'all have been so good to me," he replies. Nothing to complain about? He just lost four months of his life, I thought. "I am alive," he said and laughed like he just read my perplexed mind.

"Tell me more, Mr. J," I said. Then, he began narrating his life's course. His attitude added vibrant colour to the story he painted, which included his days in the hospital. An hour passed by before I interrupted, "What was the most difficult aspect of hospitalization, Mr. J?" I asked, trying to keep the question open ended.

"The isolation, doc," he paused and continued, "I wish families were allowed to visit patients with COVID-19. I understand the hospital policy and need to limit contact, but those days when my family was not with me, they were *the hardest*." As the rest of the day progressed, I questioned myself repeatedly: How have I not been sensitive to this need of my patients? If I were in his place, I would also have wanted the warmth of my family.

Days passed, and the day of his discharge arrived. We had made arrangements for transfer to a rehabilitation centre. "Hi, Mr. J. Today, we think you can be discharged," I said with a big smile. "Soon, you can go home to your family."

Mr. J teared up a little. "This hospital is a family that I am going to miss." With that, he made me realize how patients view their doctors and medical providers and how special is this doctor-patient relationship.

"This is worth the long hours in PPE, the meals we skip, and sleepless overnight calls we do as residents," I thought, as I signed his documents: Discharge! **SGIM**

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**FROM THE SOCIETY** *(continued from page 4)*

shop presented a novel approach to countering online misinformation about a COVID-19 vaccine. Lastly, we should support the ABIM and the FSMB in their efforts to combat misinformation and disinformation in our profession.

**References**
1. Confronting health misinformation. The U.S. Surgeon General's Advisory on Building a Healthy Information Environment. 2021. https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf. Accessed October 15, 2021.
2. FSMB. Spreading COVID-19 vaccine misinformation may put medical license at risk. https://www.fsmb.org/advocacy/news-releases/fsmb-spreading-covid-19-vaccine-misinformation-may-put-medical-license-at-risk/. Published July 29, 2021. Accessed October 15, 2021.
3. CDC. How to address COVID-19 vaccine misinformation. https://www.cdc.gov/vaccines/covid-19/health-departments/addressing-vaccine-misinformation.html. Updated September 4, 2021. Accessed October 15, 2021.
4. ABIM. Joint statement on dissemination of misinformation. https://abimfoundation.org/blog-post/joint-statement-on-dissemination-of-misinformation. Published September 8, 2021. Accessed October 15, 2021.
5. Kutner J. Dispelling disinformation in the time of COVID. https://www.youtube.com/watch?v=XOpK0rHnHmQ. Conducted June 12, 2020. Accessed October 15, 2021.

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it, to ensure that score is improving. From a national quality reporting standpoint, significant reductions in the total score indicates that the health professional is appropriately treating the depression. If health professionals don't achieve depression remission in the form of "better" PHQ-9 scores, they may receive lower reimbursements. This places physicians in the difficult position of "improving" their patient's moderate and severe depression with medications, in ways that often overlook cause.

Psychosocial factors, such as trauma, housing, education, and income, impact health; in fact, the U.S. Centers for Disease Control and Prevention estimates these factors make up 70% of a persons' physical and emotional well-being.[1] If a patient is depressed because a relative died, they have no housing, or because they have a substance use disorder, behavioral therapy may help with coping skills, but this does not resolve the underlying issues. Using the PHQ-9 as our mainstay is seriously problematic because it promotes a system that encourages health professionals to rely on numbers and circled answers instead of listening to patients and understanding the background, context, and etiology of their symptoms. We need time to diagnose situational depression, complicated grief, comorbid substance use disorders, and bipolar disorder. To the degree that the score stimulates such conversations and inquiries to occur, it may prove useful. If we fail to explore these factors, we ignore our patients.

The challenges of our healthcare system make this type of dialogue difficult at best. Ethnic minorities, in particular, often encounter additional barriers to treatment, including mental illness stigma, lack of insurance or underinsurance, lack of culturally competent care, and inadequate mental health services in safety net settings. Assuming such barriers can be overcome, how can we then juggle—in a time-constrained clinic

visit—five chronic conditions, yet still find time to have meaningful conversations lending insight into what's really on patients' minds? Issues with time likely also underlie the fact that while mental health disorders are the third leading cause of disability in the United States,[2] less than half of patients receive any pharmacotherapy or psychotherapy treatment.[3,4]

## A Way Forward

Given these many barriers, delivering care for mental health problems in primary care offices, with the assistance of embedded counselors, psychologists, and/or psychiatrists, has become an alternative model of care.[5] As primary care physicians, we are grateful for the integrated behavioral health services recently implemented in our safety net hospital primary care center. When our patients become tearful—from, for example, grief or stress—we are someone they can go to and talk to in real time. Our behavioral health team is keenly aware of the additional resources available and give us real-time feedback on management plans—whether it's cognitive behavioral therapy, group support, goal setting and action planning, or linkage to community resources and social worker support.

To the extent that the PHQ-9 has increased focus and enthusiasm around implementing integrated behavioral health, we are grateful. We look forward to continued funding and reimbursement of longitudinal integrated behavioral health across healthcare systems. Particularly im-

portant are capitated payment models that truly assess and reimburse based on social risk; such payment models might allow behavioral counselors, licensed psychologists, and psychiatrists the time needed for patients to feel heard. However, it is important to note that *health care alone does not have the resources or capacity to provide psychosocial solutions for all our patients' needs*. In truth, reducing depression rates starts long before the doctor ever sees a patient—it lies in part within the social constructs, pooling of resources, and political decisions made by local, state, and federal governments. To that end, we embrace community-engaged approaches, government advocacy efforts, and public health collaborations focused on improving the many social determinants that afflict patients and building resilience/empowerment within vulnerable communities, all of which can promote mental health and well-being.

## References

1. CDC. About Social Determinants of Health (SDOH). https://www.cdc.gov/socialdeterminants/about.html. Published March 10, 2021. Accessed October 15, 2021.
2. NIMH. Mental Illness. https://www.nimh.nih.gov/health/statistics/mental-illness. Accessed October 15, 2021.
3. Olfson M, Blanco C, Marcus SC. Treatment of adult depression in the United States. *JAMA Intern Med.* 2016 Oct 1;176(10):1482-1491. doi: 10.1001/jamainternmed.2016.5057.
4. McCarron RM, Vanderlip ER, Rado J. Depression. *Ann Intern Med.* Oct 4 2016;165(7):ITC49-ITC64.
5. Cooper LA, Gonzales JJ, Gallo JJ, et al. The acceptability of treatment for depression among African-American, Hispanic, and white primary care patients. *Medical Care.* Apr 2003;41(4):479-489.

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The SGIM's Advocacy agenda also comes to life in November and creates a path forward for our work. The Health Policy Committee develops the advocacy agenda alongside our government relations firm and brings it forward to Council, who then provides guidance and approves the plan which includes both coalition and active advocacy initiatives.[5] SGIM works with other large and small organizations to advance our goals and positions to create "coalition advocacy." You might find SGIM's signature on letters written by other organizations to show our support and endorse issues related to SGIM's core mission and vision.[6] Each decision to sign those letters and support various issues within a coalition is guided by our historical record on an issue; previously written white papers authored by our Health Policy Committee, as well as other SGIM Committees/Commissions, and approved by Council; as well as our own mission and values.

Our "Active Advocacy" efforts are germane to the work of the Health Policy Committee. The current advocacy agenda includes the following:[5]

- Advocating for payment and delivery models that ensure high quality, equitable primary care;
- Ensuring that primary care and other cognitive care visits are appropriately reimbursed within and after the COVID-19 public health emergency;
- Advocating for telehealth and telephone visits, ensuring that patients continue to have access to these services;
- Championing a policy environment that supports the National Institute for Minority Health and Health Disparities (NIMHD) as it works to eliminate disparities and promote equity and inclusion;
- Advocating that health equity is front and center as the NIH works to create Advanced Research Projects Agency for Health, or ARPA-H (a new initiative);
- Supporting the Agency for Healthcare Research and Quality and policy efforts to create a Center of Excellence in Primary Care Research;
- Supporting Graduate Medical Education reform to ensure institutions receiving Medicare funding for GME produce educational outcomes that lead to an equitably distributed high-quality workforce; and
- Championing policies that provide loan forgiveness and hazard pay to physicians in training and those in practice.

Every November, as well as at various times throughout the year depending on your locale, we must all recommit to performing our civic duty to vote. We do this alongside SGIM which continues to use its Advocacy Agenda as a tool to cultivate a "system of care in which all people can achieve optimal health."

## References

1. DeSilver D. Turnout soared in 2020 as nearly two-thirds of eligible U.S. voters cast ballots for president. *Pew Res Ctr.* https://www.pewresearch.org/fact-tank/2021/01/28/turnout-soared-in-2020-as-nearly-two-thirds-of-eligible-u-s-voters-cast-ballots-for-president/. Published January 28, 2021. Accessed October 15, 2021.
2. Patient Voting. https://www.patientvoting.com/. Accessed October 15, 2021.
3. Vot+ER. https://vot-er.org/. Accessed October 15, 2021.
4. CISA. Joint Statement from Elections Infrastructure Government Coordinating Council & the Election Infrastructure Sector Coordinating Executive Committees. https://www.cisa.gov/news/2020/11/12/joint-statement-elections-infrastructure-government-coordinating-council-election. Published November 12, 2020. Accessed October 15, 2021.
5. SGIM Health Policy Agenda: 2021-2022. https://www.sgim.org/File%20Library/SGIM/Communities/Advocacy/2021-22-HPC-Annual-Agenda-CRD-final.pdf. Accessed October 15, 2021.
6. SGIM Legislative Endorsements. https://www.sgim.org/communities/advocacy/legislative-endorsements. Accessed October 15, 2021.

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and ultimately eliminating bias. Establishing new patterns of practice that emphasize individuation and perspective taking have been shown effective in reducing racial bias. This focus on the individual's unique characteristics and perspectives results in increased clinician empathy and patient-centeredness which have been shown to improve patient outcomes.[2]

### I—Internet

*An 80-year-old man with a history of diabetes, hypertension, and prostate cancer was not offered information to sign up for the patient portal by his medical team.*

Digital health inequity has been exposed and brought to the forefront by the COVID-19 pandemic. While a digital divide still exists, it is worth acknowledging that most seniors (73% 65+ years-old), low-income (82% <$30k income), and racial-ethnic minority (85% Black, 86% Hispanic) Americans have Internet access, own smartphones, and are open to using digital health tools. In particular, low-income, racial-ethnic minorities often rely solely on their device for Internet access which doubles as a digital opportunity for patients who also tend to have worse health outcomes.

Beginning March 2020, the Office of the National Coordinator for Health Information Technology's (ONC) Cures Act aimed to increase the pace of innovation and investment in patient-facing tools.[3] Clinicians need to proactively offer access to digital tools to all patients and not just those who are presumed to have Internet or to use technology. In addition, primary care teams need to support patients' use of these digital tools and consider tailoring care delivery based on digital health delivery to maximize the end-user experience. The COVID-19 pandemic has made clear that telemedicine, patient portals, etc., are here to stay, such that clinicians need to encourage all patients to use digital health tools as part of standard care.

### A—Access

*A 58-year-old woman with a history of congestive heart failure and "noncompliance" does not show up to her three-month follow-up appointment.*

Bias may lead clinicians to hastily describe some patients as being "noncompliant" with follow-up or treatment, indirectly implying that a patient is apathetic to their own health. This characterization is inherently problematic given the lack of specificity of what can be true barriers related to social determinants of health.

As unemployment rates reached 14.7%, the highest point since the Great Depression, concerns for people losing employment-sponsored insurance and becoming uninsured and unable to access care increased.[4] High out-of-pocket costs and fewer paid sick leave will affect even the insured, forcing many to choose between their essential day-to-day living needs and maintaining health.

Further compounding these concerns, patients who rely upon public transportation to attend their appointments not only sacrifice substantial time and earnings, but they also increase their risk of viral exposure in doing so. Those with multiple comorbidities must navigate often fractured and distant networks of clinicians, placing the very same individuals at highest risk of COVID-19 complications at the highest risk for exposure during transit. Many bus and train schedules have also been reduced, making this commute more difficult than ever before.

To avoid missing these critical issues that inhibit patients from connecting with care, the best intervention is to consistently check personal biases in perceiving noncompliance by proactively screening each patient at every encounter for these barriers to access care. No patient visit should ever conclude before clinicians ask their patients if the plan of care realistically **"FITS"** any **F**inancial/**F**ood, **I**nsurance,

**T**ransportation or **S**helter barriers to access of health resources.

### S—Safety

*After you recently saw a 32-year-old woman via telemedicine for wrist pain, she was seen in the emergency department following an assault by her husband.*

There are concerns about whether individuals who experience intimate partner violence (IPV) are safely able to access a safe place. At the height of the pandemic in New York City, NYPD responded to a 10% increase in domestic violence reports compared to the prior year; however, domestic violence arrests decreased by 43% as compared to the preceding months. Fundamental to identifying IPV and healing from trauma is for the care be provided in a psychologically and physically safe environment. Assuming the same privacy previously afforded in clinic exam rooms while using telehealth modalities is dangerous when screening for IPV and discussing safety planning. In addition to explicitly asking if the patients can freely speak, offering flexible and alternative times for call back that may be outside the traditional work hours will improve access to care.[5]

It may be assumed that patients following precautions are easily able to balance their concern about exposure to coronavirus in the healthcare setting with the need to seek care in person care for concerning medical symptoms. In the first two months of the pandemic in the United States, there was 43% drop of patient visits at community health centers even when counting telehealth visits, and reductions in emergency room visits for myocardial infarction and stroke. Given patients' fear to return to care, clinicians must proactively reach out to patients at higher risk for disease complications, assess their fear of virus exposure in returning to healthcare settings and educate them about all modalities available to provide safe care.

**B-I-A-S Checklist**

| Checklist | Bias Impacting Care | Mitigation Strategy |
|---|---|---|
| B: Black | Disparate communication patterns negatively impacting provider engagement and patient trust | Establish new patterns of practice that emphasize individuation and perspective taking to reduce racial-ethnic bias |
| I: Internet | Presumption that certain patient groups are not capable of or interested in health technolog | Offer access to digital tools to all patients and support patients' use of these digital tools |
| A: Access | Description of patients as being "noncompliant" and "apathetic" to their own health | Screen for barriers to accessing health resources |
| S: Safety | Assumption of home as a physically and psychologically safe haven | Ensure privacy and assess for safety during all telemedicine visits |

## Conclusion

With COVID-19 infection rates rising from variant strains, the B-I-A-S checklist is a tool for clinicians to facilitate care engagement more sensitively and to ensure that their most vulnerable patients are equipped with the knowledge and resources available to maintain health.

## References

1. De Paz C, Valentine NB, Hoseinpoor AR, et al. Intersectoral factors influencing equity-oriented progress towards universal health coverage: Results from a scoping review of literature. Discussion paper series on social determinants of health, 10. *World Health Organization*. https://apps.who.int/iris/bitstream/handle/10665/255607/9789241512329-eng.pdf?sequence=1&isAllowed=y. Published August 9, 2017. Accessed October 15, 2021.
2. Williams DR, Cooper LA. Reducing racial inequities in health: Using what we already know to take action. *Int J Environ Res Public Health*. 2019 Feb; 16(4): 606. Published online 2019 Feb 19. doi:10.3390/ijerph16040606.
3. Rodriguez JA, Clark CR, Bates DW. Digital health equity as a necessity in the 21st Century Cures Act Era. *JAMA*. 2020;323(23):2381-2382.
4. Garret B, Gangopadhyaya A. How the COVID-19 recession could affect health insurance coverage. *Urban Institute*. https://www.urban.org/sites/default/files/publication/102157/how-the-covid-19-recession-could-affect-health-insurance-coverage_0.pdf. Published May 4, 2020. Accessed October 15, 2021.
5. Boserup B, McKenney M, Elkbuli A. Alarming trends in US domestic violence during the COVID-19 pandemic. *Am J Emerg Med*. 2020;38(12):2753-2755.

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Geriatrics. I could not be happier with this move. This most recent path of my journey as a human learner has provided me with the opportunity to interact with wonderful people and take care of vulnerable older adults in a variety of settings. These experiences have resulted in precious knowledge and led me into further exploration of my spiritual life. Needless to say, this career "sabbatical" has reinjected my practice of medicine with purpose and has given my life new meaning.

There is no question that life in the times of a pandemic has provided us with many negative and painful life changing experiences. However, it has also given us a gift to collectively experience uncertainty and discover new opportunities for spiritual growth. Staying present and attentively listening to others not only has deepened my human interactions but also has helped me heal. This pandemic has granted me a better understanding of what it means to suddenly lose a map and a destination. I now feel closer to patients who are constantly challenged by the raft of fear and who struggle with the dimensions of grief. I can better relate to what having an imposed life-pause means. And because I also ride the dark waters of uncertainty, I can connect more with those who do the same. Sharing the crowded, small dinghy with my seriously ill patients is also a constant reminder that there can be healing in the middle of the storm.

## References

1. Frank AW. *The Wounded Storyteller: Body, Illness & Ethics*. 2nd ed. Chicago: University of Chicago Press; 2013.
2. Richter D. Tarifa. Oil on canvas.137 ¾ x 110 ¼ in. Private Collection. *Artnet Worldwide Corp*. http://www.artnet.com/artists/daniel-richter/tarifa-UMnF2G4aNVSrw3ObwVMi5w2. Accessed October 15, 2021.

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**BREADTH: PART III**

# PUTTING OUT FIRES

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*The following poem was one of the top three Arts and Humanities submissions presented at the plenary session of the 2021 Mid-Atlantic SGIM Annual Meeting.*

I fear that this fury will burn itself out
That this righteous rage will be too easily quelled
I fear that this wound will scab and scar
And in the parts where there was once fire, a callous will form
A bitterness
A numbness
An acceptance
Will all this grief and fraught labor give birth to nothing?
After all, one must grow weary of this constant emotion
The buzzing in the head
The tightness in the soul

Maybe it is easier to feel nothing
To withdraw hands outstretched to the world
And to sleep inside oneself instead
To be aware of the slap, of the knot twisting in the belly
But still refuse to cry out
To endure, endure, and endure more
Suffer now, later, forever
Without making a sound

I pace the bridge between this Long Hot Summer and its ash
And I feel myself already flagging
Already growing weak in the knees
Burnt by the flames but also fearing their end

It is all to say I've a fear of myself
Either
Blowing, with each breath
New life on the embers
Or putting them out