

HEALTH POLICY CORNER

WHAT IS COMPREHENSIVE PRIMARY CARE AND HOW SHOULD IT BE PAID?

Robert Doolan, MD, FACP

Dr. Doolan (Robert.Doolan@CUAnschutz.edu) is an associate professor of clinical practice in the Department of Medicine at the University of Colorado School of Medicine and medical director of primary care for the Division of General Internal Medicine.

Primary care plays a central role in health care and provides comprehensive, patient-centered care across a patient's lifespan. Primary care helps patients focus on wellness, manage complex medical conditions, and navigate an ever changing and complex healthcare system. Access to primary care has been shown to improve patient outcomes and lower cost.¹ Yet, primary care in the United States is in a crisis.² Compensation models based solely on fee for service no longer align with all the demands placed on our primary care practices.³ What does primary care look like when it is highly functioning and how can our country support this critical mission?

Primary care has changed dramatically in recent years. Traditionally a primary care practitioner (PCP) would see patients scheduled in clinic, with minimal work outside of these visits, no population management, and no way for a patient to directly contact a clinician. The staff in clinic were there to support a PCP's ability to see patients. Payment was solely by billing of discrete patient visits through fee for service.

We have evolved into a new standard called *comprehensive primary care* which provides acute care, chronic disease management, preventative care, coordination of care across the medical spectrum, and outreach to at risk populations. As practices advance in their ability to deliver this care, they address mental health, social determinants of health, nutrition, transitions of care and longitudinal care management. Population based care and the change in patients' access to clinicians due to advances in technology are leading to new demands on clinicians and practices. Access standards, utilization rates, and cost of care are new metrics for our practices.

Unfortunately, current payment models neither adequately fund this new model nor support the work required of PCPs to meet these goals. A fee for a service payment model, as is currently prevalent, focuses compensation incentives solely on visit volume. This creates an incentive to see patients for visits when a visit may not be necessary and also provides a disincentive to more creatively addressing patient concerns through messaging or using ancillary staff, when appropriate. Instead, compensation needs to align with this new care model and create incentives to provide the appropriate level of care in the correct setting at the correct time adding value rather than volume.

The key to developing a new payment model is understanding the work that is accomplished in a clinic and tying funding directly to those activities. Medical assistants need to effectively room and move patients through the clinic (or virtually in telehealth visits), administer vaccinations, and provide ancillary testing. While these tasks can fit into a fee for service model, medical assistants also gather patient information, assess and pend orders to close gaps in health maintenance, and are key contributors in managing the flow of information with patients outside of office visits. Such work is clearly not tied to in clinic visit volume and fee for service billing.

Comprehensive primary care also relies heavily on nurses to manage the increasingly complex flow of asynchronous patient communications. Nurses using protocols can manage routine clinical issues avoiding patient visits, a practice clearly discouraged by current fee for service models. Nurses are able to assist with completing

continued on page 7

CONTENTS

1. Health Policy Corner.....	1
2. From the Editor.....	2
3. President's Column.....	3
4. From the Society.....	4
5. Leadership Profile.....	6
6. Best Practices.....	8
7. Book Review.....	10
8. Breadth.....	12

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FROM THE EDITOR

TIME TO RETURN HOME

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

What will it be like returning to an in-person conference? I have no doubt that this question has been on each of our minds as the SGIM 2022 Annual Meeting nears. Only days away, the annual meeting promises to be a memorable event. The last in-person SGIM meeting was in 2019 in Washington, DC, and feels like so very long ago. After all, the COVID-19 pandemic managed not only to distort our daily life and routines in unpredictable ways but also to warp our perceptions of time over these last years. What will it feel like to again assemble in large social or professional gatherings? How will we feel being together again in-person—connecting, networking, socializing, mentoring, and growing—at an event like the SGIM annual meeting?

When I wrote about “Finding Family in #MyFirstSGIM,” I channeled a special kind of nostalgia related to finding a professional home where I felt my values as a primary care clinician-educator were seen, heard, and fully embraced.¹ When I met with SGIM Council members at the December 2021 retreat at the conference venue in Orlando, Florida, an after-dinner conversation morphed into serendipitous discovery of shared childhood experiences (or more specifically, a shared third grade teacher, separated by a decade). Or, an initial bit of waffling on my part about being in a crowd, even outdoors, turned into a spontaneous decision to join a group outing to a local amusement park to stroll among the orchestrated attractions and then marvel at the impressive light and music show at the end of the night. Being present together offers opportunities to connect in so many ways: the two-dimensional alternatives on which we have survived these last couple years pale in comparison. What we really want, though, is not only to survive but to *thrive*.

The annual meeting marks an SGIM leadership transition: Monica Lypson, SGIM President, writes her final president's column in this issue before LeRoi Hicks, SGIM President-Elect, begins his term. During the annual meeting, *SGIM Forum* Editors want to hear from *you*:

- What excites you about being back at in-person SGIM?
- What special experiences or stories are you learning about or sharing with new and old colleagues at in-person SGIM?

continued on page 15

CELEBRATING THOSE BEHIND THE CURTAIN AND IN THE FRONT ROW

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

"During the past year as President, I tapped into sources of renewal and strength. If it were not for these many sources, neither I nor the society would be able to make progress forward. I recognize that it is the members that continue to ensure SGIM grows and adapts to the changing realities of the world we live in. I express my deepest appreciation for everyone behind the curtain who help ensure SGIM's innovative educators, researchers, clinicians, and staff can achieve our mission to ensure better health for everyone and establish a just system of care in which all people can achieve optimal health."



Over the past year, we have continuously navigated the impact of the SarsCoV2 virus on our loved ones, patients, and our small and mighty society of general internist and its supporters. I am grateful for the opportunity to pause and consider how we continue to face continuous challenges and change.

On any given day, especially those filled with regret, disappointment, and failure—Yes, I, too, have those—I stand firmly on the shoulders of those who supported before me to go on to another day. I am indebted to all those who cheer me on or lighten the load daily. During the past year as President, I tapped into these sources of renewal and strength. If it were not for these MANY sources, neither I nor the society would be able to make progress forward.

I am personally able to lead, grateful for my belief in a higher power that moves beyond me. I am also forever grateful for my ancestors for whom if they had given up, I would not be here today. As someone who can trace their ancestry back to the 1870 census, with formally enslaved family members on both sides, I am sure I have exceeded their wildest dreams.

I want to publicly express my deepest appreciation to both the inherited and chosen family members who supported me, even at times when they could not fathom what they were supporting me to do. I owe a great deal of my ability to navigate medicine and academia as a mother to Morgan and Grant and wife to Andrew Campbell, MD, because as Caitlin Moran put it, there is no glass ceiling in my home.¹ My mother Annie Lypton is a force to be reckoned with. She has always ensured I had the space and fortitude to fail, fail, and fail again knowing

continued on page 5

SGIM Forum

Editor In Chief

Tiffany I. Leung, MD, MPH, FACP, FAMIA
Editor.SocietyGIMForum@gmail.com

Managing Editor

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frank.darmstadt@ymail.com

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sjjani@usf.edu
Francine Jetton, MA, CAE
jettonf@sgim.org
Eric Kutscher, MD
eric.kutscher@nyulangone.org
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
Shobha L. Rao, MD
shobha_rao@rush.edu
Jorge A. 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 THE PRESIDENT AND CEO OF THE ALLIANCE FOR ACADEMIC INTERNAL MEDICINE (AAIM)

Eric B. Bass, MD, MPH; D. Craig Brater, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Brater has been the President and CEO of AAIM since 2007.

EB: What are the main goals of AAIM's current strategic plan?

CB: In September 2020, the AAIM Board of Directors approved a new strategic plan with a charge to elevate diversity, equity, and inclusion as the foundation for launching all initiatives.¹ The plan has two main goals: 1) AAIM will provide transformational professional development to physician and administrative leaders in academic internal medicine (IM); and 2) AAIM will redesign the transitions across the continuum of IM education.

EB: What are the most important current initiatives for achieving AAIM's main goals?

CB: To address the first goal, AAIM launched three initiatives:

1. Initiative One focuses on developing a new executive leadership and professional development program. The program includes new pathways for professional development.
2. Initiative Two focuses on creating a business of medicine education portfolio. The portfolio includes education and professional development opportunities to meet the needs of underrepresented faculty and administrators.
3. Initiative Three focuses on developing and disseminating best practices to improve medical education faculty performance. The objective of this initiative is to become the "go-to" resource for clinician-educators at the medical school, residency, and fellowship training levels.

To address the second goal, AAIM launched three more initiatives:

4. Initiative Four focuses on promoting innovation in medical education research. We expect this initiative to generate curricula across the continuum of IM training that support cultural competency, diversity, equity, and inclusion, as well as enhance medical knowledge and skill.

5. Initiative Five focuses on developing and disseminating best practices to expand opportunities for underrepresented faculty to be part of the physician-scientist workforce. This initiative involves creation of educational and networking opportunities.
6. Initiative Six focuses on developing robust evaluation and trustable communication processes for transitions during IM training. As part of this initiative, AAIM formed task forces that are developing recommendations on: competencies across the IM education continuum; refinement of the IM structured evaluative letter; the IM match process; standards for a robust handoff to include individual learning plans and graduate medical education (GME) orientation standards; inclusive and equitable standards for the interview process; meaningful and verifiable IM GME program attributes; and Electronic Residency Application Service filter options for holistic sorting of applicants.

EB: What are the best ways for SGIM members to contribute to AAIM's initiatives?

CB: AAIM seeks to facilitate collaboration between all organizations having a stake in IM education and training. For several years, AAIM has hosted regular meetings of the Internal Medicine Education Advisory Board (IMEAB), with representatives from the Accreditation Council for Graduate Medical Education (ACGME), ACGME Residency Review Committee for IM, American Board of Internal Medicine, American College of Osteopathic Internists, American College of Physicians, American Medical Association, Association of American Medical Colleges (AAMC), Education Commission for Foreign Medical Graduates, National Board of Medical Examiners, Society of Hospital Medicine, and of course SGIM. When the IMEAB met on February 11, 2022, we had a great opportunity to share the progress on our current initiatives and obtain valuable feedback from representatives of these organizations. We welcomed the participation of a representative of SGIM's Education

continued on page 5

Committee, Laura Snyder, MD, who is helping to identify opportunities for more SGIM members to contribute to the AAIM initiatives. For example, because many SGIM members serve as clerkship directors and residency program directors, they could provide input to the task force on standards for a robust hand-off, or the task force on inclusive and equitable standards for the interview process. In addition, SGIM members with expertise in the methods of medical education research could contribute to analytic work needed to support development of evidence-based standards. SGIM members also could help to disseminate and implement recommendations that emerge from AAIM's initiatives as well as study the subsequent impact of recommended changes in IM education and training.

EB: What do you see as the most important accomplishments of AAIM during your tenure as the CEO and President?

CB: This is hard for me to answer because there are many. But if I look at it from a macro-perspective, it goes back to the reason AAIM was birthed in the first place. All five of its constituent organizations were frustrated that they felt they were always in a reactive mode and that they had negligible clout with organizations making decisions that affected them such as AAMC, ACGME, etc. The notion was that if all could join together, we would have a seat at the table. So, we merged all five organizations. It took some time to get to what I would call "group think" and that is a constant effort not unlike within a Department of Medicine itself.

We now have a great forum for the different areas of medical education to talk with and understand one another. That has been very gratifying. To continue the theme of seats at the table, my position was created with that in mind; namely, the President would for the most part be the outward face of AAIM building relationships with stakeholders. I think our most important accomplishment is that it has worked and we now have great collaborative relationships with numerous organizations in the house of medicine including SGIM.

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SGIM

PRESIDENT'S COLUMN (continued from page 3)

that success is made up of getting up after all those falls. Andrew's parents and siblings have allowed me to move from one goal to the next. Many of you know my sister Lori Lyson and my bonus sister Helen Campbell, Andrew's twin, who ensure my head always fits securely on my neck and that my children have two aunts and others to help them navigate the world. You know these two aunts because they often travel with me and support me in my professional pursuits.

Finally, Morgan and Grant Lyson-Campbell, who tolerate mom being on a call, away at meetings, and at times distracted because they are inherently filled with radical empathy for those I am serving. Their well-being would not be on solid ground if it had not been for the nannies and babysitters who continue to pray and secure their safety as they travel through this world, including Shela Sequin-Johnson, Brandon Harrison, Shelby Jefferson, Nisha Seebachan, Monica Coggins and

Adeola Lawal, in addition to aunts and grandparents. These kind-hearted people are my secret sauce.

What you may not know is that I have an extended family and friend network that reaches into the hundreds; they are always there with a kind note via snail mail, homemade candies, and unbelievable support. The "Grants," "The Browns," "The Campbells," and those who I did not even realize had no blood connection to me have reappeared in technicolor over the last two years in a weekly now monthly family zoom call.

Professionally, my first exposure to SGIM as you know was as a resident at Brigham & Women's Hospital.² I could not be more grateful for their Title VII grant that ensured this first contact with our society. Those BWH colleagues continue to sponsor me...sometimes I know it and other times I find out afterwards. I was able to solidify my work with the society with the support of the faculty and leadership at the University of Michigan. Thank

you, Larry McMahon and James Woolliscroft who championed my work with SGIM as an important career milestone. My success in medical education research, presentations and publications at our meetings would not be possible without my friendship and collaboration with Paula Thompson.

It was JudyAnn Bigby, Valerie Stone, Giselle Corbie-Smith and Susana Morales who showed me the way as a woman of color in this organization. It is the ongoing guidance of Eric Bass, Arlene Brown, Jada Bussey-Jones, Crystal Cene, Hollis Day, Cristina Gonzalez, LeRoi Hicks, Dan Hunt, Thomas Inui, Jean Kutner, Rita Lee, Chavon Onumah, Donna Washington and many more that provide me respite on those difficult professional days.

I could not have run for office, nor succeeded in office, without the support of those affiliated with the VA and the George Washington University Medical Faculty

continued on page 15

LEADERSHIP PERSPECTIVE WITH DR. AMY S. GOTTLIEB, SGIM'S DISTINGUISHED PROFESSOR FOR WOMEN'S HEALTH 2022

Megan McNamara, MD, MS; Meagan Williams, MD; Deborah Kwolek, MD

Dr. McNamara (megan.mcnamara@va.gov) is a professor of medicine at Case Western Reserve University School of Medicine. Dr. Williams (meagsw@uw.edu) is a clinical instructor in general internal medicine at the University of Washington Roosevelt Women's Health Care Center. Dr. Kwolek (dwkwolek@gmail.com) is an assistant professor of medicine at the Massachusetts General Hospital. All co-authors are members of the SGIM Women and Medicine Commission.

Dr. Amy S. Gottlieb is the Distinguished Professor for Women's Health for the Society of General Internal Medicine Annual Meeting 2022. Dr. Gottlieb is Professor of Medicine, Obstetrics and Gynecology, and Associate Dean for Faculty Affairs at University of Massachusetts, Chan-Baystate, and Chief Faculty Development Officer of Baystate Health.

Reflections on a Career Advocating for Women Physicians and Faculty

Gender-based pay inequity in medicine has been well-documented, but concrete strategies for addressing it are lacking. We asked Dr. Amy Gottlieb, Editor of *Closing the Gender Pay Gap in Medicine: A Roadmap for Healthcare Organizations and the Women Physicians Who Work for Them*,¹ former Chair of SGIM's Women and Medicine Commission, and Chair-Elect of the Group on Women in Medicine and Science (GWIMS) of the American Association of Medical Colleges (AAMC) to reflect on her career in advocacy, her interest in gender equity, and "lessons learned" as a leader in academic medicine.

Not a Typical Path

Dr. Gottlieb's undergraduate training in Economics and her experience working in Corporate Finance in New York City provided her with a unique lens with which to view gender inequities in medicine. Her early career efforts were focused on improving health care for marginalized populations and developing curricula to educate providers about often-overlooked health concerns, such as Intimate Partner Violence. She joined the Society of General Internal Medicine (SGIM) in 2005 hoping it would provide a community of colleagues and an organizational home for her professional interests. As her career continued to unfold, she noticed "gaps" in leadership opportunities for women physicians nationally, prompting her to establish the SGIM Career Advising Program (CAP) in 2013. This program, dedicated to advancing the

careers of women physicians through sponsorship and networking, has impacted more than 360 SGIM faculty. During our conversation, Dr. Gottlieb drew a parallel between finance and medicine, noting that "the inequities we see (in medicine) are a confluence of traditional business practices and outdated gender expectations."

Finding a Career Focus that "Feels Right"

Dr. Gottlieb believes in the power of Ikigai, which may be defined as one's reason for living, and as a convergence of one's personal passion, vocation, profession, and mission. Ikigai is a concept that perfectly describes her efforts to combine her understanding of business practices, her energy for advocacy, and her medical knowledge into a fulfilling career. Dr. Gottlieb remarked that writing her book was the "first time in my life where all my professional experiences truly came together." She was excited to wake up early and work on a project to address the root causes of gender-based pay inequity, noting that "this problem is not unique to medicine." Her background in finance, as well as her ability to communicate with thought leaders outside of medicine, allowed her to approach the problem of pay inequity in a novel way. She recommends that physicians choose a career focus that allows them to channel their skills and passions into an endeavor, big or small, that they believe "could benefit the world."

The Importance of "Finding Your People"

Dr. Gottlieb acknowledges that membership in SGIM has had a profound influence on her, stating that "Everything that I have accomplished in my career stems from my involvement in SGIM." Dr. Gottlieb notes that SGIM provides opportunities for developing creative and unconventional initiatives around "ideas that one is passionate about" and for fostering deep connections with physicians and faculty across the country. In particular, SGIM allowed her to join a "community of women who

continued on page 7

advance and support other women,” which helped to sustain and inspire her throughout her career. She emphasized the importance of women physicians encouraging each other while working towards systems-based change in medicine and reminding themselves that even small gains in addressing gender disparities are meaningful.

“Lessons Learned” about Gender-Based Pay Inequity

Gender-based pay inequity is “everywhere,” not just in the United States, and solutions need to focus on organizational change. Second generation bias, manifesting as unconscious expectations around how women’s work is assigned and valued in our institutions, underlies many of the

compensation disparities in medicine as well as in other industries. While closing the gender pay gap may seem a daunting problem, Dr. Gottlieb recommends being hopeful, noting that “organizational progress can be very incremental, but it is beginning to bend toward equity.”

As the Distinguished Professor for Women’s Health for the SGIM 2022 Annual Meeting, Dr. Gottlieb will be giving her Keynote Lecture on Friday, April 8, 2022, at 3:45 pm Eastern Time. Check the annual meeting program for the final location.

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SGIM

HEALTH POLICY CORNER (continued from page 1)

paperwork and collect necessary records to authorize a myriad of patient services. Nurses also play a critical role in responding back to patients with results and coordinating scheduling of the care plan for needed follow up of results. None of this work is adequately accounted for in a fee for service model.

Wrap around support services expanded significantly in clinics successfully providing comprehensive primary care. Alternative payment models, such as Comprehensive Primary Care Plus, already demonstrated a successful approach to funding these critical roles through prospective payments, recognizing that myriad services provided by pharmacists, mental health providers, dietitians, nurse care coordinators, and social workers in the primary care setting cannot be covered through fee for service reimbursement. This is mainly due to reimbursement rates too low to support the salary of these providers or are not currently billable services.

There are more complicated issues affecting the PCPs:

- Appropriately compensating the work of physicians and advance practice providers is the most pressing issue.
- Current fee for service payment models is unable to address the changing demands being put on clinicians.
 - This handcuffs a practice’s ability to provide this level of care.
- Small private practices need to ensure that revenue projections cover expenses and large salaried practices set wRVU targets to measure production.
 - These currently remain closely aligned with the work done traditionally by clinicians and paid for through fee for service billing.
 - This requires templates to be weighted heavily to patient visits.

It is not sustainable to ask clinicians to continue to keep a traditional schedule and absorb the exponential increase in asynchronous work. PCPs are exposed to increased

patient access through telephone and especially patient portal messages creating demand for care outside of scheduled in person or virtual visits. Home oxygen orders, home health orders, FMLA forms, medication refills, prior authorization requests, durable medical equipment orders, and any number of future demands not tied to a clinic visit require time to complete. A new payment model needs to better align with the work being asked of our clinicians, prospectively paying for the critical asynchronous work that comprehensive primary care demands and allowing time to be reallocated appropriately. A key to successfully implementing a new payment model is quantifying the balance of time required between patient visits and asynchronous work and negotiating appropriate compensation for the asynchronous work with payers.

Comprehensive primary care requires a hybrid payment model combining fee for service with prospective payment for asynchronous services considering the changes

continued on page 13

RESPONSE TO BLACK PATIENTS' COVID-19 VACCINATION CONCERNS: CLINICIAN COMMUNICATION PRACTICES

Taylor Hollis, BA*; Raquel Garcia, BS*; Gisselle De Leon, BS; Juliana Baratta, MS; Cati Brown-Johnson, PhD

*Co-first authors

Ms. Hollis (taylor.hollismt@gmail.com) is a research assistant in the Stanford School of Medicine Division of Primary Care and Population Health and will be an MD candidate, 2026. Ms. Garcia (raquelsgarcia01@gmail.com) is a social science research professional in the Stanford School of Medicine Division of Primary Care and Population Health and will be an MD candidate, 2026. Ms. De Leon (gisselle.deleon28@gmail.com) is a pre-health professions post-baccalaureate student at San Francisco State University and preparing to be a physician's associate. Ms. Baratta (jmarieb@stanford.edu) is a project manager for the Presence 5 team in the Stanford School of Medicine Division of Primary Care and Population Health. Dr. Brown-Johnson (catibj@stanford.edu) is a qualitative researcher in the Stanford School of Medicine Division of Primary Care and Population Health.

Over the past year, we witnessed two pandemics—COVID-19 and racism—disproportionately impacting Black and other systemically marginalized communities. The COVID-19 pandemic further shed light on the more significant issue of racial injustice in the United States and its impact on health disparities, with Black patients dying from the disease at 1.7X the rate of White patients.¹ Black individuals' mistrust of the health-care system is rooted in historical and systemic racism and perpetuated by their experiences when receiving medical care. This mistreatment contributes to greater COVID-19 vaccine deliberation among Black individuals. Although the differences in vaccination rates between White and Black individuals have narrowed, the percentage of White patients who have received at least one COVID-19 vaccine dose remains higher than the rate for Black patients.² With the racial/ethnic disparities in COVID-19 infection and mortality rates, we sought to better understand Black individuals' perspectives about the COVID-19 vaccine to guide clinician communication that builds trust.

We conducted 45-minute, semi-structured interviews in November 2020-March 2021 to learn about Black patients' perceptions about the COVID-19 vaccine and identify clinician communication strategies to support their patients in vaccine deliberation. Since this study occurred before vaccine rollout, we acknowledge patient perceptions may change over time as more information regarding COVID-19 vaccines becomes available. We recruited interviewees from four clinics that primarily serve Black patients in Alabama, California, New York, and Tennessee. We interviewed 37 Black patients with 50% interviewer-interviewee race concordance. Four distinct coders coded transcripts to identify emerging themes. We also mapped clinician practices to the five communication domains in the Presence 5 for Racial Justice (P5RJ) framework.

"Our history shows us that we have been experiments in America, and we don't wanna be the frontline guinea pigs in trying out all that, and turn out disfigured, malformed ... We don't wanna be the test drive."

—Black Patient Interviewee

Black patient interviewees expressed concerns over vaccine safety, side effects, composition, efficacy compared to personal protective behaviors, and a lack of transparency in the media around COVID-19 in Black communities. Interviewees expressed distrust around the intentions of the COVID-19 vaccine compared to existing vaccines. Interviewees shared fears about misinformation and lack of information around the vaccine, current health disparities and racism in medicine, historical instances of racism in medicine (i.e., Tuskegee Syphilis Study), and racially discriminatory treatment in quality or access to the vaccine (see Table).

How Can Clinicians Work with Their Black Patients to Build Trust in the COVID-19 Vaccine?

With a greater understanding of Black individuals' concerns around the COVID-19 vaccine, specific practices are needed for clinicians to work with their Black patients to promote comfort and confidence in the COVID-19 vaccine. The P5RJ framework provides five anti-racism communication practices for clinicians to build trust with Black patients:

1. Prepare with Intention
2. Listen Intently and Completely
3. Agree on What Matters Most
4. Connect with the Patient's Story, and
5. Explore Emotional Cues.

continued on page 9

The following case study illustrates how these practices can guide vaccine conversations.

Case Study

During the height of the pandemic, a 65-year-old Black man comes in for a regular check-up. He has asthma and diabetes, and you are concerned about his increased risk for adverse outcomes if he contracts SARS-CoV-2. You notice that he has not received the COVID-19 vaccine. As the clinician, you say, “I see you haven’t received a COVID-19 vaccine. Would you like me to set up that appointment for you?”

The patient responds, “I don’t want to take the vaccine because I have a few things running through my mind. How do I know the vaccine is

safe? I believe that they’ll give one race the real vaccine and give Black people the vaccine that will kill us. I’m worried about side effects. If something happens to me, the media will sweep it under the rug like another Black person who died. I don’t want to be a guinea pig like we were in Tuskegee.”

As his clinician, how do you respond using the PSRJ practices to address all of these concerns?

Prepare with Intention

Greater awareness about current and historical instances of racism will allow for better understanding and empathizing with your patients’ concerns. Staying well informed on the influence of racism on social and environmental factors can increase

your ability to engage in transparent and supportive patient discussions.

Physician Preparation: Take time to stay updated on race-related news, media, and historical and current events.

Listen Intently and Completely

Your patient may have experienced racism, stigma, and discrimination in their lives and interactions with the healthcare system. Listen and be mindful of how adverse experiences or historical racism in medicine may contribute to vaccine distrust. Acknowledge these experiences and provide a safe space for patients to share their concerns.

Physician Response: “Thank you for sharing that with me. I can see that this concern is affecting you

Black Patients’ COVID-19 Vaccine Concerns: Themes and Quotes

Themes	Example Black Patient Interviewee Quote
Misinformation and/or lack of information around the COVID-19 vaccine	“I don’t know, you don’t know, ‘cause you hear different things, so this person took the shot and it killed him and all of that, all of this stuff, and you hear people saying, ‘Oh, they’re giving it to all white folks and letting the Black folks to die,’ and all of that. I’d just rather stay in the house and try to just maintain ‘cause every time you hear something it’s something different about it ... It’s just confusing.”
Rapid timeline of COVID-19 vaccine creation	“I do not want to take it because I’m scared. I just feel like it’s something they just whipped together. I don’t trust it. I would take it maybe a year from now. And just give it time for other folks to take it and see what’s going on, because I’m afraid that it’s not gonna work. I don’t know, I do feel like it’s going to kill off some people. I don’t know, it’s just what I think about it.”
Concerns over COVID-19 vaccine side effects	“I’ll say, I don’t know, most of them are kinda hesitant. You know, they have those commercials on TV, where you take this one pill and you got like 50 side effects from it, so we never know what the vaccine side effects are like its first time. you don’t know if you’re going to have a side effect. You don’t know what side effects you might have, but it seems to be effective on some people.”
Efficacy as compared to personal protective behaviors	“I’m gonna be honest, I’m not ready to taking that vaccine shot. What I’m doing is just being cautious and very careful. Wherever we go we always, of course, wear our masks. As long as I’m staying healthy and sound and focus on taking care of my body, in my heart, I believe that I’m gonna be alright for the rest of my life as far as not catching that virus.”
Mistrust around COVID-19 vaccine intentions	“Maybe they give one race the real dose or better dose. I hear about Black people saying ‘they’re gonna kill us all by giving us that vaccine. They’re trying to do the race war.’ The whatever-they-want-to-call-it. Try to wipe out the minorities.”
Racial discrimination in quality or access to the COVID-19 vaccine	“Okay, well, whichever the good, the one that White people get, that’s the one I want. I don’t want the other one.”
Historical instances of racism in medicine	“But in my family, everybody feels a little bit uneasy about taking a new vaccine. You know, there’s this idea, looking back to Tuskegee and things like that, that Blacks or anybody who’s a minority or doesn’t have money is tested like a guinea pig.”
Racism/Lack of Transparency in media	“Again, I’m a person who has a lot of allergies, next thing you know, I have a heart attack and die, and they’d like ‘oh, she’s another Black person who died. Let’s keep it under the rug,’ or ‘let’s not give it too much news.’ A lot of times things enter the news and as soon as it comes is as soon as it goes, because of covering up.”

continued on page 14

BOOK REVIEW: UNDERSTANDING CLINICAL NEGOTIATION

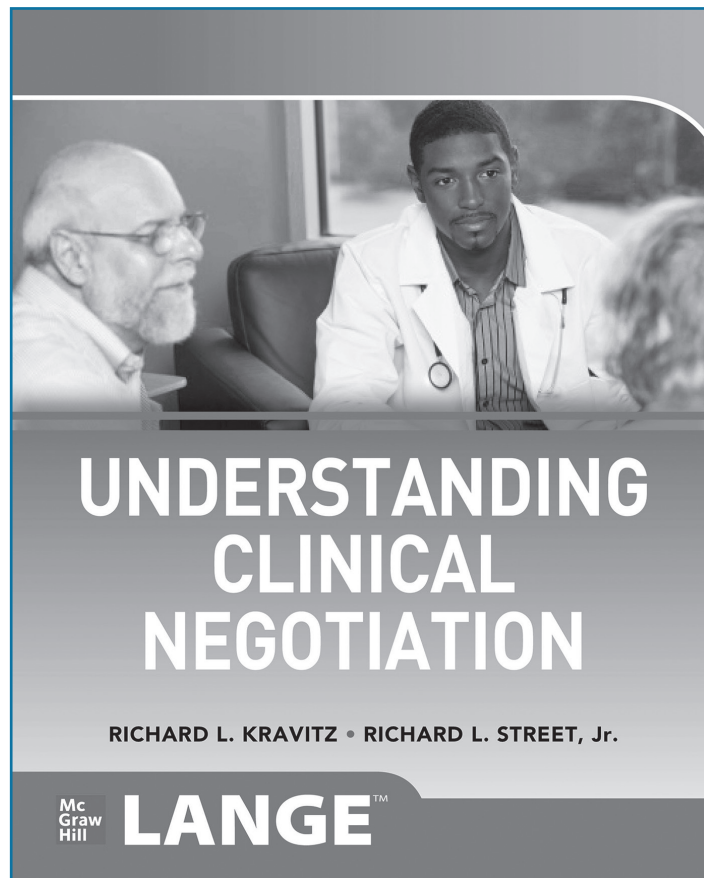
David W. Walsh, MD

Dr. Walsh (dawalsh@augusta.edu) is an associate professor and division chief of Hospital Medicine at the Medical College of Georgia at Augusta University.

I had the pleasure to read and review *Understanding Clinical Negotiation* by Drs. Richard L. Kravitz and Richard L. Street, Jr.¹—a tour de force of how clinicians can help promote better overall health through communication techniques backed by rigorous evidence. As a practicing physician, I found the topic to be of particular interest given the current U.S. healthcare environment as it pertains to the ongoing pandemic. Among other issues, this pandemic has caused unique challenges to the way in which we communicate with our patients—the effect is far reaching and touches across the spectrum of healthcare ecosystem.

I strongly recommended this book because it is a mix of deep dives, pragmatic approaches, and case-based illustrations. The authors have an extensive publication background in communication, publishing hundreds of academic papers: Dr. Kravitz is a past Editor-in-Chief of the *Journal of General Internal Medicine* and Dr. Street is a national award winner from the American Academy on Communication in Healthcare. Both are thought leaders in the area.

The book starts by laying the foundation as to the importance of communication and negotiation that takes place in almost every clinical encounter. The authors take time to explain how *clinical negotiation* is the appropriate term to describe today's clinician-patient encounter.



This phrase emphasizes the key concepts of mutual understanding and the need to find common ground. The authors highlight the transition in medicine from a more paternalistic or authoritarian model of care delivery to one that is focused on active participation from both clinician and patient.² The term *negotiation* helps to include the active discussion with the hopes of reaching a mutual agreement. It is with this definition and framework that the remainder of the book builds.

Early in the text, we are introduced to the “Deep Dive” sections that often accompany many chapters in this book. The first we see is on the “Interruptive Clinician”.

Many reading this have likely been taught at some point during training about the issue around clinicians interrupting patients within seconds of the clinical encounter and its negative consequences.³ With these Deep Dives, however, we are provided with layers of context that are more nuanced and impact our daily interactions with patients. One example is a deep dive in Chapter 4 that explores how the meaning of words can often breakdown in a clinical negotiation because medical terms mean one thing to clinicians and potentially something very different to patients. This is juxtaposed to common, everyday language where shared meaning of words is often aligned.

continued on page 11

The authors then go a step further to explore how words don't simply mean something, but rather *do* something that have very real and tangible effects on patient outcomes. Within these sections, the authors are masterful in framing unresolved issues, identifying evidence-based data to help guide decisions, and providing a path forward on ways to scientifically address unanswered dilemmas. A good example in Chapter 8 is the Deep Dive into using vignette studies to measure clinical interactions in a scientific manner. The authors highlight where vignettes are shown to be useful and where there is limitation (external validity, their hypothetical nature, and their variable nature to simulate real life) and discuss the unresolved nature of the scope of the vignettes ability to understand clinician-patient communication and outcomes.

The authors use a combination of bolding important messages, tables, graphs, summary points, and questions for further discussions as a multifaceted approach to offer either a quick references or exhaustive text, as needed by readers. This stylistic approach promotes optimal education and learning beyond standard book pages.

The second part of the book turns to provide the blueprint for clinical negotiation. Reasons for failure or suboptimal patient-clinician negotiation are many and range from organizational characteristics, clinician resources, patient resources, and trust to name a few. The authors take time to explore each of these issues in detail and then to help provide clinicians with tools to navigate these often-difficult situations. The authors stress the importance of introspection on the part of the clinician and the need to be able to bring an empathetic mind to the encounter. In this part of the book, the authors

provide a seven step, strategic, and systematic evidence-based approach to clinical negotiation.¹ Clinicians of all levels and years of experience can learn from this and find applicability in their everyday practice.

Additionally, in this section, the book pushes us, as clinicians, to better understand our roles when clinical negotiations go awry. Not only are we challenged to be aware of our own implicit bias but also we are motivated to explore those attributes necessary for optimal clinical negotiation. Characteristic drivers, such as humility and curiosity, are shown to help promote an environment that reaches a mutual agreement—alertness of verbal and non-verbal cues are stressed.

The book then pivots to application with a strong emphasis on using published data to guide strategy. As quoted in the book from Lord Kelvin, “when you can measure what you are speaking about...you know something about it.”¹ Oft areas of difficult discussion are addressed, including care of the hospitalized patient, negotiating when patient's preferences conflict with principles of diversity, equity, and inclusion, negotiating through clinical uncertainty, and negotiating goals of care discussion. For example, the book explores clinical negotiation of controlled substance prescriptions, describing the importance of clinical context, tapering strategies, and reviewing optimal approaches on how to place primary focus on symptoms and symptom control. There is framework provided to assist clinicians. The framework walks through how to start with preparation for the encounter and continues up through developing a goal-directed plan. By so doing, the context shows broad applicability not just to patient-clinician discussions around opioids

but also around all controlled substances—an area of which there is much less published data.

Understanding Clinical Negotiation provides a balanced approach to any healthcare clinician interested in learning how to better promote their patient's overall health. The authors highlight areas where data is sufficiently positive and, conversely, where data is lacking or negative.^{1,4} Although many stories are tailored towards the generalist, the skills taught and lessons learned have much broader applicability. This book will serve either as a quick reference for specific scenarios or an all-encompassing textbook on a critical topic not often elucidated in modern medical education. To quote the authors, “The trick for the thoughtful clinician is to respect patient autonomy while exercising the professional judgment that years of training and experience have produced.”¹

I hope you enjoy this book on clinical negotiation as much as I did!

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SGIM

MYSOPE: COMBATTING IMPOSTER SYNDROME WITH ART THERAPY

Catherine A. Pressimone, BS*; Anjana Murali, BA, BPhil*; Melissa A. McNeil, MD, MPH; Sarah B. Merriam, MD, MS

*Co-first authors

Ms. Pressimone (cap128@pitt.edu) is a third-year medical student at the University of Pittsburgh School of Medicine and a scholar in the Physician-Scientist Training Program. Ms. Murali (anm225@pitt.edu) is a third-year medical student at the University of Pittsburgh School of Medicine and a scholar in the Physician-Scientist Training Program. Dr. McNeil (mcneilma@upmc.edu) is a professor of medicine and of obstetrics, gynecology, and reproductive science at University of Pittsburgh School of Medicine, and vice chair of education in the department of medicine at University of Pittsburgh School of Medicine. Dr. Merriam (sullivansb@upmc.edu) is a clinical assistant professor of medicine at the University of Pittsburgh School of Medicine and VA Pittsburgh Healthcare System and assistant director for degree granting programs in Medical Education for University of Pittsburgh Institute for Clinical Research and Education.

Background

Imposter syndrome (IS), or unrelenting self-doubt despite objective evidence to the contrary, is pervasive in the competitive culture of medicine. People who suffer from IS are convinced they are unworthy of their environment, forcing them to wrestle with a constant worry of impending failure. Not surprisingly, IS is highly correlated with exhaustion and cynicism¹ and may contribute to anxiety, burnout¹, and suicide². Medical students are especially vulnerable to IS, with recent studies estimating that 22-60% of medical students experience IS.³ As with most mental health phenomena, these reports are likely to be significantly underestimated. Addressing medical student IS is pivotal to maintaining a healthy and safe physician workforce. Unfortunately, discussions of IS are stigmatized and are rarely addressed in medical curricula.

Because IS is a manifestation of logical and emotional incompatibility, one potential mechanism to mitigate the anxiety that results from IS is to borrow from the mindfulness techniques used in Cognitive Behavioral Therapy. Previous work has demonstrated that mindful peer sharing normalizes vulnerability, provides support, and combats sequelae of IS.⁴ Furthermore, art therapy is a mechanism of attentively relieving stress by creating visual media, such as photography and printing. Participation in art therapy has been correlated with decreased burnout amongst healthcare workers.⁵ The MyScope project combines art therapy and peer sharing to help trainees mindfully reflect on and work through their experiences with IS.

What Is the MyScope Project?

MyScope is a novel, creative approach combining photographic, verbal, and written media to combat medical student IS. The MyScope project involved first- and second-year medical students at the University of Pittsburgh

who volunteered to reflect on their personal IS experience through one-time, peer-led interviews. Each interview lasted 20 minutes and was composed of one interviewee and two peer interviewers. One of the interviewers asked the interviewee the following questions to initiate their reflection:

- 1) What are qualities in good physicians that you admire?
- 2) What intrinsic qualities can you identify in yourself that will make you a good physician one day?
- 3) What is your personal relationship with IS?

While the interviewee was answering a question, the other interviewer took candid, mid-sentence photographs of the interviewee, aiming to capture authentic emotion and expression. With permission, quotes from the interviews were printed and paired with a photograph of each interviewee. Ultimately, the final work was displayed as an exhibit at a local art gallery, generating thoughtful conversations about the role of mindfulness in combatting IS. The gallery opening was attended by medical students and the general public, and the exhibit ran for four months.

Medical Students Reflect on Imposter Syndrome through Art and Discussion

Nearly every student that was interviewed for MyScope revealed that they had at some point suffered IS during medical school. Triggers of IS ranged from academic (e.g., feeling insufficient) to cultural (e.g., coming from a different upbringing). Some students endorsed that their self-doubt was exacerbated by peer-peer interactions in the classroom. They saw their peers as “people who are absolutely brilliant” and, in response, felt that they were “not doing enough” and comparatively underachieving

continued on page 13

needed to support the staff and physician work demands. Different clinics may be able to provide different levels of services and there may not be a one-size-fits-all ratio of fee for service and prospective payments. A practice starting to take on comprehensive primary care should have a payment ratio more weighted to fee for service while a mature comprehensive primary care practice able to provide more wrap around services should have a payment ratio more evenly balancing fee for service and prospective payments. This hybrid model would be able to avoid some of the problems that developed in prior fully capitated HMO type payment models by not overly incentivizing limiting scheduled patient visits and care, keeping a reasonable percent of payments tied to fee for service.

The model would have to also allow for risk adjustment based on the complexity of populations of patients being seen in practices. There is a clear correlation with more complex populations requiring more resources. Comprehensive Primary Care Plus used a payment model that adjusted based on patient complexity

level. This creates an appropriate incentive for clinics to provide care for complex patients. Practices need to deliver on quality measures that need to be clearly defined and should be aligned between payers; practices should also take on some level of risk in payments tied to delivering quality care and living up to the value component promised with comprehensive primary care.

The final issue that needs to be addressed is the amount a payer should pay for comprehensive primary care. It has been noted that primary care is chronically underfunded and the country is looking at a crisis in PCPs. More clinicians will be needed to provide comprehensive primary care with current physician employment trends moving away from primary care. The United States currently allocates far less than 10% of healthcare spending on primary care. Moving this target to 10% of spending would allow for competitive compensation and support comprehensive primary care.⁴ The proposed hybrid payment model would financially support the value promised by comprehensive primary

care and ensure that the benefits of comprehensive primary care are realized by patients, clinicians, staff, and payers, while providing appropriate controls to ensure quality measures are met.

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SGIM

BREADTH (continued from page 12)

in their studies. Other interviewees reported their IS was triggered by identifying with a different background than their peers (e.g., not having family or friends in healthcare, pursuing a non-biology major in college, or coming from a family of immigrants). As a result of their background, these students described feeling inferior and disadvantaged compared to their peers—"I wish I could've had privileges that other people have."

Many students reported that participating in MyScope provided them significant relief from IS. Participants noted that reflection combined with art therapy, as utilized in MyScope, was a helpful strategy for practicing positive self-thought and normalizing IS. For one student, the MyScope

interview "was a necessary 'stop and reassess' point." The interview helped another student feel that they had permission and space to "start to fully process my thoughts," enabling the exploration of IS in a mindful way. Multiple students reported that MyScope helped them reflect on the irrationality of IS. One student said, "it's possible not every thought I have is rational," and then went on to describe that recognizing this helped to stop the downward IS spiral in real time. Many students valued the novelty of diffusing IS with art, stating that it was "calming to see IS so normalized" and that "this was the first time in all of my educational training that I felt like imposter syndrome was discussed in a public setting."

Recommendations for Curating an Artistic Intervention to Combat Medical Student IS

The MyScope project was a pilot initiative that explored and attempted to combat medical student imposter syndrome with art therapy. This project was not research, and thus cannot produce evidence of its efficacy. However, MyScope was received positively by the student body and could be easily implemented in other institutions as an attempt to combat IS. The following are some recommendations on implementation:

1. Recognize that some students may have reservations about sharing private thoughts in a public display. Make sure to

continued on page 14

deeply. I acknowledge there are many faults in the medical system, but I am here for you and want to provide you with the best care.”

Agree on What Matters Most

If a patient deliberates regarding the vaccine, discuss their perceptions and beliefs without judgment. If the patient is not comfortable sharing their concerns, provide reassurance of confidentiality and discuss concerns other patients have shared. Acknowledging that some decisions require multiple conversations, it may be beneficial to schedule a subsequent visit.

Physician Response: “I hear where you are coming from with your concerns. I want to work with you to help keep you as healthy as possible. Other patients have shared similar thoughts about the COVID-19 vaccine, and I went over vaccine information with them in-depth. Is it okay if I share some resources that other patients have found helpful? This may take more than one conversation. We can schedule a time to talk further about this, and I can walk through some of this vaccine information with you.”

Connect with the Patient’s Story

Consider socio-cultural reasons for a patient’s health beliefs and actions.

Use humble inquiry to learn about your patient’s life and circumstances.

Physician Response: “Thank you for this opportunity to get to know more about you. I understand why you feel the way you do. Your concerns are valid, and your health and values are important. I want to hear all of your thoughts and support you in making an informed decision that is right for you.”

Explore Emotional Cues

Pay attention to the non-verbal cues from your patient as they discuss emotion-evoking topics. Recognize racial trauma and practice trauma-informed care throughout the visit. Reflect, validate, and confirm your perceptions of your patient’s emotions.

Physician response: “How are you feeling at this moment? I realize that talking about the vaccine or negative and racist experiences with your healthcare can be traumatic or make you feel like you don’t control what happens to you. This decision is yours to make. I am here to support you through this.”

Conclusion

The racial and ethnic disparities highlighted by the COVID-19 pandemic have served as a call to

action for clinicians to take on systemic racism in medicine. While the proposed framework is not a fix-all guide to combating racial disparities in COVID-19 and treatment, it offers practical strategies for clinicians to understand Black individuals’ concerns around the vaccine and support them in making informed decisions. Further research is needed to evaluate the efficacy of these practices in increasing vaccination rates in Black communities.

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SGIM

BREADTH (continued from page 13)

- obtain consent and reassure participants that they may opt out of anything that creates personal discomfort (e.g., being interviewed but not photographed).
2. Create a safe, welcoming environment that allows students to share imposter feelings, if they exist. Considerations include participation being voluntary, working in a space that is quiet and separate from passers-by, and starting off the interview with affirmational language such as “thank you for choosing to share your feelings with us.”
3. Help students separate fear from

- fact during their reflections. The goal is to stop the “spiral” of illogical thought. Considerations include asking questions that focus on self-affirmation and respectfully pointing out when interviewees’ self-criticism is discordant with fact.
4. Provide students ample space (and encouragement) to reflect on their positive traits.
5. Be prepared to show grace and support for the interviewee, because the interviews may trigger strong emotions for participants as they process their thoughts.
6. Secure a long-term space to

display the art, like a medical school lobby or a public art gallery, such that the physical art product can be a continuous reminder of combatting IS.

Imposter syndrome contributes to medical student burnout and must be combatted to maintain a healthy and active physician workforce. The MyScope project suggests that art therapy successfully allows students to address and normalize IS feelings and creates a physical product to continuously reinforce student mindfulness.

continued on page 16

Associates, Division of General Medicine faculty and the support of Chairs Alan Wasserman and Anton Sidawy and staff support Willie F. Dunne and Deborah Corvalan. I am also grateful to Columbia University Vagelos College of Physician & Surgeons in their championing my continued engagement with all of you.

As a society, over the course of the past 12 months we have been good stewards of our fiscal resources and solidified our philanthropic pillar. That work would not have been possible without Martha Gerrity, Liz Davey, and the philanthropy committee, Leslie Dunne, Hollis Day, and the support of the finance committee. We have ridden the ups and downs of at least two viral variants and subsequent surges to host a successful in person annual meeting. Corrine Melissari, with the support of Loubna Bennaoui, Matthew Tuck, and Nicole Redmon made the Annual meeting possible.

Despite the fiscal threats to our previous operational model, it was the hard work of the staff and others that ensured the opportunity to meet and network in person at our Council Retreat and ACLGIM's Summit in December 2021. It is the fortitude of Kay Ovington, that has continued to lead the staff and our members in successful programming and meaningful work. Erika Baker with assistance from Naomi Waltengus successfully ensured the committee and commissions continued their engaging work and Dawn Haglund with Margaret Lo, on the Learning Management Taskforce, and its members launched our system

that holds many promises for our members and our future work as a society.

Our regions continue to thrive despite the virus having profound impacts on the way they have done their work. Julie Oyler, with the nimble team of Judy Dalie and Tabria Lee-Noonan continue to engage our membership at the regional level and ensure virtual meeting success.

We continue to have outsized impact despite our size on critical issues related to access, health equity, primary care and its associated research, as well as with our peer organization. This, too, would not have been possible without Eric Bass, Liz Jacobs, and the health policy committee, Francine Jetton, and our collaborators at Cavarocchi-Ruscio-Dennis Associates. We are also indebted to Brenda Zacharko and Linda Woodland who served in key administrative supportive roles, with Mx.Woodland also assisting with accounting issues.

SGIM can only achieve as much as our infrastructure allows. In the past two years, we have realized how much we rely on our technical resources and the work of Julie Machulsky, who oversees this area. Muna Futur, with the assistance of Marley Dubrow, provides support to retain, grow, and engage our members with the assistance of Joe Hinkley who ensures our "SGIM Brand" is alive and well. Jennie Clarkson, and Rachel Roberts, Managing Editor, have worked with our journal editors to showcase the work of our members and others in the peer-reviewed scholarship arena. Taylor Wise uses a systemat-

ic approach to share our activities, announcements, and advances via our social media channels. Tiffany Leung, Frank Darmstadt, and Howard Petlack, ensure that our monthly *Forum* is captivating with each "turn" of the page.³

Finally, I am grateful to all of you for your patience and continued engagement with our awesome society. I recognize that it is the members that continue to ensure SGIM grows and adapts to the changing realities of the world we live in. I express my deepest appreciation for everyone behind the curtain who help ensure SGIM's innovative educators, researchers, clinicians, and staff can achieve our mission to ensure better health for everyone and establish a just system of care in which all people can achieve optimal health.⁴

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FROM THE EDITOR

 (continued from page 2)

Find me, Gaetan Sgro, Lauren Block, or David Walsh in-person at #SGIM22 and share your thoughts and reflections with us about what is special about in-person SGIM or tweet us at @SocietyGIM to share your reply to these questions using

#SGIM22. *SGIM Forum* will publish member quotes in a future issue!

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