

ASK AN ETHICIST

ASK AN ETHICIST: RETURNING TO WORK AFTER COVID-19

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“Ask an Ethicist” is a new *SGIM Forum* department that provides answers to questions in clinical ethics posed by SGIM members. Members of the SGIM Ethics Committee respond to real ethics cases and questions submitted by SGIM members. Responses are created with input from the Committee but do not necessarily reflect the views of the Committee or SGIM. To submit a case or question, visit: <https://www.sgim.org/communities/other-sgim-committees/ethics/ask-an-ethicist>.

Scenario

A patient presents for an acute care appointment with a physician she has never seen before to request a letter allowing her to return to work. The patient tested positive for COVID-19 one month ago after having symptoms including rhinorrhea and cough. She has been on sick leave from work since she developed symptoms, and she is now asymptomatic. The patient works at a nursing home that has recently instituted a COVID-19 vaccine mandate for its workers, but she says she is unwilling to receive a COVID-19 vaccine under any circumstances. She asks the physician to write a letter stating that she may safely return to work. Should the physician provide this letter to the patient?

Analysis

As vaccine mandates become more common in workplaces throughout the United States, general internists might encounter cases such as this one: an unvaccinated worker, subject to a mandate, requests a return-to-work letter.

Our response should be guided by both scientific considerations and ethical principles of autonomy, beneficence, and justice, following from our commitment to promote the good of individual patients as well as the common good.

At first glance, this patient’s question seems straightforward: guidelines have consistently recommended that isolation is no longer medically indicated for asymptomatic patients who tested positive weeks ago. A physician might simply clear her to return safely to work and avoid addressing the mandate altogether, allowing the patient to negotiate that issue with her employer. However, some internists may believe that such a letter requires a statement on the patient’s desire to be exempted from the nursing home’s mandate.

At the individual patient level, the science regarding “natural immunity,” which develops as a patient recovers from COVID-19 infection, informs this question. Some evidence suggests that natural immunity protects against subsequent infection as well as vaccines do,^{1,2} even in patients whose symptoms were mild.^{3,4} Other evidence suggests reinfection with COVID-19 is more common in the unvaccinated, and that natural immunity may vary among individuals and wane over time.^{4,5} However, much of the currently available evidence is in flux or awaiting peer review, leaving clinicians to make decisions under profound uncertainty.

Based on the above-cited evidence, it seems reasonable to conclude that convalescent patients, at least within the first few months after a COVID-19 infection, have at

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FROM THE EDITOR

OUR STEPPINGSTONES TO THE FUTURE

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

"When you can see obstacles for what they are, you never lose faith in the path it takes to get you where you want to go. Because this I know for sure: who you're meant to be evolves from where you are right now. So learning to appreciate your lessons, mistakes, and setbacks as stepping stones to the future is a clear sign you are moving in the right direction."

—Oprah Winfrey, *What I Know for Sure*

Continuous learning and growth towards the future are essential for individuals and organizations. As a professional society, SGIM is no exception. In this issue of *SGIM Forum*, SGIM President Monica Lypton announces the society's plans for embedding anti-racism, diversity, equity, and inclusion into all aspects of society activities and structures. This plan and its detailed recommendations from the SGIM Executive Committee's DEI Workgroup offer a detailed roadmap forward for our membership.

The *SGIM Forum* Editor team is committed to advancing DEI in accordance with the DEI Workgroup recommendations. In spring 2020, *SGIM Forum* examined the diversity of our Associate Editor (AE) team. In parallel, steps to retain and recruit talent to address known disparities were already in progress: last year, our Editor team welcomed two inaugural associate member AEs and the *SGIM Forum* immediate past Editor in Chief as an emeritus member. Additionally, AE liaisons serve as official representatives of *SGIM Forum* to committees and commissions, offering bidirectional links between each group. *SGIM Forum* AE liaisons and AEs who are actively engaged in a variety of SGIM activities are invaluable to growing these collaborations. Without their engagement across the society and in *SGIM Forum*, this newsletter would not be the platform for thoughtful and critical society communications that it has become.

Sustaining and building new collaborative relationships with SGIM commissions, committees, groups, and regions also offer the following opportunities for growth and inclusive engagement:

- Health Equity Commission and *SGIM Forum* teamed up to publish the September 2020 theme issue on Systemic Racism and Medicine;¹
- The 2021 Mid-Atlantic Regional Annual Meeting

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STEPS IN THE RIGHT DIRECTION: SGIM'S ANTI-RACISM, DIVERSITY, EQUITY & INCLUSION EFFORTS

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

"SGIM's mission is to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone. For us to remain true to this mission, we must take a careful and close look at ourselves to determine how we ensure 'all' of our members are on the path to a sustained and fulfilled career that leads to 'better health for everyone.'"



Who could have imaged that attending a “strange” meeting in Chicago in 1998 as a second-year primary care resident would spark my lifetime commitment to SGIM and my ethos as a generalist in internal medicine? Thinking back on this meeting, I remember looking forward to several days of intellectual curiosity and more importantly a “free” trip to my hometown where I could see my family. Somehow over the years, I have always reconnected to SGIM as it is where I found near-peer mentors, many of whom looked like me and could guide me in the potential and real dangers of navigating a career in general internal medicine. SGIM has always been a nesting place for me and others to develop their full professional identity as an academic generalist. SGIM is also a place where I discov-

ered a diverse cadre of colleagues and allies who were also interested in, and more importantly committed to, systemic changes to garner equity in health care.

The fond recollection of my long SGIM membership must acknowledge the realities of the organization during this same time period. If I poke the memories a bit, I can also recall several struggles SGIM faced—for example, the annual battle to ensure that the Minority in Medicine Faculty Development Precourse was held and the reoccurring defense of the contribution of the Minorities in Medicine Interest Group. Not to mention the organization's debate on whether to maintain or disband the Disparities Task-Force. I also recall the scars created when the decision was made to hold the annual meeting in Arizona despite the enactment of SB 1070, Arizona's anti-immigrant law (criminalizing many daily interac-

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The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.

Q & A WITH SGIM'S CEO ON EXTERNAL RELATIONS AND RALLYING AGAINST ADVERSITY

Eric B. Bass, MD, MPH

Dr. Bass (basse@sgim.org) is the CEO of SGIM.

How do SGIM's external relations help to rally attention to our mission amidst the adversity of the last year?

In 2020, SGIM's Council adopted a strategic framework for guiding our approach to external relations.¹ The framework identifies our four main organizational goals and calls for each relationship to support one or more of those goals, as shown in the table.

To address the goal of advocating for a just health system, we partner with organizations that share interest in improving support for primary care physicians and hospitalists, and in eliminating disparities in health care access and outcomes. Given the challenges imposed by the pandemic and injustice in our health care system, it is noteworthy that all of the organizations listed in the table have a mission and/or strategic priorities consistent with SGIM's vision for a just system of care in which all people can achieve optimal health.² SGIM joined other primary care organizations, including the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), Alliance for Academic Internal Medicine (AAIM), and American Geriatrics Society, in co-sponsoring the report by the National Academies of Sciences, Engineering, and Medicine on Implementing High-Quality Primary Care.³ SGIM also collaborated with the AAFP, AAP, ACP, and American Board of Internal Medicine in preparing a unified vision statement calling for investment in health as the new paradigm for financing primary care as a public good.³ SGIM's leadership has met with leaders of ACP, AAIM, and the Society of Hospital Medicine (SHM) to share ideas and plans for promoting diversity, equity, and inclusion. Furthermore, the current mission of the Association of American Medical Colleges (AAMC) focuses on transforming health care in four areas: medical education, patient care, medical research, and diversity, inclusion, and equity in health care.⁴ Since the AAMC seeks to collaborate with members to ensure that all people get the care they need from a diverse, inclusive physician workforce, it is natural for SGIM to also work closely with the AAMC.

To help foster development of general internal medicine leaders, we collaborate with professional societies and governmental agencies that can provide leadership opportunities for members or help to enhance career development. One of the best examples of such a partnership is the Academic Hospitalist Academy. Despite the limitations of the pandemic, SGIM partnered with SHM to run a highly successful virtual Level 2 form of the Academic Hospitalist Academy in November 2021. Another example is the career development program on partnered research that completed its first cohort in July 2021, thanks to a partnership with the Health Services Research and Development Service of the U.S. Department of Veterans Affairs (VA).

To promote scholarship in person-centered and population-oriented approaches to improving health, we nurture relationships with agencies that can help to stimulate innovative work in clinical care, education, and research in general internal medicine. SGIM's Health Policy Committee has been very active in advocating for increased funding of primary care research, health services research, and disparities research by the Agency for Healthcare Research and Quality (AHRQ), Patient Centered Outcomes Research Institute (PCORI), National Institutes of Health (NIH), and VA. SGIM's leadership and Research Committee also have given input on the strategic plans and priorities of AHRQ, PCORI, and NIH.

To foster the health of our own organization, we pursue partnerships that can provide funding for initiatives, help to grow membership, or increase the visibility and well-being of members. The VA has been a great partner, helping to launch the program on partnered research in addition to sponsoring a special symposium at SGIM's Annual Meeting and sponsoring a supplement in JGIM on implementation science and quality improvement. By participating in the Societies Consortium on Sexual Harassment in Science, Technology, Engineering, Math, and Medicine, we gained access to new resources for updating SGIM's code of conduct, aiming to ensure we provide a friendly, safe, and welcoming environment for all.

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Overall, our external relations have grown stronger in the last year despite the inability to meet in person with other leaders. By working together with organizations that share overlapping missions, we have found much common ground. By rallying with partners against the adversity, we have been able to amplify the voices of our members in pursuing SGIM’s vision for a just system of care in which all people can achieve optimal health.

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Relevance of SGIM’s External Relations to Our Organizational Goals				
Organizations by Category	Relevance to Organizational Goal			
	Just Health System	Foster GIM Leaders	Promote Scholarship	Organizational Health
Professional Societies				
Academy Health	*		*	
Accreditation Council for Graduate Medical Education	*		*	
Alliance for Academic Internal Medicine	*	*	*	*
American Academy of Family Physicians	*	*		*
American Board of Internal Medicine	*		*	
American College of Obstetricians and Gynecologists	*	*		
American College of Physicians	*	*		*
American Geriatrics Society	*	*	*	
American Medical Association	*			
American Medical Informatics Association	*	*	*	
Association of Departments of Family Medicine	*			
Association of American Medical Colleges	*	*	*	*
Cognitive Care Alliance	*			
Council of Medical Specialty Societies	*	*	*	*
Endocrine Society, The	*		*	
National Hispanic Medical Association	*	*		
National Medical Association	*	*		
Primary Care Collaborative	*	*		
Societies Consortium on Sexual Harassment in STEMM	*	*		*
Society of Hospital Medicine	*	*	*	*
Society of Teachers of Family Medicine	*		*	
Governmental Agencies				
Agency for Healthcare Research and Quality	*		*	
Centers for Medicare & Medicaid Services	*		*	
Health Resources and Services Administration	*		*	
National Cancer Institute	*		*	
National Institute on Minority Health and Health Disparities	*		*	
Patient Centered Outcomes Research Institute	*		*	
Veterans Affairs	*	*	*	*

STEMM = Science, Technology, Engineering, Math, and Medicine

ORAL HEALTH CHAMPIONS READY TO REVOLUTIONIZE INTERNAL MEDICINE EDUCATION

Hugh Silk, MD, MPH, FAAFP

Dr. Silk (hugh.silk@umassmemorial.org) is a professor at the University of Massachusetts Chan Medical School in the Department of Family Medicine and Community Health and is a primary investigator at the Center of Integration of Primary Care and Oral Health.

Oral health is an important aspect of our patients' overall health. Dental caries is the most pervasive infectious disease in the world—one that impacts 90% of adults in the United States.¹ Caries and periodontitis can cause worsening of diabetes and heart disease and lead to hospitalizations, loss of time from work, and poor self-esteem.^{2,3} Furthermore, it is a health equity issue; close to twice as many Black and Mexican-American adults have untreated cavities compared to non-Hispanic White adults.⁴ Meanwhile, tens of millions have no access to a dentist for various reasons, including a shortfall of approximately 10,000 dentists.⁵ We need internal medicine academic doctors to help bridge this gap in care and address this important health issue. Now there is a unique opportunity for internists to help improve oral health outcomes.

The Center for the Integration of Primary Care and Oral Health (CIPCOH) is looking for individuals to join the One Hundred Million Mouths Campaign

(100MMC), our national network of oral health education. The 100MMC will create 50 oral health champions over the next decade, one in each state, to work with health profession schools/programs (internal medicine residencies, medical schools, physician assistant schools, et al) in order to integrate oral health into their curricula. Champions will also be selected from primary care backgrounds.

Individuals who are chosen to be state champion will be trained and provided with tools and resources to engage schools and programs in their state to teach more oral health to their students and residents. Each of the selected champions will collect a small stipend and an allowance for supplies as well as funding to offer stipends to patients to engage them as patient-educators participating in planning and teaching and funds to cover other costs (e.g., travel, parking, supplies).

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Mark Deutchman, MD, professor of family medicine, and Denise Kassebaum, DDS, dean of the University of Colorado School of Dental Medicine, supervise an oral anesthesia training. Source: <https://www.aamc.org/news-insights/open-wide-medical-education-real-teeth>.

THE SIX-ACTION QUEST FOR PROFESSIONAL DEVELOPMENT IN MEDICINE: A PERSPECTIVE AND PROPOSAL

Maria G. Frank, MD, FACP, SFHM

Dr. Frank (Maria.Frank@dhha.org) is a hospitalist at Denver Health and Hospital Authority, the director of faculty development and advancement for the Division of Hospital Medicine, and an associate professor of medicine at University of Colorado, School of Medicine.

When we choose a career in medicine, we commit to lifelong learning and growth—an ongoing quest that alternates between a straight line and an ever-winding road. Regardless of your ultimate path of choice, I propose the following six simple actions (that can be enacted in both academic and non-academic environments) to make your quest purposeful, attainable, and successful while, I hope, remaining enjoyable:

1. Define Success and What It Means to You

Throughout our pre-professional lives, particularly during school and training, success is very clearly and externally defined for us: achieve good grades; receive acceptance to college and graduate school; match in your dream residency and/or fellowship program; pass your boards; obtain your first professional job. However, all that comfort fades soon into your first job when faced with innumerable choices: Academics or private practice? Research? Teaching? Clinician, Administrator or Leadership track? These decisions are further complicated by competing priorities, such as family and leisure time.¹ If I do prioritize family, does that mean I am less successful in my career? It's likely there are no easy or single answers. In the end, solutions to these matters are personal and ever evolving. Moreover, your colleague's definition of success is unlikely to match yours, and the goals you set at age 25 may not seem meaningful at 35. Outlining your mission and vision will facilitate revealing your definition of success, which *must* be aligned with your values.

2. Set Your Professional Goals

Goals are indeed required to establish and assess performance. When developing your own professional goals, keep in mind who you are, your strengths and weaknesses, and your passions.² Be realistic, stay on target, and set deadlines. When possible, make your goals specific, measurable, attainable, and realistic. Have a timeline attached. Above all, write your goals down as it leads to accountability. As an example: if your professional goal involves becoming an inspirational educator, perform an individual skill inventory: think about what the skills are you already dominate (i.e., bedside teaching of physical exam);

and what the skills are that need more development (i.e., providing meaningful feedback to the struggling learner). Identify available resources, institutional, regional, or national, for addressing your gap, such as online or in-person courses, peer-coaches, etc., as well as time commitment and leadership support needed. Discuss with and seek support from your supervisor and then set a timeline for the acquisition and testing of your newly developed skill. These later steps are part of creating and executing your plan that will be discussed in step number five.

Linda Pololi³ proposed nine steps for developing professional goals, including clarification and prioritization of personal values, identification of individual strengths, abilities and talents; a 10-year visualization of what you would want your professional status to be, rather than worrying about how to get there. Subsequently she recommends setting one-, three- and five-year goals. After these goals are set, she encourages the reader to identify skills and tasks needed to reach the one-year goal. Before you commence your quest, involve your supervisor and receive assurance that your plan is achievable, has institutional alignment, and that you procure necessary resources.

3. Procure Mentoring Relationships

A meaningful mentoring relationship provides a mentee with skills, knowledge, experience, advice, guidance, and support—it is a key component of professional development and success.⁴ Unfortunately, effective mentoring is usually identified as a gap for faculty development. Some authors report the prevalence of mentoring in academic medicine to range between 19% and 84%.⁴ For some medical disciplines, a relative paucity in senior faculty can lead to mentorship gaps, resulting in mentor fatigue and perception of suboptimal mentorship training. Another point to consider is the unlikelihood that one mentor will be able to meet all the mentee's needs, hence a mentoring team becomes essential.

Mentees play a significant and central role in identifying, creating, and maintaining effective mentoring relationships. A successful mentee will identify individual mentorship needs and potential mentor or mentors to sat-

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WRITING SPRINTS: A COLLABORATIVE APPROACH TO EFFICIENT PUBLICATION FOR CLINICIAN EDUCATORS

Sarah Merriam, MD, MS; Eloho Ufomata, MD, MS; Carla Spagnoletti, MD, MS

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Scholarship is a promotion requirement for clinician educators (CEs) typically achieved through collaboration.¹ However, barriers to collaborative efforts, such as time, motivation, individual expertise, and inequities in work distribution, exist. The COVID-19 pandemic has amplified some of these barriers and has required collaboration at a distance.

The *sprint* method, first described for the purpose of idea generation and prototyping business innovations,² has been adapted for use by teams of clinician-researchers to mitigate barriers to research study planning and manuscript preparation.^{3,4} The writing sprint is defined as a collaborative, novel method to write academic papers as a team, in order to synthesize ideas.⁴ This method ensures that all authors have substantive contribution to the final work while allowing for maximal efficiency and time-management. Incorporating a writing sprint in manuscript preparation is efficient and fosters networking, cross-institutional collaboration, and group cohesiveness. The sprint framework may be particularly useful to educators who might otherwise feel that they lack the bandwidth or expertise necessary to publish their work. It may also represent an effective way to leverage knowledge and mentorship of senior authorship, beyond the editor role.

The use of this method was classically described for secondary analyses in research;⁴ however, the use of this method to produce scholarly work common to CEs (e.g., perspective pieces, review articles, innovations) has not been previously described. In this article, we outline

a straightforward 10-step approach for CEs to employ writing sprints, based on available literature and on our own experience.

Once an idea for a written piece by three or more authors

is conceived, the primary author and the senior author (if applicable) should do the following:

1. Identify the members of the writing team (i.e., the coauthors) and establish authorship order.
2. Define goals and objectives for the written piece, outline its major sections with key references and disseminate to coauthors for feedback.
3. Distribute the final outline to coauthors and assign sections to each author.
4. Ask coauthors to prepare for the sprint (i.e., generate ideas based on the outline, review references, perform a focused literature review).
5. Utilize an online scheduling tool to find a sprint meeting time conducive to all coauthors. Sprints should ideally last 2-3 hours on average, depending on the length and complexity of the proposed piece.
6. Choose a sprint method depending on topic complexity, manuscript length/type, and size of authorship group. If a large group is collaborating on a nuanced perspective piece, it may be beneficial to break into smaller sprint subgroups of 3-4 members and utilize Method 1, as discussed below. Alternatively, if a small authorship group is writing a more straightforward manuscript, Method 2 may be more effective.

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- Method 1: Each author/subgroup works on one section for the duration of the sprint.
 - Method 2: Each author/subgroup contributes to all sections. Each coauthor drafts one section and, after 30-45 minutes, the drafted section is passed to another coauthor to continue the writing.
7. Plan to conduct the writing sprint on an online meeting platform with capability of screen sharing and breakout rooms.
 8. Set the stage at the start of the sprint by 1) reviewing the goals, objectives, and agreed upon outline and 2) clarifying the steps of the sprint writing process. Once the sprint begins, periodically check in with each author/subgroup to keep them on task and on time.
 9. Refine and format the written products of the sprint into a cohesive manuscript. This is ideally done by the primary author following the sprint.
 10. Obtain approval from the entire authorship group before submitting the final manuscript.

Within the past year, the authors have utilized this process successfully to write a four-page perspective piece with co-authors from nine institutions,⁵ utilizing three hours in sprint. Through this virtual sprint experience, we refined the simple 10-step approach. In addition, this current article was written via sprint in two hours. We believe that the paper sprint presents a unique opportunity to foster distance collaboration for clinician educators in an increasingly virtual world due to the coronavirus pandemic. This can help to improve scholarly productivity for clinician educators, enhance collaboration effectiveness, and improve the richness of idea generation in the produced works.

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SIGN OF THE TIMES (continued from page 6)

Currently there are champions in Delaware, Hawaii, Iowa, Missouri, and Tennessee with new Champions being selected and trained in Alabama, Arizona, Georgia, Kansas, Kentucky, Maine, New Jersey, New Mexico, and Ohio. If you are an internal medicine clerkship director or a residency program director and would like to have a champion work with your school or residency, you should contact CIPCOH to get connected with the champion in your state. They can help train faculty or find local dental colleagues to teach your students and residents. Whether it is learning how to do a proper oral exam for cancer screening or learning how to make referrals to dentists' part of routine preventive care, the 100MMC champions can help.

If you wish to learn more about the 100MMC or connecting with an oral health education champion in your state, e-mail Diana Rinker at diana.rinker@umassmed.edu. You can learn more about CIPCOH by visiting its website: <https://cipcoh.hsdm.harvard.edu/one-hundred-million-mouths-project>.

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STARTING AN OBESITY MEDICINE TRACK FOR INTERNAL MEDICINE RESIDENTS

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Obesity is a major healthcare issue in the United States, affecting nearly 40% of the US adult population,¹ with healthcare costs estimated at \$147 billion annually.² Additionally, obesity is a risk factor for diseases such as metabolic syndrome, diabetes, chronic kidney disease, nonalcoholic fatty liver disease, and many cancers.³ Despite these facts, many physicians feel unprepared to treat patients with obesity.¹ Despite national guidelines for primary care physicians stressing the importance of treating obesity, only one-third of patients with obesity report receiving weight counseling.² Clinical knowledge is one of the major barriers to physicians evaluating and managing patients with obesity.² Physicians report receiving inadequate training in weight counseling and having insufficient knowledge of the tools involved in treating obesity.² Physicians that are trained in obesity screening, evaluation and counseling in residency are more likely to initiate conversations about diet and exercise with patients who are overweight or obese.² Specifically, physicians express increased comfort in treating patients with obesity after receiving educational training and direct clinical implementation with oversight about the pharmacological and surgical treatment of obesity.⁴

Although there are obesity medicine learning experiences in medical schools⁵ and obesity medicine clinical tracks in family medicine (University of Pittsburgh Medical Center McKeesport) and pediatric medicine (Mount Carmel) residencies, there are currently no obesity tracks within internal medicine residency programs that offer a longitudinal clinical experience to evaluate and manage patients with obesity. Our aim is to fill this gap by developing a longitudinal two-year obesity medicine experience within the Northwell Internal Medicine Program at Hofstra to train residents in the multidisciplinary and comprehensive management of obesity. This track expands on a previous one-year clinical obesity medicine experience offered in the program with the addition of teaching, educational and research activities.

The aim of creating this track is for residents to feel confident in their ability to evaluate and assess patients with obesity and treat these patients through a multimodal approach, which includes nutritional guidance, behavioral therapy, physical activity, and treatment with pharmacology or surgery.

Obesity Medicine Track

We believe there is a tremendous need to train internal medicine residents through a longitudinal clinical experience that provides the skills to properly assess, diagnose, and counsel patients on the comprehensive management of obesity using a multimodal approach. The longitudinal two-year clinical and educational obesity medicine track, embedded within the ambulatory experience, provides categorical internal medicine residents with opportunities to practice obesity medicine by evaluating and managing patients and to participate in teaching, educational, and research activities related to obesity medicine.

The main goals of the track include the following:

1. Recognizing the complex nature of obesity and why it requires a multimodal approach for treatment.
2. Performing a weight history and dietary assessment.
3. Learning to counsel patients with obesity about different treatment modalities.
4. Completing an academic project promoting obesity medicine research and/or education.

First Year of Track

First-year categorical internal medicine residents apply to participate in this track in the spring of their first year of residency with a short essay about their interest in studying and practicing obesity medicine. Beginning in their second year of residency, the track consists of five second-year residents, as our program's residents are split up into five firms.

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A JOURNEY ACROSS SEALED BORDERS!

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“Congratulations, you have matched,” read my e-mail at the beginning of the Match week marking it as one of the joyous days of my life. Having longed to see this message in my inbox, the competitive nature of the match instilled a sense of luck and accomplishment. But this year was unique, not only to the applicants but also to the entire world. The first case of COVID-19 was identified in Wuhan, China, three months prior to Match Day, with subsequent spread worldwide making it a public health emergency. The Isle of Man, my home until mid-2020, a tiny British crown dependency with a population of 85,000 had yet to witness its first case. It came in the form of a traveler, who transferred via United Kingdom, the gateway of entry to the island via air and sea. Although the pandemic spread to British soil in January 2020, the inevitable transmission to the island occurred only two months later. The Isle of Man government imposed strict lockdown banning the entry of non-citizens to the island. With the air and sea borders sealed, the 314-bed hospital that I worked at geared up for the challenge. Soon I realized that securing a visa to travel to the United States for my residency training would be no easy task.

The functioning of the U.S. embassy in London was limited, given the COVID-19 pandemic. Interview

appointments for visas were limited and were granted only on an emergency basis. A letter from my prospective residency program director supporting my request for an emergency visa interview and processing worked wonders. With these supporting documents, I was successful in securing a visa appointment. I bid adieu to the Isle of Man and sailed off with hopes of obtaining a visa, but with a palpable fear of being ineligible to return to this island if need be.

The U.S. embassy wore an unusually deserted look. With fewer applicants, it took little time to leave with the emergency visa approval. In less than 24 hours, I embarked on a flight to the United States. Landing on American soil marked the end of this adventurous trip and the beginning of a new phase of my life as an Internal Medicine resident. Assistance from individuals who continued to render services during the early phase of the COVID-19 pandemic made this possible. I am thankful to my program director and the program coordinator, who not only wrote to the embassy requesting emergency visa processing but also provided added documentation addressing the airport staff and immigration officers. The aviation industry which continued to provide emergency services during their toughest phase also deserves its share of commendation.

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MEDICAL EDUCATION: PART III *(continued from page 10)*

The first-year track activities are similar to the one-year clinical obesity medicine experience offered in the program. Residents participate in half-day clinical sessions evaluating and treating patients with obesity. These sessions take place once a week during their respective ambulatory clinic cycle, which occurs every five weeks. The sessions begin with a 30 minute-didactic led by the obesity medicine fellow. Topics covered include foundational areas in the management of patients with

obesity such as nutrition, physical activity, pharmacology, bariatric surgery, eating disorders, and endocrine disorders. Interactive case-based questions are included at the end of each didactic.

Following the didactic sessions, the residents evaluate and manage patients with obesity under the guidance of both the obesity medicine attending and fellow. Residents receive experience counseling patients about nutrition and physical activity, as well as prescribing weight loss medi-

cations. They also gain experience in coordinating with multidisciplinary members and having continuity with the patients they assess and evaluate throughout the year.

Second Year of Track

The second year of the track expands on the previous clinical experience offered in our program by providing opportunities for the residents to implement a significant educational or research project. Residents

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tions with penalties for undocumented immigrants).

SGIM’s mission is to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.¹ For us to remain true to this mission, we must take a careful and close look at ourselves to determine how we ensure “all” of our members are on the path to a sustained and fulfilled career that leads to “better health for everyone.” One of the ways in which our organization is making progress toward this aim is by confronting the dual epidemics of COVID-19 and racism. Under the leadership of Jean Kutner and the loving provocation of our devoted staff member Ms. Muna Futur, SGIM revisited our commitment to diversity, equity, and inclusion (DEI) beyond our statements of support. With Council endorsement, they assembled a DEI workgroup charged with crafting a formal statement and plan of action.² The Council DEI workgroup, led by Eleanor “Bimla” Schwarz, with representation from the Health Equity Commission and the Women and Medicine Commission, developed the recommendations (see Table).

Early in this process, the Council noted that SGIM needed to keep these issues top of mind to make progress on these recommendations as they are our fiduciary and generative responsibility. Given the diverse nature of our attention, they felt SGIM needed to keep our progress on these issues top of mind as to not to fall into complacency, as outlined by Dr. Deborah Plummer, former vice chancellor and professor at University of Massachusetts Medical School (UMMS) outline a similar path forward. In her article, “Leading in the Post-Floyd Era, The Cost of Doing Nothing About Race in the Workplace,” she cautions about staying stagnant in our leadership in regards to race and notes that making real progress in the workplace means: 1) avoiding the overreliance on hard data, 2) focusing on

strategy talk not advocacy talk, 3) leading with authority, rather than power, and 4) making quality decisions, in this work to enhance our DEI focus.⁴ For SGIM, this means paying attention to how our members feel and how we as an organization consider issues of “belonging,” not attempting to make everyone as-

similate into our cultures, traditions, or mores. Although we are a small organization with national credibility, we must be quality exemplars, not just good enough, in our focus on DEI and anti-racist initiatives.

The workgroup also recommended Council oversight of these
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SGIM Executive Committee DEI Workgroup Recommendations
Data Tracking & Assessment <ul style="list-style-type: none">• Collect & share data on race/ethnicity and other characteristics of SGIM membership that we want to track to assess progress toward goals.• Aim for transparency & standardization in existing processes for nominating and selecting leaders and making awards.• Use past external reviews of our organizational culture as a reference for assessing progress toward achieving DEI goals.• Conduct an annual assessment of progress achieved with diversity, equity, and inclusion efforts using a validated instrument that could be integrated into a dashboard metric. (Long-term goal after at least one calendar year of strategic DEI efforts). Think about how to measure so that we can determine what is needed to measure in the long-term.• Identify a Council member responsible for ensuring overall progress toward achieving DEI goals.
Setting Policy & Communicating to Members <ul style="list-style-type: none">• Share DEI policies created at the national level with all regional leaders, committees, and commissions.• Share with entire membership the external partnerships SGIM has committed to developing and maintaining and summarize the results of these collaborations.• Formalize and disseminate a professional code of conduct for SGIM members clarifying shared expectations for a commitment to promoting diversity, equity, and inclusion in SGIM activities.• Create an anti-racism strategy to guide SGIM’s research, education, clinical practice, and advocacy activities within the organization.• Create mechanisms where members can donate funds to specific activities within the organization that support minorities underrepresented in medicine & members or health equity or social justice/advocacy focused initiatives.• Enhance the involvement of minorities underrepresented in medicine in the JGIM and SGIM <i>Forum</i> editorial teams.• Capitalize on opportunities created through our career development programs, leadership training, and leadership clusters to produce leaders underrepresented in medicine and identify leadership opportunities beneficial to those participants and/or our organization.
External Relations <ul style="list-style-type: none">• Establish or strengthen partnerships with leaders, organizations, and institutions who have historically defended and supported anti-racism actions while sharing values core to the mission of SGIM at the national, regional, and local levels.³

planning committee and SGIM *Forum* teamed up to publish top-ranked Arts & Humanities submissions from trainees who presented their work at their regional meeting in October 2021;^{2, 3, 4}

- This issue features a new SGIM *Forum* Department in collaboration with the Ethics Committee: “Ask an Ethicist” addresses common and important ethical questions faced by general internists. To Ask an Ethicist, members are encouraged to contact the Ethics Committee with their questions that can be addressed in future articles.

Each of these collaborations have been rewarding community-learning opportunities. I look forward to seeing more strong and long-lasting bonds within SGIM in the future. Nevertheless, SGIM *Forum* can continuously learn, within and alongside SGIM and its constituent

groups and members. Together, we strive to improve and grow to be more anti-racist, diverse, equitable, and inclusive, in accordance to the mission and vision before us. In the words of Monica Lypson, SGIM President, “*The SGIM community must continue to learn from history...so that we can change our future for the better.*”⁵

Members are welcome to e-mail me with comments, ideas, and questions.

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PRESIDENT’S COLUMN (continued from page 12)

activities. To achieve this, the immediate SGIM Past-President, who is a member of the Council, will chair a workgroup to review and monitor progress on DEI goals and make recommendations for areas of focus and resources that are needed to ensure timely progression.²

The Council has also charged an additional workgroup, led by Council member, Rita Lee, to 1) review Committee and Commissions annual plans in relation to anti-racism, 2) ensure collaboration and advocacy for needed resources, and 3) provide recommendations on anti-racism strategies needed to guide SGIM’s research, education, clinical practice, and advocacy activities within the organization.

With these two workgroups, Council support, and feedback from our members, SGIM aims to make quality decisions in our next steps to ensuring our commitment to a “Just System of Care” by remaining an anti-racist organization focused on diversity, equity, and inclusion.

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least as much protection against infection as vaccinated individuals do.⁶ At the individual level, a requirement that naturally immune patients also receive a COVID-19 vaccine seems to demand greater immunity of them than it does of vaccinated individuals, a double standard. However, vaccine mandates may eventually require fully vaccinated individuals to receive boosters to further improve their immunity or research may show that natural immunity wanes or does not reduce transmission. Under any of these conditions, it would be equitable to require convalescent patients to increase their immunity as well by receiving a vaccine.

This case also involves potentially competing ethical concerns. Respect for this patient's autonomy means allowing her to refuse the vaccine. In terms of beneficence to her, individually, one could also argue that vaccination simply exposes her to very rare risks of vaccination (such as myocarditis and thrombosis) without any corresponding benefit, since she already has sufficient immunity. This line of argument suggests the possibility of exemption for those with recent COVID-19 infections; in fact, some countries, such as Israel, do not require vaccination for six months following infection.⁴ Without permission to return to work, this patient may also be harmed by losing her job, leaving the nursing home short staffed.

One might point out that the physician and patient have a social obligation in justice to take steps to protect the residents and other employees in the nursing home. Yet, we lack evidence to suggest that this individual patient's risk of getting re-infected and transmitting COVID-19 to the nursing home residents is higher than that of vaccinated workers, whose protection appears to wane over time.⁷ No doubt physicians have a duty to promote COVID-19 vaccination generally, but that obligation does not override the physician's primary obligation to the individual patient.

A clinician seeing this patient might begin by carefully and sensitively inquiring about the reasons behind the patient's hesitancy. Unfortunately, an acute care visit with a new physician is not an ideal setting for such a discussion. Ideally, a patient's primary care provider should consider writing the letter only after a careful dialogue that addresses the potential benefits of vaccination for this patient. Of course, not all patients have a PCP or can access their providers within the timeframe demanded by their employers in certain cases.

If I were seeing a patient who had established with a colleague in my own practice, I would be willing to provide a letter. In such circumstances I am acting in some sense on their PCP's behalf, and I think the practice has an obligation to meet patients' needs. However, I would decline to write such a letter if I were working in a detached urgent care facility that provided no continuity of care.

In my opinion, it would be ethically acceptable to write a letter supporting this patient's ability to return to work safely, provided she complies with all the other protective measures, such as mask-wearing, in effect at her workplace. I would recommend testing the patient's serum for the presence of COVID-19 IgG antibodies to confirm prior to writing the letter that she in fact had COVID-19. Given the uncertainty of the available scientific evidence, I would also recommend using careful language in the letter, stating that it would be reasonable to allow the patient to return to work now but taking no position on whether vaccination will eventually be necessary. Although my analysis focuses on this physician-patient relationship, I would also note that there is another agent involved in this case, namely the patient's workplace. Whereas the physician has a fiduciary duty to promote the good of the individual patient in alignment with the common good, healthcare administrators

have more direct responsibility for the common good of their workers and the patients they serve. This perspective may understandably lead them to deny the patient's request to return to work, even with a letter from the physician. In this brief response, I take no position on which exemptions to vaccine mandates administrators are obligated to grant.

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isfy individual areas of development. Intentionality during all mentorship interactions, including preparation, accountability, and mutual feedback are key for success.

In academic institutions, these relationships can be facilitated by proactively creating and delivering mentorship training, focusing not only on how to be an effective mentor but also a successful mentee. Coaching and facilitated peer mentorship represent additional, innovative models to better meet needs of junior faculty. The creation and distribution of databases highlighting faculty areas of interest can facilitate matching of mentors and mentees. In addition, tracking mentorship dyads may help identify overburden of some faculty and existing gaps.

4. Develop and Nurture Your Professional Network

Building relationships with peers and like-minded professionals, aka networking, open a door to new career opportunities through introductions, collaborations, recommendations, and referrals.⁵ Start building your network early, and develop networking strategies with contacts to grow trusted, enduring professional relationships (e.g., set times to meet in national meetings, share research using social media, convene at leadership conferences). While nurturing a professional network can take time and energy, it's well worth the investment. Successful networkers recognize the value of these relationships—they manage and market their personal brand; give back and volunteer; aim for quality over quantity; actively participate in professional associations; and schedule time for networking. Networking enriches your professional and academic experiences.

5. Create and Execute Your Plan: Be Creative, Strategic, and Proactive

Being innovative, deliberate, and strategic will deliver success. Tailor your professional goals to your definition of success. Remember to clarify and prioritize your values;

identify your strengths and be aware of your weaknesses, remember that self-awareness is key not only for setting goal but also for creating and executing a successful plan. Consider where you want to be in 10 years; once you know where you *want* to be in 10 years, define where you *need* to be in 1, 3, and 5 years to accomplish your 10-year goal. Determine what skills you need to better develop to achieve your immediate goal. Write it down and stay accountable. Involve a supervisor and revisit your goals and adjust as needed. Other tools that will assist in your development and goals include networking, mentorship, resources, and creativity.

Concretely, and with the help of your mentor, identify the skills you need to develop and act on them. If extra training is what you need, then identify and pursue training that best fits your needs and is most attainable to you. Know your resources and use them liberally. Share your interests and goal with possible sponsors. Create and frequently maintain your CV, and practice your “elevator pitch” (your three-sentence summary of who you are, what drives you, what resources you need, and how your project will make a difference). If you work in an academic institution and one of your goals is academic promotion, becoming familiar with your institution's rules and periodically work on your promotion matrix to timely identify and address matrix gaps.

Give yourself permission to say “no” to projects that do not align with your roadmap. Nonetheless, be cognizant that detours are sometimes necessary to meet potential collaborators and future sponsors. Ultimately, every “yes” should take you closer to your goals. Your professional path will be as unique as you; it will rarely resemble a straight line and, often-times, it will be winding and rocky.

6. Real-time Inventory

Humans are complex, and complexity brings change. Expect and embrace change and you'll thrive.

Because change is natural, it is also expected that your definition of success and your ultimate goals may change. Revisiting these steps often will assure your path still aligns with your desired destination.

In summary, the critical first step in effective professional development is to define what success means to you and to develop individual goals to achieve it. After you have your destination (success) and your roadmap (professional goals), make sure you become familiar with your vehicle (promotion criteria, career path), consider a hybrid vehicle (non-traditional scholarship, non-clinical careers), prepare enough food, gas, water (resources), identify and obtain a great co-pilot (meaningful mentorship), assist “hitchhikers” along the way (be collaborative and generous), be prepared and ask for help when needed, expect and learn from detours or rocks along the way. And above all enjoy the quest!

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MEDICAL EDUCATION: PART III (continued from page 11)

also apply the educational concepts taught in the first year by the fellows and act as “teachers” for incoming track members. The goal of expanding on the previous experience by implementing this track is to give the residents the opportunity to utilize the skills learned in the first year of the track to contribute significantly to obesity medicine education and research.

- *Teaching:* Residents take part in a “Resident as Teacher” activity, in which they lead one of the didactics for the first-year track members in their respective firm.
- *Academic Project:* In the first year of track, track members will identify an educational or research project that they will implement in the second year of their track. Each resident will be assigned an obesity medicine specialist within the Center for Weight Management as a mentor for their project.
- *Reflection:* At the end of the track, residents will submit a reflective piece on a specific patient experience and/or their experience in the track as a whole.

We plan to evaluate this track through surveys that residents fill out before and after the track. Surveys will assess their comfort and confidence in the assessment and management of patients with obesity, and their attitudes and beliefs about obesity. The surveys also contain knowledge-based questions about

foundational topics within obesity management.

At the beginning and end of the first year in the track, residents will be observed in a clinical encounter. Faculty observers will be scoring residents with an observer checklist that focuses on gathering a comprehensive weight history and performing a dietary and physical activity assessment. This assessment will provide constructive feedback to the residents, as well as information about their progress in the track.

Physicians have the opportunity to play a major role in addressing the obesity epidemic through counseling and managing patients for weight loss and understanding when it is appropriate to refer patients to weight loss programs.⁴ Despite the importance of these skills, physicians still feel unprepared to treat patients with obesity¹ and do not feel as though they have received adequate training in obesity medicine management.² Educational training along with direct clinical experience is a strategy to mitigate this discrepancy. Therefore, we created this track for residents to feel confident in their ability to evaluate and assess patients with obesity and treat these patients through a multimodal approach. Additionally, the track provides an opportunity for the residents to apply the knowledge gained to contribute significantly to obesity medicine education and research. The goal of this experience is to train residents who will go into their respective specialties with an understanding of the

complexity of obesity as a chronic disease and be provided with the appropriate tools to better manage it.

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