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BREADTH: PART I

"IF I AM TO CARE ADEQUATELY FOR THE SICK…"—LESSONS FROM PANCREATIC CANCER

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On November 25, 2005, my mother died of pancreatic cancer—a death that represented the culmination of a courageous battle against a near-undefeated foe. Losing my mother was crushing. It created a disorienting and suffocating void in my life. Lacking direction personally and professionally, I felt paralyzed and aimless. In the years since her death, I have juggled life as a husband, father, and physician attempting to establish a medical career. At the same time, I have long struggled to understand my relationship with the disease that cost my mother her life.

Upon my medical school graduation nearly three decades ago, my parents gave me a beautiful plaque of a modernized version of the *Hippocratic Oath*. Their gift commemorated a landmark educational accomplishment, and no doubt reflected pride in their son. Days later, I drove across the country to embark upon my internal medicine residency. Over the arc of my medical journey since, the plaque has hung on the wall of various work offices, gazing over my shoulder and career.

Shortly after my mother died, I admitted a woman with painless jaundice. She was about the same age as my mother at the time of her untimely diagnosis. I explained the likely cause of her illness to this matriarch and her anxious family. I swallowed the lump in my throat and my pity for her, knowing what lay ahead for everyone in the room and took note of the gnawing pit in my stomach as I recalled the familiar "mass…pancreas" imaging report.

We struggled to coordinate timely outpatient follow-up and care for someone who lacked medical insurance. I understood her financial limitations and could envision how this might play out. In the end, I excused myself from the room, rushed into the nearest bathroom, and wept. I understood her financial limitations and could envision the truncated life that lay ahead, with its stark contrasts to my own family's full access to care and resources. Through her unconditional love, altruism, and benevolence, I was provided a guiding vision as a clinician. *I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability.*

Five years later, I cared for a man admitted with bleeding complications caused by anticoagulation for pulmonary emboli driven by his underlying pancreatic cancer. He was a highly successful investor and entrepreneur; both he and his wife had clear expectations that our medical team would heal him completely and provide an expeditious return to their life pursuits, with minimal interruption. However, their expectations would quickly prove unrealistic. Cancer had plans of its own, and, despite our best treatments, his health declined rapidly.

Conflicting emotions stirred within me as I tried to reconcile our provision of escalating, near-futile medical care with medical reality. Entitlement? Unrealistic expectations? In the days ahead, I spent inordinate amounts of time communicating evolving facts and professional recommendations. He and his family repeatedly wondered aloud why we could not make him better. In conveying the certainty of his decline, I shared with them—through welling eyes—the story of my mother's cancer journey.

After the patient died in the hospital two weeks later,

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A YEARLY TRADITION

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

On March 18, 2022, U.S. President Biden signed the Dr. Lorna Breen Health Care Provider Protection Act (H.R. 1667) into law. Under law, key objectives for the Department of Health and Human Services will include: "improving mental and behavioral health among health care providers, removing barriers to accessing care and treatment, and identifying strategies to promote resiliency."[1] Our communities as general internists, educators, researchers, advocates, and trainees have lived and sought to influence these realities long before this policy shift. Nevertheless, this is a landmark change in policy that will offer greater support for a healthcare workforce that continues to be challenged socially, culturally, and even ideologically.

As of March, the specter of another SARS-CoV-2 variant looms at the same time that we have a time-honored annual tradition in the United States for medical students all over the world who are seeking U.S. residency positions: Match Day.[2] Despite persisting concerns about primary care workforce attrition accelerated by the pandemic, I was heartened to see on the National Resident Match Program report, "*Primary care specialties offered record-high numbers of positions and had high position fill rates*".[2] The healthcare workforce lifecycle sustains itself, recalibrating collectively to meet present day public health and patient care needs. Nevertheless, the growth of the workforce has yet to match the projected primary care physician shortage reported by the American Association of Medical Colleges.[3]

In primary care and Internal Medicine, reflection on difficult moments, continuing to innovate and learn, and especially advocating for a more robust, supported primary care and health system offer the pathway to the future. This month's issue of SGIM *Forum* is marked by several reflective pieces, in the form of essays, artwork, and poetry. LeRoi Hicks, SGIM President, publishes his first president's column, sharing his optimism in the face of experiencing serious illness as a patient. A column this month also acknowledges important issues during the month of May, which is Asian American and Pacific Islander (or Asian Pacific American) Heritage Month. I wish you inspiration from the new perspectives offered in this month's issue of SGIM *Forum*.

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APPRECIATING THE PROMISE OF OUR FUTURE

LeRoi S. Hicks, MD, MPH, FACP, President, SGIM

"Despite the many challenges of the past two years, I have witnessed the tireless efforts of our SGIM staff members to deliver educational and research content to SGIM members in continued support of our collective efforts to derive benefit from our membership in support of the patients we serve despite the circumstances thrust upon us. I am honored to be able to continue my work as part of this community. I believe the members of our society have all it takes to promote improvements in how we train, advance knowledge among our peers, inform public policy, and improve the health of our patients in a rapidly changing world."

I was bewildered initially as I looked around the Intensive Care Unit (ICU) room from my hospital bed and noticed my crying wife and best friend smiling as they looked at me from the couch in my room. As I began to recover my senses after four days of heavy sedation, my bewilderment transformed into a sense of relief that I must have survived a nearly fatal disease course. As I recall, my wife ran quickly to sit on my bed and held me closely while crying on my shoulder. At that moment, I was overwhelmed by an additional feeling of gratitude.

Starting in October 2019, I was hospitalized for severe sepsis secondary to hepatic abscesses. Surviving that, I endured a two-year course of illness that would lead to several more hospitalizations due to disease complications and multiple surgeries. During that period, I was frequently sidelined from work for months at a time. In those times, I simultaneously experienced both the fear for my colleagues who dedicated themselves to meeting the needs of a community overwhelmed by the first COVID wave and the fear of navigating life as a patient whose medical care was significantly impacted by the need to preserve hospital capacity. Those experiences have informed my view of our profession in ways likely unknown to a physician who has never been on the other side of the stethoscope. As I reflect on this time for my first SGIM *Forum* column, this is a prime opportunity to simply introduce myself, express my gratitude for the support of SGIM membership, and share my excitement about the opportunities we now have as Internists to significantly improve the world in which live.

For those who do not know me, I have been a member of this society since starting my fellowship in

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Q & A WITH SGIM'S CEO AND LEADERS OF THE SGIM—VETERANS AFFAIRS (VA) PARTNERED RESEARCH CURRICULUM

David A. Haggstrom, MD; Jeffrey Whittle, MD, MPH; Erika Baker; Eric B. Bass, MD, MPH

Dr. Haggstrom (david.haggstrom@va.gov) and Dr. Whittle (jeffrey.whittle@va.gov) are the leaders of the SGIM-VA Partnered Research Curriculum, Ms. Baker (bakere@sgim.org) is SGIM's Director of Project Management, and Dr. Bass (basse@sgim.org) is SGIM's CEO.

EBB: Why did VA partner with SGIM to create a curriculum on partnered research?

DH/JW/DH: While most medical research has health improvement as the ultimate goal, the VA Office of Research, and the Health Services Research and Development (HSR&D) service in particular, has a commitment to fund research that will improve the quality of the healthcare it delivers to America's military Veterans. VA leaders have recognized that even well studied healthcare innovations do not impact VA practice as quickly as they should. To speed the transition from research discovery to better healthcare, researchers seek to partner with organizations responsible for putting medical innovations into practice. However, differences in training, culture, and incentives make it challenging to form and nurture partnerships between researchers and health system leaders.

With this in mind, the director of the HSR&D service (David Atkins, MD) was looking to help researchers develop the skills to facilitate such partnerships. The VA–SGIM Partnered Research Curriculum is one such opportunity. The Curriculum gives researchers methodologic training in partnership formation and maintenance, using didactics, interactive small group sessions, and supervised steps toward developing partnerships *they have identified as vital to moving their research into practice*.

VA and SGIM have a long-standing relationship due to their shared values, including commitments to high-quality health care, learning health systems, and excellent healthcare delivery science. Many investigators who seek to conduct research that will improve clinical practice are members of SGIM and work in the VA healthcare system. Many of the people who first recognized that partnerships between researchers and health system leaders could facilitate translation of research into practice are members of SGIM and/or are VA employees. Their successful partnerships provide a model for other investigators to achieve similar success. Furthermore, SGIM has a long track record and continuing commitment to promoting leadership and academic development through programs such as TEACH (Teaching Educators Across the Continuum of Healthcare), LEAD (Leadership Development Program), and LEAHP (Leadership in Health Policy Program).[1] Finally, VA's emphasis on using research to guide practice change created a need for a training program in this area that SGIM was well positioned to develop and deliver.

EBB: What are the objectives of the curriculum on partnered research?

DH/JW/EB: The overall goal is to deliver a training program for early career stage investigators, or scientists who are new to partnered research, to pursue partnered research in a learning healthcare system. The curriculum addresses several key questions:

- How can we better understand the needs and goals of stakeholders in a learning healthcare system, and how do they differ between investigators and clinical or operational stakeholders?
- How can we continuously engage stakeholders during a study?
- How do we balance the tension between sharing early study results and lessons learned with concerns about compromising study design?
- How are research results best communicated to different stakeholders?
- How can physician-investigators best advise leaders on policy issues?

EBB: What educational methods and content are included in the curriculum?

DH/JW/EB: The Partnered Research Curriculum consists of three main components:

1. structured learning sessions;
2. partnered research project activities; and
3. assigned mentorship.

The structured learning sessions include seven 90-minute sessions over nine months. At each session,

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HIDDEN CURRICULUM, VISIBLE OPPORTUNITIES

Steven X. Chen, PhD; Daniel I. Kim, MD, MBA; Robert T. Chow, MD, MBA;
Elisa I. Choi, MD; Joshua M. Liao, MD, MSc; Tammy L. Lin, MD, MPH

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The culture of medicine can be transmitted implicitly through examples, stories, and defined hierarchies. This hidden curriculum, a set of lessons learned but not explicitly intended, can positively or negatively affect learners' attitudes, behaviors, and professional formation. In 2018, an American College of Physicians position paper suggests that educators can mitigate the untoward effects of the hidden curriculum by empowering learners in environments that support inquiry and leadership advancement.[1] These efforts are critical because without them, the hidden curriculum may actively impede growth.

The dynamic is perhaps no more apparent than among learners of Asian descent. Approximately 20% of the physician workforce, active residents, and matriculated medical students nationwide are Asian. Yet, far lower proportions—12.5% of males and 6.1% of females—were tenured faculty at U.S. medical schools in 2021.[2] Similar trends exist within the specialty of Internal Medicine. Though there are multiple reasons for these findings, one may be that the hidden curriculum conveys messages to Asian learners that impede their professional advancement.

"The traits associated with this stereotype such as likability, industriousness, respectfulness—though positive in their own rights—can become barriers to professional advancement if educators reinforce them through the hidden curriculum."

Asians are often mythicized as the monolithic "model minority." The traits associated with this stereotype—such as likability, industriousness, respectfulness—though positive in their own rights can become barriers to professional advancement if educators reinforce them through the hidden curriculum. For instance, learners who receive praise for displaying these traits may receive the hidden, implicit message that these should always be prioritized. Furthermore, the pressure to maintain these qualities may prevent learners from asking for help when they experience anxiety, depression, or isolation.[3] Educators may not perceive outward signs of distress that would otherwise prompt attention. Asian women face additional gender-related barriers and challenges. Compared with White female physicians, Asian female physicians were 2.5 times more likely to report being subjected to racially or ethnically offensive remarks by a coworker.[4]

These issues can be compounded by the fact that many other traits associated with being a "model minority"—deference to authority, humility, internalization of personal feelings, placing group needs over individual ones—are inextricably linked with some Asian cultural norms. They run counter to classical leadership traits such as confidence, decisiveness, and charisma. The ultimate effect of educators' expectations and implicit biases may be a failure to foster qualities and social connections that are less inherently culturally aligned but significantly needed for professional advancement.

Fortunately, shining a light on how the hidden curriculum can impede professional advancement also illuminates new opportunities to counteract it. There are likely parallels between issues faced by Asian learners and those of other racial, ethnic, or other backgrounds. One is that given the tremendous power that educators wield through the hidden curriculum, they play a key role in supporting learners' development, beginning with the understanding of cultural beliefs, stereotypes, and communication styles to redesign implicit messages and break down barriers.

Beyond effective mentorship, learners would benefit from a curriculum that provides culturally sensitive approaches to learning and honing leadership skills. Using a structured approach, such as REVIEW (Reflecting & Evaluating Values Implicit in Education in the Workplace),[5] hidden curricula may be addressed through exposure to dilemmas, discussion of choices and compromises underlying a professional microculture

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TIME TO RETHINK PHYSICIAN UNIONS IN THE WAKE OF COVID-19

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Physicians and other frontline health professionals around the world risked their lives to serve those who needed medical attention from SARS-CoV-2. As physicians, we were strained in hospitals and other healthcare settings across the country, overburdened by the sheer volume of patients. Early on, healthcare settings struggled to ensure the safety of their workers, who were often at high risk for COVID-19 infection. Ensuring adequate protection was challenging given the uncertainty of the virus, requiring physicians to rely on a patchwork of local resources, including their practices, hospitals, or public health systems, to provide the equipment they needed.

Physicians and other health professionals beset by these challenges often had no effective means to express concerns. Although physician professional associations such as the American Medical Association (AMA) and American College of Physicians (ACP) provide a national voice for physicians and advocate for relevant payment policy changes, they rarely offer a clear or effective voice at the local level where these challenges arose. This difficulty may have been felt by physicians working in large provider organizations. Most private sector physicians now work in such organizations and may have limited power to control their work environment and safeguard their ability to deliver high-quality patient care. In view of limited alternatives to ensure such physicians have an effective voice for their professional concerns, this is an excellent time to consider the benefits of physicians organizing into a doctors' union.

> **"Organizing has numerous advantages including ensuring an appropriate professional workload and sense of control and engagement, thus fighting burnout for frontline clinicians."**

Primacy of the Physician-Patient Relationship

With the rise in control of physician practices by large corporations there is concern that the physician-patient relationship, already strained by the fractured U.S. healthcare system, may further erode. Inherent to the physician's responsibilities in this relationship is the vast asymmetry in information between the physician recommending a service and the patient who must act on this recommendation. For efficient, effective, and compassionate care, patients must trust the physician to provide appropriate clinical recommendations specific to their needs and to not be unduly motivated by personal financial gain. The ACP's recent position paper on financial profit in medicine sends a strong message that, "[p]hysicians are permitted to earn a reasonable income as long as they are fulfilling their fiduciary responsibility to provide high-quality, appropriate care within the guardrails of medical professionalism and ethics."[1]

The rapid rise in physician management by larger healthcare organizations widens the potential gap between the physicians who discharge these professional responsibilities at the point of care and the managers who control the clinical settings. This may result in these physicians having less power in controlling their work environment, with the corporate decision-makers often distant from the settings, professionals, and patients impacted by these decisions.[2] Management decisions made at these large and complex organizations may create even greater risks that could run counter to the physician's professional responsibilities to their patients. The repercussions of these management decisions can undermine the fundamental tenets of the physician-patient relationship. These problems can be challenging when responding to even routine variations in clinical demands, such as those brought on by seasonal influenza surges.

Provider Consolidation Woes

The COVID-19 pandemic exposed additional weaknesses in the fragmented and fractured U.S. healthcare deliv-

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ery system. For example, the many practice organizations relying on traditional fee-for-service reimbursement struggled with requirements to curtail face-to-face services. The pandemic necessitated the rapid transition to telehealth visits, posing severe challenges to medical practices slow to respond, with various anecdotes suggesting larger health systems adapted more quickly.[3]

There is extensive evidence supporting the advantages of smaller, independent physician practices and that consolidation of smaller practices may be associated with higher burnout rates from a poorer work environment.[4] Nonetheless, it seems likely that the diverse financial struggles of smaller physician practices may force more of them into consolidation under larger organizations, for profit and non-profit alike. As a result, there may be further constraints on physician control of their work environment and ability to fulfill their professional responsibilities to patients.

What Options Do Physicians Have?

Physicians within large organizations often have little control over their practice settings where mangers are distant from the frontline, leading to decisions with negative impacts on patient care. These physicians may feel powerless to take action to improve their work environment; some have even expressed concerns about job termination for speaking up.

In some communities, physicians may have few or no options to shift to alternative settings to serve patients. For example, large organizations often rely on non-compete agreements to limit their physicians' options to practice in the community. As single healthcare systems start to dominate local communities, some physicians will face the prospect of uprooting their professional and personal lives in response to poor corporate management (e.g., moving their family from the community). In markets where these systems cannot enforce such non-compete arrangements, concerned physicians may still face the daunting task of joining (or even establishing) a private practice in competition with the dominant local provider.

As we have seen with the COVID-19 pandemic, clinical work environments can change quickly with the need for major adjustments to staffing, professional responsibilities, and schedules. While the hope is that the responsible managers of clinical settings ensure the proper support, safety and well-being of the clinicians, the size and speed of change in many large healthcare organizations is not reassuring. Thus far, physician professional societies, such as the AMA, have not been organized or governed to address the local concerns of such physicians. Nor have concrete policy proposals emerged to create regulations that ensure these growing healthcare systems effectively address such concerns expressed by health professionals at the point of care.

Where Organizing Can Help

By organizing into a unified voice, physicians in these large organizations could gain leverage to negotiate greater professional control over clinical settings and the resources needed to ensure high-quality patient care. Organizing has numerous advantages including ensuring an appropriate professional workload and sense of control and engagement, thus fighting burnout for frontline clinicians. These changes may improve health outcomes, and provide a more consistent and concrete avenue to advocate for our patients and effect real, sustainable change.[5] Prior experience from house staff unions has shown that unions can provide better pay and benefits, and potentially lead to higher quality care.[5]

The AMA once created a nationwide physician union but there was little support due to the complexities of the U.S. healthcare workforce. The Union of Physicians and Dentists is the largest independent physician union in the United States; but, with only 4,000 members, it pales in comparison to large professional societies, such as the AMA. While these professional societies have strong and powerful lobbies to impact federal policy change, they lack the power needed by employed physicians to secure adequate support and benefits for their workplaces.

Employed physicians in large healthcare systems or multi-specialty group practices do offer benefits but in the wake of COVID-19 and the corporatization of healthcare through provider consolidation and private equity acquisitions, physicians need to advocate and bargain for themselves more. Organizing into a union, for instance, can provide the negotiating power needed to improve working environments and general well-being by giving doctors back their agency and maintaining their moral obligation to patients.[4] Happier doctors could lead to better care delivery and happier patients.

Now What?

COVID-19 has accelerated many aspects of healthcare innovation out of necessity. Now is the time for physicians to band together not only to form a unified voice beyond policy lobbying but also to ensure their well-being. With a unified voice, physicians can continue to care for patients safely and effectively and counter the corporate winds that may corrode their professional responsibilities. COVID-19 exposed weaknesses in the healthcare system that relies on physicians and the many other frontline workers to bear through. With collective action, physicians can provide the high-quality care patients need while caring for themselves.

Disclaimer: *Opinions expressed by Dr. Meiri are his own and not reflective in any way of the U.S. Government or Department of Veterans Affairs.*

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TEACHING LEARNERS TO ADDRESS MISINFORMATION: GETTING BACK TO THE BASICS

Eva Rimler, MD; Elisa Sottile, MD; Cornelius James, MD; Tanya Nikiforova, MD, MS

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You are supervising resident continuity clinic when Dr. Gabriel, PGY-2, presents a 45-year-old woman seen for follow-up. At the end of his presentation, Dr. Gabriel says, "We discussed the COVID-19 vaccine, and she's completely against it. She read online about the vaccine causing side effects and altering her DNA. I told her that the vaccine is safe, but she doesn't believe me and won't get it even though one of her kids is immunocompromised." You notice that Dr. Gabriel is visibly upset. After probing further, you learn that they just completed an ICU rotation and took care of many young patients with COVID-19 who had poor outcomes. They ask you, "What is even the point of me talking to patients about vaccination?"

The COVID-19 pandemic has led to an exponential increase in the quantity and speed of misinformation spread and unprecedented distrust of public health systems. Internists in primary care and hospital settings have been uniquely affected by these trends, having provided direct care to patients suffering from COVID-19 complications, pandemic-related mental health challenges, and grief related to loss of loved ones to COVID-19. At the same time, internists have used considerable emotional reserve and time to help patients navigate pandemic-related misinformation and counsel on vaccination benefits. Internal medicine residents experience these complex roles even more acutely as many have been deployed to COVID-19 units and have reckoned with the oversized impact of the pandemic on their training and personal lives. In this article we focus on how clinician educators can prepare and support trainees in addressing misinformation, particularly surrounding COVID-19 vaccination.

> **"Educators can support internal medicine trainees in addressing vaccine and COVID-19 related misinformation by naming and debriefing the strong emotions these conversations may evoke, emphasizing connection with patients, providing frameworks for effective communication, and addressing misinformation using principles of EBM."**

Acknowledge the Emotions

Although vaccine hesitancy isn't a new phenomenon, the circumstances surrounding COVID-19 vaccine uptake are unique. After months of tirelessly caring for patients who previously declined COVID-19 vaccines, our learners are understandably weary and frustrated. This may translate into an emotional response while addressing vaccine misinformation. Educators should be prepared to acknowledge and debrief the emotions experienced by learners during such discussions. Naming the observed emotional response ("It seems like that was an upsetting conversation.") can be a first step in exploring and unpacking the emotional impact of the conversation, and can open opportunities for sharing, learning, and feedback. Educators can even perform a pair-share with their learners, each sharing feelings related to vaccine hesitancy. This conversation then serves to teach reflective listening. Beyond debriefing these experiences, educators can recommend that learners prepare for these challenging discussions by first attending to their own state of mind. Helping our learners practice mindfulness will put them in a position to engage in shared decision making more effectively with patients.[1]

Emphasize Connection

The pandemic is not the first time that learners have interacted with patients of differing views or beliefs, and it will undoubtedly not be the last. During discussions surrounding COVID-19 vaccines and misinformation, learners need tools to help them respond with empathy. One such resource, "The Humanism Pocket Tool," helps

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clinicians remember that each of their patients is a unique individual with their own story.[2] This could promote learners' curiosity about each patient, reducing the act of simply placing patients in the category of "anti-vaccine". While listening to the patient's story, there is value in paying close attention to the words and body language used by patients as they serve as clues to uncovering their agenda and feelings. Direct observation of learners during these conversations can help educators commend learners that recognize emotions in others and provide specific guidance when they struggle with this skill.

Provide Communication Frameworks

Beyond addressing emotions and encouraging mindfulness and connection, learners can be taught the use of expert-recommended and evidence-based tools to construct more effective conversations about COVID-19 vaccines and misinformation. For instance, experts caution physicians against focusing exclusively on sharing data to dispute misconceptions about vaccines and their adverse effects.[3,4] This strategy can backfire, leaving patients more convinced that the misinformation they believe is fact. When confronted with an inaccuracy about the COVID-19 vaccine it is best to identify it as such and then offer a brief alternative explanation. Overall, it is more impactful to focus on the risks associated with the disease itself, the real risk of contracting the illness, and most importantly the power of the patient to take control over these risks by getting vaccinated.[4]

While frustrating, it is understandable that patients may be hesitant to try a "new" vaccine. With frequently changing recommendations and misinformation that has been rapidly transmitted throughout this pandemic, the already tenuous trust many patients have for experts and the medical field has been eroded. When trust has been lost, it is best to start with listening instead of talking. In these situations, employing tenants of motivational interviewing (MI) can be helpful. Take the time to elicit a patient's concerns, ask permission, and then provide information in a non-judgmental way, and then again elicit how the patient responds to that information. Understanding and appealing to patients' values and emotions is crucial to conversations surrounding vaccine acceptance.

One large safety net hospital has integrated these tools of MI into a method for providing vaccine information that they call the "No Judgment Zone."[5] Their approach starts and ends with expressing gratitude for the patient taking the time to talk about the vaccine. From this vantage point, residents and faculty gauge the patient's interest in vaccination, elicit their concerns, provide brief facts when needed, affirm the emotions surrounding this decision, and then offer patients the opportunity to get vaccinated that day if interested. Addressing misinformation and vaccine myths with compassion and empathy is foundational to engender trust and necessary to guide patients toward health decisions that align with their values.

Address Misinformation

With information readily available with the click of a button, learners must be comfortable navigating the information cycle and responding appropriately as information moves through each step of the cycle and changes over time. Evidence based medicine (EBM) provides a framework for addressing misinformation by asking relevant clinical questions, identifying and appraising information sources, and applying best available evidence. This process has historically occurred in the silo of the clinician's mind, without much patient involvement. Recognizing the need to increase patient engagement in the decision-making process, Hoffmann and colleagues described the interdependence of EBM, shared decision making (SDM) and patient-centered communication (PCC) to provide optimal patient care.[5] Therefore, increased attention should be given to SDM and PCC in EBM curricula. With an appreciation for the learners' level, clinician educators must intentionally introduce and reinforce these skills in didactic and clinical settings, including through use of patient experience panels, role play activities, and in-clinic, real-time teaching related to using SDM and PCC when making evidence-based recommendations. In addition, we must teach our learners to empower patients to be informed consumers of information. Learners and patients should have a shared vocabulary when coming together to make clinical decisions. For example, asking the 5W questions (who, what, when, where, and why) may be a useful place to start when patients and clinicians are discussing sources with information that will influence medical care (see Table).[6]

5Ws to Evaluate Information

Who	Who is the author? Credentials?
What	What is the purpose of the information? Agenda?
When	When was the information published?
Where	Where can the information be verified? References provided?
Why	Why should I use this resource?

Conclusions

Through their roles in hospitals and clinics, IM learners are on the frontlines of addressing vaccine and COVID-19 related misinformation. Clinician educators should support learners in these discussions by

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AMERICA'S SCORCHING MELTING POT

Taylor Hollis, BA

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The following poem was one of the top three Arts and Humanities submissions presented at the SGIM Northwest/California-Hawaii Regions' Annual Meeting in January 2022.

We are told America is a melting pot
We think of the vibrant colors of the broth
The vegetables
The seasonings
The smell of rosemary and garlic
The longer you let the broth cook
The better it tastes
...or so we think
But left boiling too long
The heat escaping from each individual produce
Begins to hiss and scream
Triggering alarm
BUT no one is listening
Ignored
It BURNS
THEY BURN
Carbon dioxide in the air finally waking America up
To the deathly and explosive chemical reaction
That is…
Systemic racism
Boiling in America for centuries
At the very bottom of that pot sits the soot
black powdery substance
Amorphous carbon
The byproduct of coal
That under pressure turns to diamonds
resiliency
Is that why you fear us?
Drown us in water to remove what you believe is
Dirt…
We cannot breathe
And the type of pain that caused my body to seize from
asphyxia
Came from you kneeling on my neck like
We are all George Floyd
Our Black Lives have not Mattered
We are only a platitude of our skin's tone…
You see as weapon
Black.
Evil.
Dark.
Slave.
Negro.
Nigger.
The poignancy of the words that so easily
dehumanizes us.
We are shackled and killed by 3 Ps
Phobias
Prejudice.
And the Police
So what side of the line do you stand on for racial justice?
Is awareness enough?
Can you connect the dots between
Covid-19?
When poor Black clinics suddenly gleaned
White
As you took the vaccines
We are no longer protected
Because our homes are multigenerationally filled
And we can't find ways
To relax our minds
outside
Because our neighborhoods
Arent places you've decided to gentrify
And we continue to die
Are you Truly prepared to be an ALLY?
Because Hate is a villainous state
Let's change the narrative an be more
Preparative
Decolonize our minds
Do our due diligence
Research in our own time
Reflect so you don't regret
Living behind times
A slow non changing mind
Embrace our differences
Learn what makes us connect
Never forget
History continues to repeat itself
And America's scorching melting pot continues to Burn

COPING WITH COVID-19

Cassedy Mahrer Owen, DO

Dr. Mahrer Owen (cassedy@uw.edu) is an acting clinical instructor in the department of medicine at Harborview Medical Center at University of Washington and is the current academic hospitalist fellow at UW.

The following artwork was one of the top three Arts and Humanities submissions presented at the SGIM Northwest/California-Hawaii Regions' Annual Meeting in January 2022.

After one particularly difficult week in August 2021, when the pandemic was re-peaking, I turned to my art journal to process the events. I was newly back at work as a hospitalist from maternity leave with my 6-month-old son. Our Nanny had just contracted COVID, despite being vaccinated, throwing our household into chaos. During my commute via the ferry from Bremerton to Seattle, >20 people were unmasked during the ride and many refused to wear their masks when asked by the crew. I performed three death exams on patients with severe COVID who had been sent to my service after a lengthy time in the ICU for the purpose of dying after withdrawal of life support. I had two patients with COVID on my service, one of whom repeatedly requested Vitamin C and Ivermectin, as his oxygenation continued to worsen and he developed ARDS. I worked 100 hours in seven days, and my milk supply for my infant, which provided him with my antibodies against this terrible disease, took a dive to critically low. It was a week where nothing felt right, and I alternated between feeling broken, feeling insufficient, feeling angry and feeling numb.

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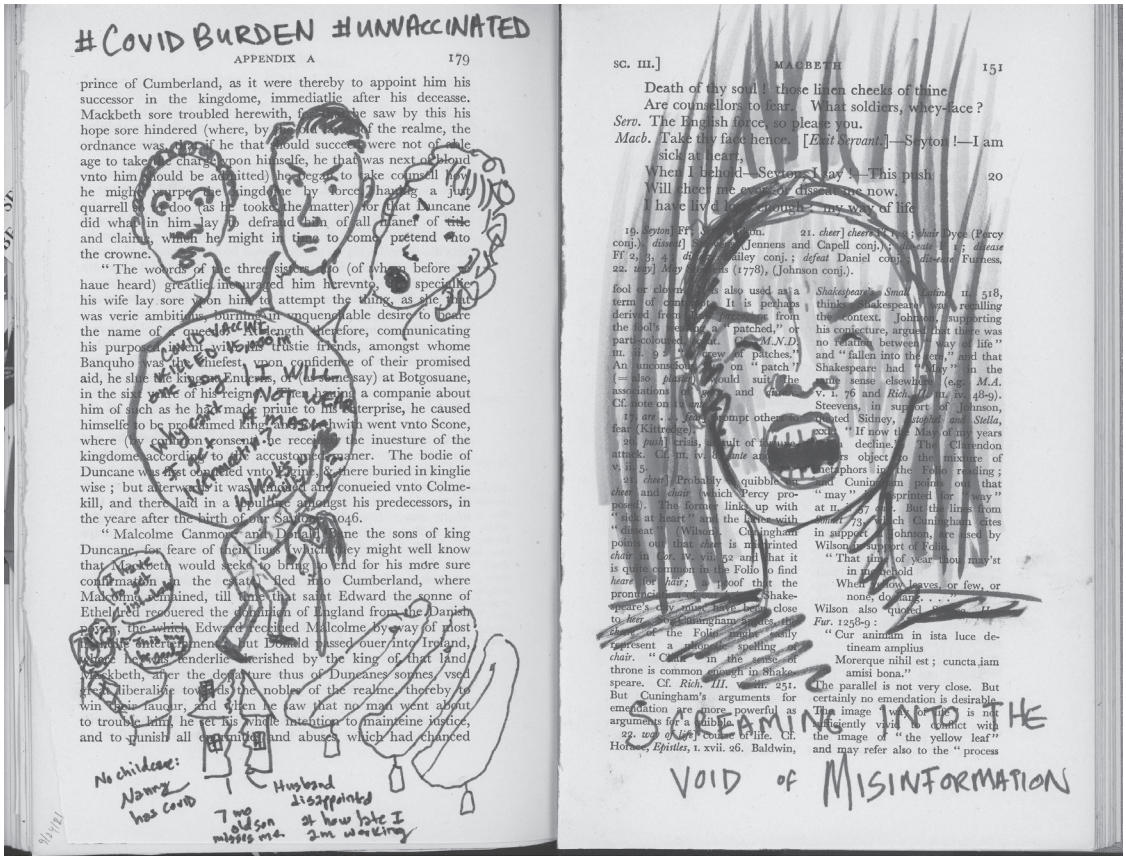

This piece, done in marker in a repurposed book, captured what I could not put into words at the time, in a raw, unfiltered, unedited sketch that once on the page, unburdened my soul from carrying all those things with me.

interactive lectures are delivered by implementation scientists and/or operational leaders. The final 30 minutes are dedicated to breakout sessions where participants meet in small groups or "pods" for networking, peer mentoring, and project feedback. Each participant develops an independent partnered research project through a series of steps or activities, including generation of a project brief, identification of potential operational partners, development of relationships with partners, analysis of the project through the partner's viewpoint, operationalization of the project, and preparation of a description of the project tailored to meet the information needs of partners. Mentors from SGIM and VA meet monthly with participants, providing a sounding board for partnered project activities as well as career development guidance. In addition, the mentors facilitate connections with potential operational partners or relevant scientific leaders.

EBB: What did the first cohort of participants say in their evaluation of the curriculum?

DH/JW/EB: The participants and their mentors were enthusiastic about the program. Participants, even those who already had high quality mentorship, identified mentors as the most highly valued part of the curriculum. Participants uniformly identified the didactic topics as being valuable, although they suggested a few topics that could be added. Finally, the participants reported that the small group sessions were particularly valuable for networking, leading to suggestions for enhancing interactions beyond the group to which one was assigned.

As one person stated, "the soft skills of partnered research are part of a hidden curriculum that we tried to bring to the surface for our learners, including how to develop shared research agendas with potential operational partners and communicate one's scientific ideas to non-research audiences. SGIM and VA are both organizations that consistently champion my professional values, and thus, the facilitation of new programming to support this organizational partnership in education, research, and service was very rewarding."

EBB: What are the plans for continuing the curriculum?

DH/JW/EB: Building upon the feedback and experience of the inaugural cycle of the Partnered Research Curriculum, we plan to invite participation from a second round of scholars who are interested in developing skills in partnered research. New areas of focus in the next set of structured learning sessions will include how to incorporate diversity, equity, and inclusion principles into partnered research, as well as the role of health information technology in learning health systems. Based on feedback from the first participants, we will enhance the small group interactions by providing more guidance and moderators for the group sessions. We plan to build on the experience of the current group of mentors by inviting them back for the next year and by providing guidance to new mentors based on their experience. Since participants learned a great deal from one another as well, we hope to do more active facilitation of interactions among the participants. Although the pandemic led to an entirely virtual experience this past year, we expect that interactions among participants and between mentor-mentee dyads will be greatly facilitated by having in person introductions to the curriculum, the faculty, and other participants.

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I felt curiously "lucky" as I recalled my mother's fortune in avoiding a single day in the hospital during her 17-month illness. My mother and family were thus spared witness to similar drama. We avoided a helpless decline within the four walls of a hospital room with my mother tethered to machines. We maintained a modest sense of clarity and control. We evaded an impersonal death among strangers. Patience, resiliency, resolution. *I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.*

More recently, a middle-aged man with ashen skin and a hollow gaze peering through gaunt eyes was admitted to my service with progressive weakness. It was quickly evident that I had seen this story before, one that surely represented an impending revelation of pancreatic cancer progression. As discussions evolved from findings of the initial workup to the minimal therapeutic options available, I was struck by the patient's serenity.

"It is time," he expressed unambiguously without uttering a word. He exuded a sense of peace and illustrated how the story can and should unfold. He appeared to embrace his imminent death. Patients are often more ready for the truth than we are as physicians. Vulnerability, honesty, tranquility. *I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.*

Three patient encounters exposed patients with their "stuff" versus me with mine. More accurately, their stuff is *in addition* to my stuff, representing patient chapters from diagnosis to death scripted over a decade, illuminating an enduring story. The collective impact of this unfortunate trio ultimately triggered a crescendo in my own self-understanding.

Time has afforded me first-hand experience of the tortuous journey of pancreatic cancer and its indiscriminate nature. It's a disease that afflicts people rich and poor, insured and uninsured, supported and alone. It traverses all demographics, family constructs, and strata in life. It unmasks helplessness and anguish for patients and their loved ones.

This singular disease—and all that comes with it—advances the ethical mandate of anyone who has taken the oath, ambiguously blurring the role between healer and healed. My professional responsibility lies in treating not only the gowned patient under a sterile bedsheet with an IV in their arm but also the human being, inevitably afraid, whose life outside the hospital is left suspended.

Patients reciprocate in subtle and profound ways. With gratitude, I acknowledge all who have unwittingly shared their intimate experiences with illness and lain bare genuine human qualities in times of their greatest vulnerability. Through an evolving reckoning along my own journey, I have come to slowly "make sense" of my own loss, the death of my own mother at too young an age.

These shared experiences united my heightened empathy as a clinician with an amplified sacrifice as parent and husband, a confluence of my life as a doctor with my life as a son, husband, and father. A bidirectional relationship has emerged between the personal and the professional- each giving to, and sometimes taking from, the other.

Illness and death spare no person. Modern medicine cannot cure all. My professional and personal journeys over a decade and a half have sharpened my vision of dying and death through a clearer lens. *If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty.*

Today, as I look up at the plaque in my office, it is with gratitude and pride. I have gained a deeper understanding of the true significance of my parents' gift and my oath. I have been awarded a supreme lesson to honor the life and death of my mother. She instilled in me empathy, sacrifice, and patience, traits that define my role as clinician beyond any textbook or lecture. I am left with eternal lessons in humility, resiliency and hope, and the indelible imprint of love and family. Patient, doctor, mother, son. *That I will lead my life and practice my art in uprightness and honor, it shall be for the good of the sick and the well.*

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(professional values prioritized and interpreted in a specific way), and by the intentional facilitation of groups (e.g., clinical teams, units, departments) to align aspects of their professional microculture with the more formal curriculum.

Utilization of a curriculum that provides culturally sensitive approaches to learning and honing leadership skills, such as REVIEW as well as a non-judgmental approach, can lead to positive professional identity formation and the perpetuation of beneficial systems of thought. Leaders wield tremendous power to influence the culture of medicine; recognizing the importance of this issue is a necessary first step. Unsurprisingly, the challenges and solutions extend beyond the walls of medicine as seen by the phenomenon of under-representation of Asians in leadership and management positions or the so-called *bamboo ceiling*. A close examination of the experiences of Asian learners and hidden curricula in other fields may provide additional insights.

Mitigation of the potential negative effects of the hidden curriculum in the medical community can foster leadership opportunities for our medical student learners and physician trainees. For those in positions of authority—attending physicians, mentors, physician leaders—there are some important approaches that can be taken by all:

A. Understanding the cultural contexts of Asian learners;
B. Actively counteracting biases (implicit and explicit) that perpetuate the "model minority myth"; and
C. Fostering behaviors and attitudes that enable the professional success of physician trainees.

Engagement by faculty and educators is crucial to overcoming challenges for trainees imposed by the hidden curriculum. Empowering learners will help unlock the true potential of future members of the physician workforce.

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naming and debriefing the strong emotions these conversations may evoke, emphasizing connection with patients, providing frameworks for effective communication, and addressing misinformation using principles of EBM.

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1999. Over the past 23 years, SGIM has meant far more to me than the annual meetings. SGIM has been an instrumental part of my professional life. Early in my career, submitting abstracts for the *Practice Innovations and Scientific Research* categories helped me hone my ability to write and communicate the significance of my work to a broader audience. I received direct feedback and advice about my work from intellectual giants in general internal medicine; advice that improved my abilities as a hospitalist, researcher, educator, community member, and administrator. Furthermore, our society offered opportunities to develop my leadership skills by assuming roles in interest groups, committees, and SGIM council. Being a part of this community afforded me the opportunity to connect with mentors longitudinally throughout my career and the opportunity to mentor brilliant physicians—many of whom are from groups under-represented in academic medicine—and to derive joy from sharing in their successes. I remain humbled by the support provided by this community and appreciative of the kind words and support offered by so many of our members to my family during my illness. Allow me the opportunity now to thank you, my fellow SGIM members, for giving me the privilege to serve as SGIM president.

I have experienced first-hand the impact that poor care coordination, medication and diagnostic errors, social isolation, and high healthcare costs have on the well-being of patients and their loved ones. As difficult as that has been, I have also developed optimistic views of what we can accomplish in medicine and the role academic internists can play in creating a better society. My optimism stems from an appreciation of the extraordinary efforts physicians, nurses, and allied health professionals take to deliver high quality care despite systems designed to result in the many poor health outcomes and in the inequality in life expectancy that continues to persist. I have witnessed colleagues fully commit themselves to rapidly learn methods to improve the detection, evaluation, and treatment of disease, despite usual processes that work against efficiency. I have been amazed at the scholarly approach SGIM members have taken to gain new knowledge and disseminate findings aimed at addressing inequality and improving the health of the populations we serve. Despite the many challenges of the past two years, I have also witnessed the tireless efforts of our SGIM staff members to deliver educational and research content to SGIM members in continued support of our collective efforts to derive benefit from our membership in support of the patients we serve despite the unprecedented circumstances thrust upon us. I am honored to be able to continue my work as part of this community.

Over the coming year, we will need clinical leaders, educators, and researchers to help us forge a better future. We enter a new era where innovative strategies may be required to educate a new generation of internists who may: 1) have more limited exposure to the broader array of disease due to disruptions during their clinical training, 2) have an increasing scope of virtual medicine in their practice, and 3) seek a greater understanding of how to address the social vulnerabilities of the patients they serve. Over the coming years, it will be vitally important to better articulate the leadership role the internist plays in the delivery of team-based care and coordinate virtual care models in an equitable way.[1-3] Perhaps most important, we will continue to support the training of general internists and provide them with the skill sets to become leaders in policy, administration, education, and research. Based on my tenure as an SGIM member, I truly believe the members of our society have all it takes to promote improvements in how we train, advance knowledge among our peers, inform public policy, and improve the health of our patients in a rapidly changing world.

We have the community of professionals we need to create a better tomorrow and I look forward to forging our future together!

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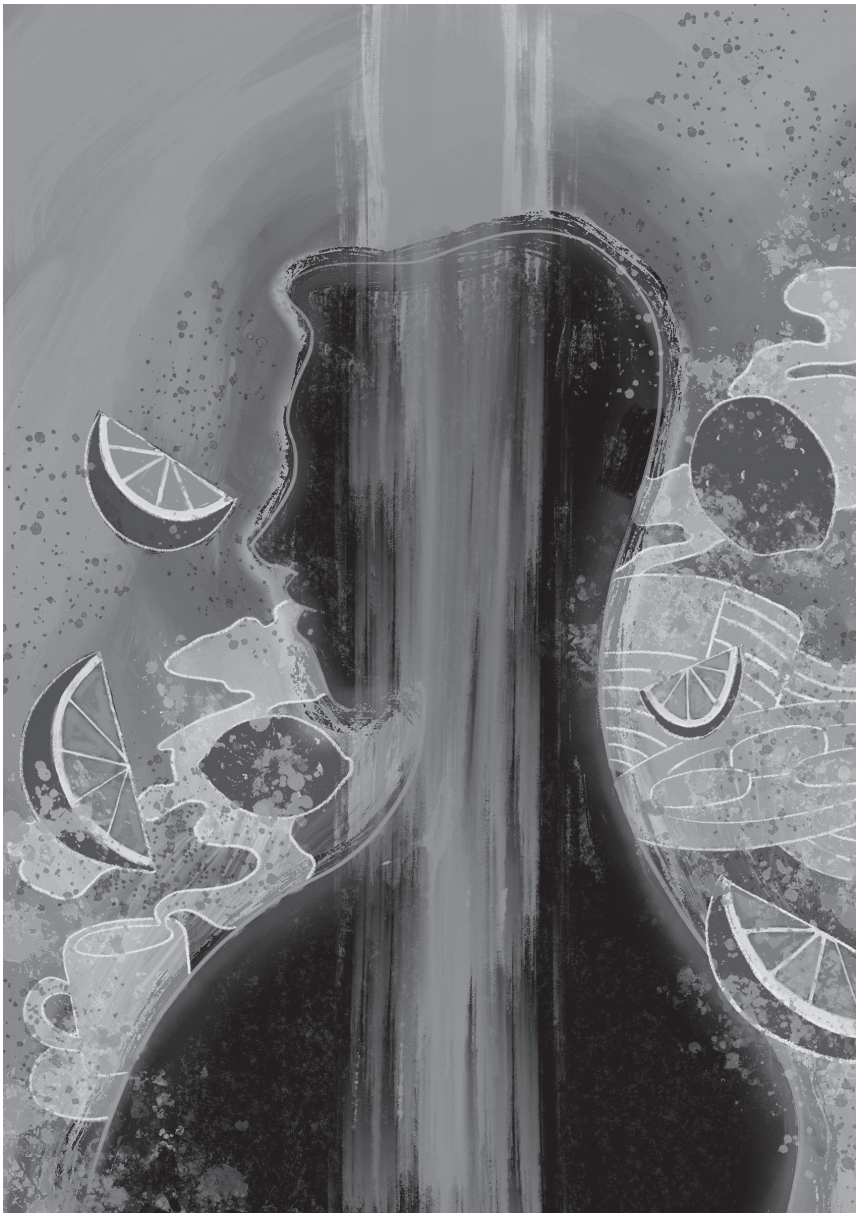

"Acute Suicidality" by Tonya C. Lee, third-year medical student [t2lee@health.ucsd.edu]. This artwork was one of the top three Arts and Humanities submissions presented at the SGIM Northwest/California-Hawaii Regions' Annual Meeting in January 2022. SGIM

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