VOL. 46 ▪ NUMBER 4 ▪ APR 23

SGIM Forum

Society of General Internal Medicine

BREADTH

UNFORGETTABLE: PATIENTS' PERSPECTIVES ON THE UNINTENDED (AND THE UNEXPECTED) IMPACTS OF PHYSICIANS' SPEECH

Gaetan Sgro, MD

Dr. Sgro (Gaetan.Sgro@va.gov) is an academic hospitalist and clinical assistant professor of medicine, VA Pittsburgh Healthcare System and University of Pittsburgh School of Medicine.

Shakespeare famously sought immortality through his words ("*When in eternal lines to time thou grow'st*"). A review of the (mostly non-medical) literature suggests that similarly ambitious physicians should be careful what we wish for, at least when it comes to the words we use in the presence of patients. Show me an illness narrative and I'll bet it contains negative attitudes towards a doctor's unwittingly insensitive speech.

In her poetic memoir, *Two Kinds of Decay*, Sarah Manguso writes, "When I told my hematologist I was worried about dying, he smiled and said, '*Look, here is the smallest violinist in the world playing you a Dvorak violin concerto,*' as he rubbed his index finger against his thumb."

Describing her own critical illness in *In Shock*, ICU physician Rana Awdish recalls overhearing a disturbing exchange between her physician and her husband while she was still intubated. Dr. Awdish had developed massive hemorrhaging towards the end of her pregnancy, and the two men were coolly strategizing about the best way to break the news that her baby had died.

"They don't think I can hear them," Awdish reflected, describing an asymmetry familiar to most anyone who's donned a hospital gown and submitted to the practices and parlance of medicine.

In *What Patients Say, What Doctors Hear*, the internist Danielle Ofri explores the barriers to communication that prevent physicians from fully apprehending their patients' concerns. The gulf between what doctors say and what patients hear is equally wide and fraught with opportunities for awkwardness and misinterpretation, which explains why most physicians who wound with words do so unknowingly.

A group of palliative care clinicians writing in the *Journal of Patient Experience*[1] tells the story of a nurse who underwent spinal surgery in the setting of metastatic cancer with the hope of becoming eligible for additional cancer treatments. The surgery went well and there were no post-operative complications apart from unexplained tachycardia, the cause of which was finally discovered by the palliative care consultants on post-op day five.

When the patient heard her care team refer to her "morbid obesity," she had been mortified and became preoccupied with the fear of dying of respiratory arrest in her sleep. When she overheard them refer to her "terminal cancer," she was devastated and confused, believing that her prognosis had suddenly changed and that she had been kept in the dark. As the patient suffered in silence, those caring for her remained unaware of the pain their words had inflicted.

John Cheever's poem, "What the Doctor Said" renders this irony most poignantly. As the title suggests, the doctor does most of the talking, opening with "it doesn't

continued on page 15

CONTENTS

1. Breadth 1
2. From the Editor 2
3. President's Column 3
4. From the Society 4
5. Sign of the Times 5
6. Medical Education: Part I 6
7. Medical Education: Part II 8
8. Best Practices 10

SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

President
LeRoi S. Hicks, MD, MPH, FACP | Wilmington, DE
LeHicks@ChristianaCare.org

President-Elect
Martha S. Gerrity, MD, MPH, PhD, FACP | Portland, OR
Martha.Gerrity@va.gov

Past-President
Monica L. Lypson, MD, MHPE | New York, NY
mll2215@cumc.columbia.edu

Treasurer
Patrick G. O'Connor, MD, MPH, MACP | New Haven, CT
patrick.oconnor@yale.edu

Secretary
Gail Daumit, MD, MHS | Chevy Chase, MD
gdaumit@jhmi.edu

Secretary-Elect
Arleen F. Brown, MD, PhD, FACP | Los Angeles, CA
abrown@mednet.ucla.edu

COUNCIL MEMBERS

Vineet Chopra, MD, MSc | Ann Arbor, MI
vineetc@med.umich.edu
Marshall Fleurant, MD | Atlanta, GA
docfleurant@gmail.com
Cristina M. Gonzalez, MD, Med | Bronx, NY
crgonzal@montefiore.org
Margaret Lo, MD | Gainesville, FL
margaret.lo@medicine.ufl.edu
Brita Roy, MD, MPH, MHS | New Haven, CT
brita.roy@yale.edu
Eleanor (Bimla) Schwarz, MD, MS | Sacramento, CA
ebschwarz@ucdavis.edu

EX-OFFICIO COUNCIL MEMBERS

Chair of the Board of Regional Leaders
Thomas Radomski, MD | Pittsburgh, PA
radomskitr@upmc.edu

Co-Editor, *Journal of General Internal Medicine*
Steven M. Asch, MD, MPH | Palo Alto, CA
sasch@stanford.edu

Editor, SGIM *Forum*
Tiffany I. Leung, MD, MPH, FACP | Maastricht, NL
Editor.SocietyGIMForum@gmail.com

ACLGIM President
Mark A. Earnest, MD, PhD | Aurora, CO
mark.earnest@cuanschutz.edu

Deputy Chief Executive Officer
Kay Ovington, CAE | Alexandria, VA
ovingtonk@sgim.org

Chief Executive Officer
Eric B. Bass, MD, MPH, FACP | Alexandria, VA
basse@sgim.org

Director of Communications and Publications
Francine Jetton, MA, CAE | Alexandria, VA
jettonf@sgim.org

FROM THE EDITOR

EXPRESSIONS OF EQUITY AND INCLUSIVITY: BIAS IN SCHOLARLY LANGUAGE

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

The April 2023 issue of SGIM *Forum* offers readers an e-collection of articles on biased language in our everyday work as general internal medicine physicians. The relevance and importance of using non-judgmental and unbiased language in our professional development from performance evaluations to letters of support—is paramount in career advancement, regardless of scientific or medical discipline. As physicians and medical trainees, we also influence the care of patients depending on how well we use person-first language that promotes equity and recognize bias in language that we read and use to describe patients (e.g., in the electronic health record, scholarly publications, and scientific research). As researchers, how we collect, analyze, and report data can be done with attention to how systemic biases influence our scientific findings. To introduce the various ways that biased language can influence our day-to-day work, authors of articles in this issue offer reflections and introductions to some of the key issues in practice.

In clinical care and research, person-first language can be used to communicate respectfully and appropriately about an individual, with a shift in language from "a person is" to a "a person who has."[1] For example, rather than referring to a patient as a "diabetic," they "have diabetes." A very thorough and complete guide to advancing health equity through language and narrative was published in 2019 by the American Medical Association (AMA) and Association of American Medical Colleges (AAMC) Center for Health Justice.[2] I highly recommend a complete read of this guide to familiarize with best practices that can apply to numerous settings in our routine work and professional (and even personal) lives.

To open this issue, Sgro notes in his column in this issue, "*That physicians' words have such power is a function of our status compounded by the vulnerable position in which we encounter our patients. And our words can do more than wound, demoralize, or bias.*" Our words can take on a sense of digital permanence also in the electronic health record: Solovieva and Rao discuss

continued on page 14

INCREASING ACCESS TO GIM PIPELINE: EXPOSING SGIM TO A NEW AUDIENCE

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

"The very enthusiasm those college students had for other specialty disciplines can be gained for academic GIM as they gain exposure to the same type of talented SGIM members that had such significant impact on our nation's health policy, in medical education, and in public health."

As I stood at the front of auditorium, I looked over the faces of the young adults in the front row and the eight-faculty sitting in the rows behind them, and I came to the realization that I have joined the demographic from which I was once so far removed. As the moderator, a talented faculty member from Emory, introduced me to the undergraduate students from Xavier University, she not only noted my SGIM role but also referred to me as "senior" and a "role model", and I came to the realization that I'm getting old.

At this year's SGIM southern regional meeting, I was invited by Dr. Ajala, the regional meeting officer for Diversity, Equity, and Inclusion (DEI), to speak to a group of pre-medical students as part of the meeting's first HBCU day. Dr. Ajala was joined by a racially and ethnically diverse group of academic internists from Emory and the Morehouse School of Medicine and each took the time to provide inspiration to the Xavier students and to provide advice on steps to obtain their goals. I told the students that I first joined SGIM during my fellowship in 1999 (a few years before any of the students was born), and that over the years I regularly interacted with peers and more experienced faculty at SGIM meetings, all of whom provided me with networking opportunities that have helped me tremendously throughout my career. After telling my story, I suggested to the students that they should follow my example and take the time to speak individually with as many of the faculty as possible.

During introductions, each student provided a succinct and uplifting story about what lead them to consider a career as a doctor. I found that each student was enthusiastic about a future career in medicine. I was invigorated by the conversations, but despite the enthusiasm I felt hearing young Black students articulating

continued on page 13

SGIM *Forum*

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

Managing Editor
Frank Darmstadt
frank.darmstadt@ymail.com

Past Editor In Chief
Joseph A. Conigliaro, MD, MPH
jconigliaro2010@gmail.com

Editorial Board
Yousaf Ali, MD, MS
Yousaf_Ali@URMC.Rochester.edu
Seki Balogun, MD, FACP
sab2s@virginia.edu
Lauren Block, MD, MPH
lblock2@northwell.edu
Alfred Burger, MD, MS
aburger.md@gmail.com
Ricardo Correa, MD, EdD, FACP
riccorrea20@hotmail.com
Elaine B. Cruz, DO
exc406@case.edu
Michele Fang, MD
michele.fang@uphs.upenn.edu
Maria Gaby Frank, MD, FACP
maria.frank@dhha.org
Kittu Jindal Garg, MD
jindal.kittu@gmail.com
Shanu Gupta, MD, FACP
shanugupta@usf.edu
Tracey L. Henry, MD, MPH, MS
tlhenry@emory.edu
Christopher D. Jackson, MD, FSSCI
cjacks67@uthsc.edu
Eric Kutscher, MD
eric.kutscher@nyulangone.org
Megan McNamara, MD, MS
Megan.Mcnamara@va.gov
Somnath Mookherjee, MD
smookh@u.washington.edu
Susana Morales, MD
srm2001@med.cornell.edu
Shobha L. Rao, MD
shobha_rao@rush.edu
Jorge A. Rodriguez, MD
jarodriguez1@partners.org
Gaetan Sgro, MD
gaetan.sgro@va.gov
Elisa Sottile, MD, FACP
Elisa.Sottile@jax.ufl.edu
David Walsh, MD
dawalsh@augusta.edu
Taylor Wise, SGIM Social Media and Communications Specialist
wiset@sgim.org

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 AND THE PRINCIPAL INVESTIGATORS OF THE SGIM PROJECT ON DEVELOPING AN EDUCATIONAL INTERVENTION TO MITIGATE RACIAL DISPARITIES IN THE DIAGNOSTIC PROCESS

Eric B. Bass, MD, MPH; Cristina M. Gonzalez, MD, MEd; Monica Lypson, MD, MHPE

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Gonzalez (Cristina.Gonzalez@nyulangone.org) and Dr. Lypson (mll2215@cumc.columbia.edu) are the principal investigators of the project.

EB: What is the purpose of the grant program on diagnostic excellence that was launched by the Council of Medical Specialty Societies (CMSS) with support from the Gordon and Betty Moore Foundation?

ML: CMSS received a grant from the Gordon and Betty Moore Foundation to promote diagnostic excellence across the field of medicine. With that funding, CMSS solicited applications from its member societies and awarded 10 grants in the amount of $100,000 each to support the development and dissemination of resources and programs on diagnostic excellence by specialty societies.

EB: What are the specific aims of the grant that was awarded to SGIM?

CG: In October 2022, CMSS awarded funding to SGIM for a project entitled "Crowdsourcing to Develop an Educational Intervention on the Diagnostic Process: Special Emphasis on Mitigating Racial Disparities in Diagnosis." The specific aims of the project are to: 1) identify physician behaviors in a simulated patient encounter that lead to disparities in the diagnostic process and diagnostic errors and crowd source solutions to improve those behaviors; 2) explore lay community members' perspectives of simulations and suggestions for instruction; and 3) develop and pilot a curriculum in equity in diagnostic excellence.

EB: How do you plan to achieve the aims of the project?

CG: To address aim 1, we chose a clinically ambiguous presentation of epigastric pain, nausea, and vomiting as the presentation of a standardized patient due to robust evidence for racial disparities in various disease processes that could precipitate that clinical presentation, as well as the clinical ambiguity itself presenting a diagnostic challenge.[1] We will seek perspectives of physicians across the spectrum of training and practice to inform our educational innovation. To address aim 2, we will ask community members to observe selected simulations and offer their perspectives on how they view such behaviors. We will use focus groups to explore community members' perspectives on the diagnostic process and solicit their suggestions for improving physician behaviors. To address aim 3, we will use what we learn from aims 1 and 2 to develop a curriculum and pilot it with SGIM members at SGIM's regional meetings in 2023 and the national meeting in 2024.

EB: How do you plan to engage SGIM members in the project?

ML: In the first quarter of the project, we recruited Erika Baker as the program manager for this research and a core team of six SGIM members (Hadeel Alkhairw, MD; Eliana Bonifacino, MD, MS; Michael Fischer, MD, MS; Megha Garg, MD, MPH; Rita Lee, MD; and Eloho Ufomata, MD, MS) representing SGIM's Health Equity Commission, Academic Hospitalist Commission, Clinical Practice Committee, Education Committee, Research Committee, Health Policy Committee, and Clinical Reasoning Interest Group. In the second quarter of the project, we will have oriented and trained the core team to review recorded simulated encounters to find representations of diagnostic error and diagnostic excellence, to inform the survey instrument we develop for the crowdsourcing. We have initiated conversations with SGIM's Board of Regional Leaders to determine how we can incorporate our work and findings into upcoming regional meetings to engage even more members. We will also

continued on page 14

WORDS MATTER: AWARENESS OF STIGMATIZING LANGUAGE IN INPATIENT DOCUMENTATION AND THE EFFECT ON ATTITUDES AND DECISION MAKING

Shobha L. Rao, MD; Ms. Irina Solovieva

Dr. Rao (Shobha_Rao@Rush.edu) is an academic hospitalist and clinical assistant professor of medicine, Rush University Medical Center in Chicago, IL. Ms. Solovieva (Irina_Solovieva@rush.edu) is a second-year medical student at Rush Medical College, Chicago, IL.

It is a call day, and you are the medical student/resident/attending working up a patient being admitted to the general medicine service. You are reviewing emergency department (ED) records and previous notes in the electronic medical record (EMR). The patient is described as "difficult" and "uncooperative." Additionally, the term "substance abuser" is seen throughout the chart. How will you approach this patient?

The pesky pager goes off again. Another ED admission. You open the chart. The HPI starts with patient reporting headaches starting 2 days ago. The HPI starts with, "27-year-old Black female sickle cell patient with repeated hospital admissions for 'headaches.' Patient states headache is 10/10 and is requesting dilaudid." Do you already have positive or negative thoughts about this patient?

It is switch day. You started looking at the handoff for your first patient. "81-year-old elderly obese female being admitted for abdominal pain." Notes say she is hard of hearing and a "poor historian." What are your expectations when you meet this patient?

These scenarios are not uncommon on a busy inpatient service. The days are busy, what with balancing patient care, admissions and discharges, and many interruptions and handoffs. Therefore, we rely heavily on our EMRs to prepare background information to assist with an efficient encounter. How many of us have done the eyeroll while reading a patient's chart or handoff? The deep breath and squaring of shoulders before proceeding to a patient room based on what we have read? My hand is raised. This unconscious and implicit bias is very common; however, it does our patients and us a disservice. Although there can be appropriately raised red flags and safety concerns in some cases, we find ourselves often perpetuating preconceived thoughts based on what has been written in the chart.

Why is it important for us to recognize that words can be stigmatizing and perpetuate bias? Because it interferes with our ability to listen to patients openly and actively. In the hospital, this is essential where trust and rapport need to be developed rapidly—these patients do not know us and we do not know them. What we read can influence our perceptions positively or negatively, leading to diagnostic error, inappropriate use of resources, propagation of healthcare disparities, and poor patient experience.

Biased Language and Testimonial Injustice

While there are few studies that evaluate the effect of how language propagates clinician bias through the chart, Goddu et al1 assessed whether stigmatizing language in the EMR is associated with trainees' attitudes towards the patient and clinical decision making. A randomized vignette study of two charts employing stigmatizing versus neutral language to describe a hypothetical 28-year-old male with sickle cell disease demonstrated that stigmatizing language used in the medical record influenced trainees' attitudes towards the patient and affected their medication prescribing behavior. The chart utilizing stereotyping and negative language cast doubt on the patient's pain and influenced the patient's pain regimen. Increased negative attitudes towards patients were demonstrated by residents versus medical students, attributed to experiential bias and ethical erosion over time. This study highlights the "powerful role of language in influencing clinician attitudes and behaviors."[1]

continued on page 12

UNINTENDED BIAS IN STUDENT EVALUATIONS: A KEY TOPIC FOR INCLUSION IN INTERNAL MEDICINE RESIDENCY CURRICULUM

Mary K. Finta, MD; Virginia Sheffield, MD; Jennifer Reilly Lukela, MD

Dr. Finta (fintama@med.umich.edu) is a chief medical resident at the University of Michigan Internal Medicine Residency program and serves as a resident lead for Equal Medicine, a novel curriculum for women in academic internal medicine in the Internal Medicine Residency Program at the University of Michigan. Dr. Sheffield (vmmorris@med.umich.edu) is a clinical assistant professor in the Division of Hospital Medicine at the University of Michigan and attends on the general medicine service at the VA Ann Arbor Healthcare System. Dr. Lukela (jlreilly@med.umich.edu) serves as the faculty advisor for Equal Medicine, a career development program for women trainees in Internal Medicine at University of Michigan, and as the Vice Chief for Clinical Strategy and Community Engagement in the Division of General Medicine.

A female medical student reviews narrative feedback from the senior resident she worked with on her third-year clerkship rotations: "MF was lovely to have on this rotation. She was warm and friendly, and patients liked having her involved in their care. I enjoyed having her on the team. She'll be a great house officer someday." After reviewing, the student struggles to understand what specifically she did well during her rotation and how to identify areas for continued growth or improvement. She wonders about her performance in clinical documentation, patient interactions, or procedural technique.

While this student received positive feedback from her supervising residents, it focused heavily on personality traits, failing to comment on her actions, specific contributions to patient care, or interactions with the medical team. Unfortunately, this is not an uncommon experience for female medical students, more likely to be described with terms illustrating personal attributes (i.e., *kind, lovely, delightful*) compared to male counterparts, more likely to be described by abilities or skills (i.e., *scientific, relevant, quick learners*).[1] Research has shown that, compared to men, women receiving narrative feedback are more likely to be penalized for not meeting stereotypical expectations of interpersonal warmth and are less benefited by meeting standards of technical competence.[2] One study of third-year medical students on an internal medicine rotation revealed this: while there was no significant difference in final grades and women scored higher than men on a variety of clinical performance metrics, the content of narrative evaluations differed dramatically by gender.[2]

Similarly, there are well-documented differences in feedback given to students who come from groups historically minoritized and who are thus underrepresented in medicine (URiM) compared to white colleagues. One study found that Black students received lower clerkship grades overall and were more likely to be described as "competent" while white counterparts were more often described with standout words like "best" or "exceptional."[1]

As narrative feedback is integral at all performance levels, identity-based differences in the character and quality of feedback may have far-reaching implications as women and URiM trainees advance in their careers. Women are less likely to be promoted to the highest ranks of academic medicine, to receive departmental and national recognition awards, and to be elected to national societies. Similarly, Black and Asian students are less likely to be elected to the Alpha Omega Alpha (AOA) honor society, even after controlling for several educational and demographic factors.[3] Honors early in a medical career, such as AOA membership, have been linked to upward mobility through academic medicine, including matching to a desired specialty/location, increased potential financial earnings, and higher rates of promotion.[3] Past work has highlighted an amplification cascade, wherein small subjective differences in assessment can lead to larger differences in grades and awards, ultimately used as objective measures of success for promotion.[3]

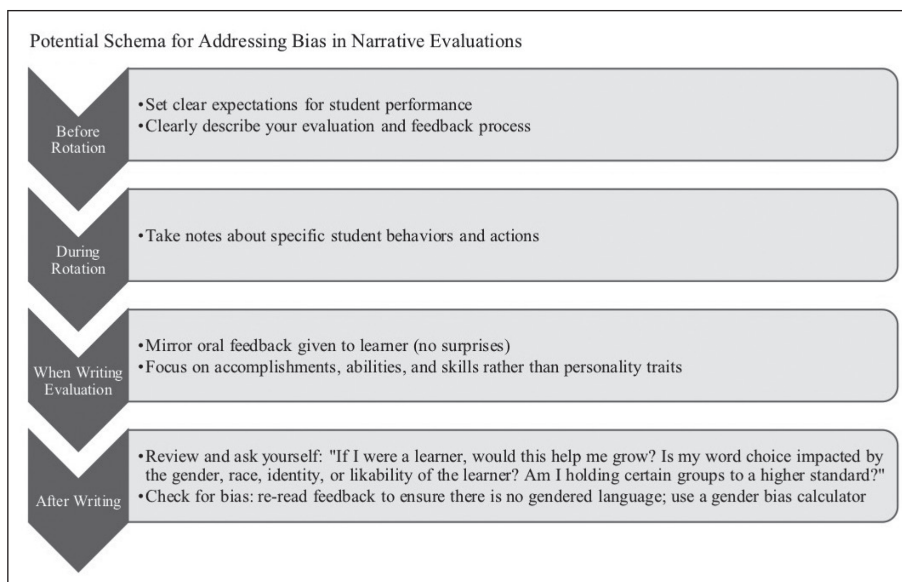
While the problem of bias in evaluations is pervasive, it can also be mitigated though active, persistent self-reflection, and intentional correction. Interventions to address bias in student and trainee evaluations thus far have predominantly been aimed at faculty who are tasked with evaluating medical students after their clerkship. However, senior residents also frequently evaluate medical students, and their comments are also eligible for inclusion on the Medical Student Performance Evaluation (MSPE). The Alliance for Academic Internal Medicine posited that "medical schools…should prioritize teaching faculty and residents the skills and strategies needed to mitigate bias when they assess students."[4] However, formalized

continued on page 7

education on this topic for residents remains sparse.

We argue that education and training in unintentional bias in evaluations should be a core component of internal medicine residency training programs. At our institution, we have incorporated this training into our "Preparing to be a Senior Resident" retreat at the end of intern year, into our inpatient morning report offerings during the year, and as part of the residency prep course for graduating medical students. Similar training could also be incorporated into the "Residents as Teacher" curricula that are offered at many IM residency training programs.

As a starting point, it is important to teach residents to proactively reflect on one's biases and consider how these biases could influence written evaluations. When writing an evaluation, consider whether the words chosen would be used for a learner of another gender or race/ethnicity. Best practice is to focus on accomplishments, abilities, and skills, rather than personality traits. One simple approach that can be shared with supervising residents to minimize unintended bias in feedback is shown in the figure; this offers checkpoints for evaluators before, during, and after interactions with junior trainees.[5] Set clear expectations with students and outline your evaluation and feedback process so they know what to expect. Throughout the rotation, make notes of laudable actions, directly observed behaviors or accomplishments by the student, and areas to offer specific constructive criticism. When writing narrative feedback, draw focus away from personality traits (no matter how positive) and emphasize what the student did during the rotation and how they grew as a trainee. Consider using a gender bias calculator or having a trusted colleague read your feedback to ensure it is not gendered. Finally, ensure written feedback matches what you have shared with the student verbally.



Based on these concepts, the following is rewritten feedback from the senior resident for the female medical student:

> *"She was a valued member of the team and asked insightful questions on rounds. She carried more patients than would be expected at this level of training, developed well-rounded and comprehensive plans for patients, and carried out those plans efficiently. She integrated well into the team and anticipated team needs, taking initiative to obtain outside records and facilitate transitions of care for patients. She is ready to be a sub-intern and have more responsibility and independence in the care of her patients."*

In summary, written narrative feedback is vulnerable to implicit bias. Given the importance of feedback on promotion and advancement in academic medicine, even early in a trainee's career, it is important to consider the language we use to evaluate medical students, and to consider a structured framework to mitigate our own biases. Formal training to recognize and avoid unintended bias in evaluations should be a core element of our internal medicine residency curriculum, considering the vital role senior residents play in the professional development of students and the weight placed on their narrative evaluations, both by learners who value near-peer feedback and inclusion in formal assessment tools like the MSPE.

References

1. Rojek AE, Khanna R, Yim JWL, et al. Differences in narrative language in evaluations of medical students by gender and under-represented minority status. *J Gen Intern Med*. 2019;34(5):684-691. doi:10.1007/s11606-019-04889-9.
2. Gorth DJ, Magee RG, Rosenberg SE, et al. Gender disparity in evaluation of internal medicine clerkship performance. *JAMA Network Open*. 2021;4(7):e2115661. doi:10.1001/jamanetworkopen.2021.15661.
3. Teherani A, Hauer KE, Fernandez A, et al. How small differences in assessed clinical performance amplify to large differences in grades and awards: A cascade with serious consequences for students underrepresented in medicine. *Acad Med*. 2018;93(9):1286-1292. doi:10.1097/ACM.0000000000002323.

continued on page 13

THE PROMOTION SUPPORT FOR WOMEN IN MEDICINE INITIATIVE: PAYING IT FORWARD BY ASSISTING WOMEN FACULTY IN THE PROMOTIONS PROCESS

Rosemarie L. Conigliaro, MD; Rakhee K. Bhayani, MD; Laura B. Bishop, MD; Susan Thompson Hingle, MD; Danielle Jones, MD; Margaret C. Lo, MD; Karen A. Friedman, MD, MS

All authors are founding members of the Promotion Support for Women in Medicine (PSWIM) group consisting of women faculty from various academic medical institutions. Please reach out to Dr. Friedman (kfriedma@northwell.edu) with any questions.

Introduction

Women in academia, particularly clinician educators (CEs), struggle to advance in their careers due to a variety of identified but often unsuccessfully addressed barriers.[1,2] In a system originally designed for traditional researchers and educators with minimal clinical roles and responsibilities, unique obstacles to promotion exist for CEs, including:

- obtaining outside references/referees,
- the attainment of a regional, national, or international reputation, and
- the production of scholarly work, often narrowly defined as *peer-reviewed publications*.

Networks and connections are needed for advancement and promotion, but women faculty may have limited access, especially in small academic institutions with fewer senior women faculty for mentorship and sponsorship.[1,3] Our innovation, entitled Promotion Support for Women in Medicine (PSWIM), is an example of a network connecting women seeking promotion to senior faculty to write letters of support for women faculty nationwide.

Methods

PSWIM evolved from a discussion in September 2020 regarding the difficulty of finding regional/national letter writers (LWs) for women seeking promotion on a listserv of the Alliance for Academic Internal Medicine (AAIM), a national organization of more than 10,000 Internal Medicine faculty and administrators of medical schools and their affiliated teaching hospitals.

The PSWIM group, created in March 2021, is composed of 16 AAIM senior-ranked women who are academic leaders, with some serving on their own institutional promotions committees. The PSWIM leader (KAF) initially posted a call to the AAIM listserv for individuals at the associate level or higher to join a shared list of volunteers to be referee LWs for women seeking academic promotion. In response, 106 associate and full professors (men and women) volunteered.

PSWIM members created a database to catalogue the demographics of the volunteer LWs, including writers' name, e-mail, institution, specialty, professional rank, professional role, primary learners, area of education scholarship, and expertise in medical education. Announcements of PSWIM services were disseminated via the AAIM listserv. AAIM members were also asked to inform their divisions and departments of this resource for women seeking promotion as a clinician educator.

Women letter seekers are asked to complete an electronic survey detailing the same information collected from LWs and the number of letters requested. A PSWIM member then matches the candidates and LWs. Candidates are provided LWs' contact information and the matched LW(s) are informed of their match with a candidate for an evaluation letter. The group created a document on tips for writing external letters which is shared with LWs and includes ways to avoid gender-biased language. PSWIM tracks the frequency of LWs contacts to avoid overburden and plans to contact candidates to determine success of their promotion. Ongoing support for our PSWIM initiative includes regular communication of our services through multiple channels, such as regional/national meetings and listserv postings and the continual solicitation of additional LW volunteers. Once candidates who use our services are promoted, they are asked to join the LW group.

Results

In 18 months, the PSWIM initiative created a repository of physician volunteers. As of this writing, we have 106 referee writers from over 70 institutions and produced 150 evaluation letters for over 35 institutions. The LWs are comprised of women (N=89); men (N=17); Professor (N=65); Associate Professor (N=37); general internists (N=61); subspecialty-trained (N=45). The LWs encompass a broad range of expertise in the undergraduate, graduate, and faculty development areas with professional roles ranging from core faculty to residency/fellowship directors to vice deans (see table). Letter writers value

continued on page 9

 (continued from page 8)

PSWIM to "pay it forward," a theme identified as important for sponsorship in academia.[2]

Discussion

Our PSWIM innovation provides a concrete way for allies to support women during the promotion process and improve parity of women at senior ranks in academic medicine. This initiative can be expanded to other women faculty to help promotions processes in other specialties, with other disadvantaged groups, and in specialties with historically fewer women. In fact, a subsequent AAIM listserv call for Grand Rounds speakers has resulted in the creation of a pool of speakers who can be contacted for invited regional and national talks and provides further opportunities for those seeking promotion (J. Koch, personal communication, March 21, 2022).

Our initiative is well received by junior faculty who have utilized this in their promotions process. Several personal testimonials include the following:

- *"Thank you so much. I am in the clinician educator track… It is challenging to go up for P&T and have imposter syndrome about your efforts, and the task of identifying external reviewers is daunting…"*
- *"I found your … information through the AAIM listserv posts about a database of potential academic referees. This is such a great idea! Thank you for developing this resource."*
- *"Thank you. Kudos to you for facilitating and organizing this effort."*
- *"… I saw your post regarding promotion support for women in medicine on the AAIM listserv and would be so appreciative to use this resource for promotion from assistant to associate professor. My department unfortunately doesn't provide help with this process."*

We recognize the challenge of sustaining the PSWIM database as the number of LWs and letter seekers grow. Efforts are ongoing to expand the pool of volunteer LWs with letter seekers and to advertise this resource for widespread adoption by division chiefs, department chairs, and members of promotions' committees and faculty affairs committees. We plan to solicit more men LWs into the database since men are important allies and many hold high-level leadership positions. Other future steps include collecting data on the number of matches and letters written and tracking the success rate of promotion and leadership for the women faculty utilizing this initiative.

Our PSWIM innovation is one approach to one problem; however, we realize that gender equity in career advancement is complicated. Thus, on a national scale, institutions and organizations should lead efforts to update formalized promotion and tenure policies and practices to reduce gender disparities in academic medicine.

References

1. Richter KP, Clark L, Wick JA, et.al. Women physicians and promotion in academic medicine. *N Engl J Med*. 2020;383:2148-2157. DOI: 10.1056/NEJMsa1916935.
2. Levine RB, Ayyala MS, Skarupski KA, et al. "It's a little different for men" - sponsorship and gender in academic medicine: A qualitative study. *J Gen Intern Med*. 2021 Jan; 36(1): 1–8. doi: 10.1007/s11606-020-05956-2
3. Nemeth A, Chisty A, Spagnoletti CL, et al. Exploring mentoring experiences, perceptions and needs of general internal medicine clinician educators navigating academia: A mixed-methods study. *J Gen Intern Med*. 2021 May;36(5):1229-1236. doi: 10.1007/s11606-020-06310-2.

SGIM

Characteristics of Volunteer Letter Writers

Characteristic	Percent (%) n=106
Gender	
Female	84
Male	16
Other	0
Race/Ethnicity	
Asian	16
Black	3
Hispanic/LatinX/Spanish	4
Middle Eastern	3
Multiple Race/Ethnicity	3
White	72
Academic Rank	
Adjunct Professor	1
Associate Professor	35
Professor	61
Professor Emeritus	2
Retired	1
Years in Rank	
0-5 years	64
6-10 years	22
11-15 years	8
16-20 years	2
Greater than 20 years	5
Specialty	
Endocrinology	3
Gastroenterology	2
General Internal Medicine	58
Geriatric Medicine	2
Hematology	1
Hematology and Oncology	2
Hospice & Palliative Medicine	3
Hospitalist	15
Infectious Disease	3
Medicine & Pediatrics	3
Nephrology	4
Pulmonary Medicine	1
Rheumatology	5
Region of Institution	
Midwest	25
Northeast	30
Southeast	26
Southwest	6
West	13

READING BETWEEN THE LINES TO PROMOTE DIVERSITY, EQUITY, AND INCLUSION

Ankita Sagar, MD, MPH, FACP; Tracey Henry, MD, MPH, MS; Swati Shroff, MD, MS, FACP;
Tiffany I. Leung, MD, MPH, FACP, FAMIA, FEFIM

Dr. Sagar (Ankita.Sagar@CommonSpirit.org; Twitter: @sagar_ankita) is the system vice president for clinical standards & variation reduction at CommonSpirit Health and associate clinical professor of medicine at Creighton University School of Medicine. Dr. Henry (tlhenry@emory.edu; Twitter: @docwithapurpose) is an associate professor of medicine in the department of medicine at Emory University School of Medicine. Dr. Shroff (swati.shroff@jefferson.edu) is the director of the Jefferson Women's Resident Clinic and associate clinical professor of Medicine at Thomas Jefferson University. Dr. Leung (Editor.SocietyGIMForum@gmail.com; Twitter: @TleungMD) is the editor-in-chief of SGIM Forum*.*

The Significance of Reading between Lines

Letters and evaluations play a significant role in higher education and career progression. This includes applications or letters for training programs, scholarships and grants, awards and recognition, leadership roles, new job opportunities, promotions and tenure, and performance evaluations relating to all of the above. Application letters are frequently used in "Round 1" selection, even before a candidate interviews for a position. This means that such letters and evaluations—and the language used to describe a candidate—can significantly, even if unintentionally, influence the candidate's consideration. In turn, language that draws from implicit biases can also influence the candidate's standing. In this article, we briefly summarize types of biased language that can appear in support letters or performance evaluations, and highlight opportunities and resources to mitigate them.

Implicit bias is a type of bias that arises from unconscious associations and stereotypes about members of a social group. Often, bias is based on gender, race/ethnicity, ability, language proficiency, or any aspect of one's identity. Gendered language usage occurs in medicine, health care, and in professions and areas beyond our usual areas as physicians: the World Bank noted in a 2019 report that, "Attitudes toward women are also influenced by gendered languages… gendered languages could translate into outcomes like lower female labor force participation."[1]

Common Terms Related to Bias by Gender

Gendered terms are words that are used to associate with a specific gender. Various studies have noted that gendered language appears in the following:

- letters of recommendation for academic faculty, science and medicine;[2]
- subjective evaluation for students applying to residency programs;[3]
- qualitative evaluations of residents and students;[4] and
- student, resident, and fellow evaluations of faculty physicians.[5]

The table provides a brief summary of common gendered terms in letters. Per Trix et al the adjective 'successful' occurred in 7% vs 3% of letters for men and women, respectively, while the nouns 'accomplishment' and 'achievement' occurred in 13% vs 3% of the letters for men and women, respectively. For women applicants "compassionate" and "relates well to patients and staff at all levels" stood out (16% vs 4% in letters for women and men, respectively).[6]

Ross et al reported that white applicants are more likely to be described with standout words (e.g., outstanding, exceptional, best) when compared to Blacks, Asians, and Hispanics; white applicants are also more likely to be described as "bright" and "organized." Women are more likely than men to be described with words related to compassion, and they are also more likely to be described as "bright" and "organized." "Competent" was the only descriptor used more frequently for Blacks than any other race/ethnic group, and additional contextual analysis implied it was used as a word of minimal assurance when describing Black and Hispanic trainees.[7]

Raising Doubt, Hedging Language, and Faint Praise

Doubt-raising language includes negative, potentially negative, hedging, unexplained, irrelevant comments, and faint praise. In a study by Trix et al, 24 % vs 12% of the letters written for female vs male applicants had at least one doubt raiser (p-value 0.01).[6] Examples of negative

continued on page 11

or potentially negative comments include: "while she has not done," "while not the best student I have had," and "bright, enthusiastic, he responds well to a minimum amount of supervision." Examples of hedging include: "it appears that" or "now that she has chosen," and an example of faint praise is "she worked hard on projects that she enjoys."

Implicit Bias Affects Faculty and Supervisors

Disparities in academic job achievements and academic promotions are widespread, especially affecting faculty identifying as women, persons of color, and/or those identifying as LGBTQ+ persons. Faculty and supervisors are not protected from similar effects in terms of biased language. Evaluations from physician trainees play a critical role in promotion decisions and awards for medical faculty in academic medicine. Furthermore, letters and evaluations using implicitly biased language could lead to high rates of attrition at multiple points along the promotion pathway.

Sheffield et al evaluated gender-based differences in the assessment of GIM faculty by trainees in inpatient and outpatient settings. Their study noted Female GIM faculty received lower overall teaching scores than their male counterparts in the inpatient setting. In the inpatient setting, males received higher ratings vs their female peers in overall teaching and across all competencies. However, in the outpatient setting, females received higher ratings vs male faculty, with no difference in ratings for overall teaching and across all competencies.[8]

Meanwhile, Heath et al reported gendered words are used frequently in faculty evaluations. Their study found that quantitative linguistic differences in free-text comments based on faculty gender persisted after adjustment for evaluator gender and level of training. Furthermore, the use of ability terms (such as *master* and *complexity*) was associated with evaluations of men, while the use of emotive terms (such as *empathetic*, *delight*, and *warm*) was associated with the evaluation of women faculty members.[5]

Common Gendered Terms Encountered in Letters of Support[3,5,6]

More Often Used to Describe Women Applicants/Physicians or Those Identifying with Racial/Ethnic Minority Groups	More Often Used to Describe Men Applicants/Physicians
Positive general terms:	**Standout adjectives:**
Compassionate	Brilliant or talented
Delightful	Exceptional
Positive	Star or stellar
Pleasant or "easy to work with"	Impressive
Caring/Nurturing words:	**Achievement words:**
Care	Notable for innovation or research
Time	Performance
Support	Leadership
Emotive terms:	Knowledge
Empathic	**Ability terms:**
Warm	Master
Grindstone words:	Complexity
Hardworking	
Dedicated	
Conscientious	

Where Do We Go from Here?

As a Division, Practice, or Health System

Implicit bias training can serve as an essential foundation for recognizing that language and the ways in which it is used can perpetuate discrimination and bias. A review of the use of letters or evaluations in advancement and ensuring the weight of the language is balanced with an objective measure of performance is helpful. Lastly, engaging in open dialogue among leadership and learners about language and the use of biased language may lead to organic solutions, customized for the local environment.

As a Candidate Requesting an Evaluation or Letter

Sponsors must be able to discuss an applicant's best skills and greatest professional accomplishments. In circumstances where candidates can choose their own letter or evaluation writers, candidates should strongly consider only asking for letters from sponsors who would describe them as excellent or outstanding candidates. Those who write a letter must be well-positioned to provide the necessary information with a sufficient perspective on the candidate's measures of performance, and do so in a convincing manner, using unbiased language. The best quality letters usually come from sponsors who genuinely believe that the candidate is the best fit for the position, promotion, grant, award, or other targeted pursuit.

As an Evaluator or Letter Writer

Focus on the applicant as an outstanding candidate—include comments about the commitment and relationship of the writer to the candidate. Dedicate the appropriate length of the text to describe the applicant's record, and give specific examples of excellence. Focus on eval-

continued on page 16

We also need awareness of how language can be responsible for perpetuating bias based on social disparities. *Testimonial injustice* is defined as "that which occurs when a speaker receives an unfair deficit of credibility due to prejudice on the part of the hearer."[2] Beach et al[3] examined medical records for testimonial injustice, identifying certain linguistic features that can be markers of disbelief in medical records of black compared to white patients. This suggested the presence of clinician bias around credibility. For example, using factual sentence structure versus evidential statements, such as "patient has a pain score of 5/10" versus "patient claims/complains pain is a 7/10," or using quotes or judgment words seemed to be highly correlated with physician disbelief. Himmelstein et al demonstrated in a cross- sectional study, analyzing admission notes, stigmatizing language varied by medical condition and more often used to describe non-Hispanic Black patients.[5]

Beach et al[3] also highlighted two possible reasons for casting doubt on a patient's credibility. The first surrounds concerns about *competency*. Can the patient interpret the situation correctly and convey it with accuracy? The second reason is *sincerity*. Do we as clinicians believe we are being deliberately deceived? These questions are often biased by a patient's background and what has been recorded in the chart. These doubts can be readily carried forward in the chart without confirming the accuracy or dismantling the bias later in the documentation.

Regarding quotations, the few studies done state that quotations from patients are not inherently negative, but thought must be given to the context and possible interpretation.

Open Notes: Patients Reading Clinician Bias

Consider the impact of biased language in charts that patients can now read due to open notes. Even if not overtly biased, some outdated terminology can be considered offensive or judgmental (e.g., "obesity" or "in distress") even if they had been previously acceptable for inclusion in documentation. Reading such language can lead to anger, distrust of the clinician and the medical system, or even negative implications for the patient's own outlook of their health. Patients may also perceive error, labeling, or evidence of respect based on a study done by Fernandez et al.[4] Disclaimers at the bottom of chart notes stating that these are meant to be communication between clinicians are insufficient and cannot negate their impact on patient perceptions.

I also experienced this sense of mistrust when reading my father's hospital records (SR). My father had a fear of surgery and chose to postpone recommendations for surgery. As an engineer, he weighed the pros and cons of the procedure and felt he still needed additional information. Although I was frustrated by this delay and his need to thoroughly analyze each part of the decision, I also had to let him process his fears of the medical system and his own mortality. When I read notes from his second hospitalization, the notes stated that my dad was declining treatment. I felt that this reflected his treating physicians' dismissal of my father as not "compliant" despite all his adherence to the recommended treatment plan otherwise. I was frustrated by the lack of acknowledgement in the clinical notes of my father's fear of surgery and his need to understand. Reading the cryptic notes, I recognized the biased attitudes of his physicians. Yet, this experience also made me question how often I am unconsciously doing this and how this influences other clinicians. Or, how often is reading others' biased language influencing me?

Striving for Better

I hope I am improving at recognizing and reflecting on biased language for myself and my learners. Sometimes, I pause a trainee's presentation to ask what they felt when they read the chart notes before they met the patient. I ask them to reflect on whether their impressions changed after meeting the patient, or I have another member of the team reflect on what they heard in the presentation. If we can take a moment to recognize when we are negatively influenced before meeting a patient, we can debrief about our own biases and strategize ways to be more conscious of it in the future. We can also take the time to observe if our medical decision making was impacted by our initial beliefs. This does take insight and time and I am sure that I am missing it more frequently than I am aware.

More studies and strategies are needed to determine how to document to communicate accurately, effectively, and without bias. Hopefully, we can continue to bring awareness to what and how we write to break down barriers to patients' trust and improve the quality of care delivered.

The next time the pager beeps for a new admission, it is time to review or write a new chart note, or it is time for handoff, take a moment to recognize and mitigate potential biases in the language written.

References

1. Goddu AP, O'Conor KJ, Lanzkron S, et al. Do words matter? Stigmatizing language and the transmission of bias in the medical record. *J Gen Intern Med*. 2018 May;33(5):685-691. doi:10.1007/s11606-017-4289-2. Epub 2018 Jan 26.
2. Fricker M. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford, UK: Oxford University Press; 2009.
3. Beach MC, Saha S, Park J, et al. Testimonial injustice: Linguistic bias in the medical records of black patients and women. *J Gen Intern Med*. 2021 Jun;36(6):1708-1714.

continued on page 13

their goals, I was disappointed to hear their thoughts on the disciplines each was interested in pursuing. As the students explained, with passion, why they were interested in addressing the healthcare needs of their community while practicing as an OB/GYN, infectious disease specialists, dermatologists, or pediatric surgeon, I recognized that none expressed an interest in a career in GIM or primary care. As I reflect on that meeting, I am appreciative of Dr. Ajala and our SGIM Southern meeting planning committee for inviting these students to the meeting because without exposure to the exciting work being presented by academic internists, there would be a good chance that none would have gained an idea of how wonderful a career in GIM can actually be nor an understanding of the scholarship produced by physicians in our discipline. The very enthusiasm those college students had for other specialty disciplines can be gained for academic GIM as they gain exposure to the same type of talented SGIM members that had such significant impact on our nation's health policy, in medical education, and in public health.

This past year, I had the pleasure of interacting with SGIM council members and with trainees and faculty as I attended several SGIM regional meetings and benefited from the dedication and hard work of our SGIM staff members as we worked to meet the needs of our society's members. I recognize that any successes we accomplished during my year as SGIM President is the result of work done by the many SGIM member-volunteers who contributed their time for our organization's committees and commissions as well as the staff that support them. This is my last presidential column in the *Forum*. In the coming weeks, I will prepare to hand over the gavel at #SGIM23 to President-Elect Dr. Martha Gerrity and succeed Dr. Monica Lypson as the society's Past-President. For my final column, I'd like to take the opportunity to thank Drs. Lypson and Gerrity for their partnership over the past two years and to highlight a few examples of their many contributions. In addition to acting as trusted advisors and council members, Dr. Gerrity played a critical part in our organizations successful in further developing our philanthropic efforts and Dr. Lypson worked diligently to maintain our organization's commitment to accountability in creating an anti-racist culture and maintaining our focus on creating an inclusive environment for a diverse array of SGIM members and staff.[1]

I have enjoyed my time on SGIM council the past two years, but am equally as excited about the year to come. As I look forward to next year, it's my ambition to follow up on the strong foundation my colleagues have developed in "Forging our Future" and our DEI efforts by supporting our many member volunteers, such as the faculty present in that auditorium at the SGIM Southern Regional HBCU day, and to continue to bring exposure to the contributions academic internists can make in improving human health to students and trainees from a diverse array of settings. As Dr. Garrity and SGIM leadership pursue ways to continue to bring value to our members, I look forward to continuing to support their efforts, and I ask each SGIM member to consider ways in which they can also expose others to the wonderful our wonderful discipline of Internal Medicine.

References

1. Lypson ML, Bass EB. Diversity, Equity and Inclusion (DEI) Statement from SGIM's President and CEO. Society of General Internal Medicine. SGIM *Forum*. https://www.sgim.org/about-us/vision—values/dei. Published June 2020. Accessed March 15, 2023.

SGIM

SIGN OF THE TIMES *(continued from page 12)*

doi:10.1007/s11606-021-06682-z. Epub 2021 Mar 22.

4. Fernandez L, Fossa A, Dong Z, et al. Words matter: What do patients find judgmental or offensive in outpatient notes? *J Gen Internal Med*. 2021 Sep;36(9):2571-2578. doi:10.1007/s11606-020-06432-7. Epub 2021 Feb 2.
5. Himmelstein G, Bates D, Zhou Li. Examination of stigmatizing language in the electronic medical record. *JAMA Netw Open*. 2022 Jan ;5(1):e2144967. doi:10.1001/jamanetworkopen.2021.44967.

SGIM

MEDICAL EDUCATION: PART I *(continued from page 7)*

4. Onumah CM, Lai CJ, Levine D, et al. Aiming for equity in clerkship grading: Recommendations for reducing the effects of structural and individual bias. *Am J Med*. 2021 Sep;134(9):1175-1183.e4.doi:10.1016/j.amjmed.2021.06.001. Epub 2021 Jun 16.
5. Gulbas L, Guerin W, Ryder HF. Does what we write matter? Determining the features of high- and low-quality summative written comments of students on the internal medicine clerkship using pile-sort and consensus analysis: a mixed-methods study. *BMC Med Educ*. 2016;16(1):145. doi:10.1186/s12909-016-0660-y.

SGIM

create a platform for crowdsourcing information from novices through clinical experts about the behaviors that promote diagnostic excellence and mitigate racial disparities in diagnostic decision making.

EB: What are your aspirations for the long-term success of the project?

CG: Ultimately, we hope the curriculum we create will become a valuable educational asset that can be used by members of SGIM and other medical specialty societies to improve training in the diagnostic process and reduce racial and ethnic bias in diagnostic decision making. Thus, we see the project as a great opportunity to advance SGIM 's vision for a just system of care in which all people can achieve optimal health.

References

1. Burgess DJ. Are providers more likely to contribute to healthcare disparities under high levels of cognitive load? How features of the healthcare setting may lead to biases in medical decision making. *Med Decis Making*. 2010; 30(2): 246-57. DOI:10.1177/0272989X09341751. Epub 2009 Sep 2.

SGIM

the concept of *testimonial injustice* or the use of language that can instill bias or disbelief in the reader through chart notes. Bass, SGIM CEO, and Gonzalez and Lypson discuss receiving a grant for a project on promoting diagnostic excellence from the Council of Medical Specialty Societies (CMSS) that focuses specifically on mitigating racial disparities in diagnosis. Hicks, SGIM President, offers his parting reflections in his final SGIM *Forum* President's Column. The more we can educate ourselves about best practices and the invisible influencers of our daily thought, the more we can be mindful to mitigate their impacts on how we think and act.

The AMA, AAMC, and CMSS naturally are not the only professional organizations that are paying attention to these issues. The American Medical Informatics Association is also developing an Inclusive Language and Context Style Guide,[3] with the aim of issuing this as a scholarly communications guide not only for their annual meeting submissions but also as a tool to potentially influence other spheres of science and publishing. Each of these types of resources offer another set of perspectives and learning points for us to potentially adopt in our practices.

Regarding career advancement, three articles in this issue focus on the issue of bias in performance evaluations and letters of support. Finta, Sheffield, and Lukela call for formal training for residents on how to give feedback in ways that avoid unintended bias. Conigliaro, et al, describe their innovative program, Promotion Support for Women in Medicine, designed to build a pool of skilled letter writers to sponsor women academic faculty in their promotions—and do so while applying best practices in avoiding gender-biased language in their support letters. Sagar, et al, summarize some of the key pitfalls of biased language in letter writing and offer specific strategies for writing letters that avoid biased language.

In the prompted words of ChatGPT: *"It is essential for general internal medicine physicians to be aware of their own biases and take steps to address them, such as engaging in diversity, equity, and inclusion training, seeking feedback from colleagues and patients, and being mindful of the potential impact of their biases on their work. By doing so, physicians can improve the quality of their research, patient care, advocacy, and professional advancement, and work towards creating a more equitable healthcare system."* I have heard numerous talks that acknowledge that no person (and no physician) is exempt from implicit bias. We all have them. To mitigate those biases and change how we think and act to benefit our patients and each other, we need to start shifting how we think about using language in our routine work as physicians, medical educators, advocates, and researchers.

References

1. CDC. Communicating with and about people with disabilities. https://www.cdc.gov/ncbddd/disabilityandhealth/materials/factsheets/fs-communicating-with-people.html. Accessed March 15, 2023.
2. AMA. Advancing health equity: A guide to language, narrative and concepts. https://www.ama-assn.org/about/ama-center-health-equity/advancing-health-equity-guide-language-narrative-and-concepts-0. Accessed March 15, 2023.
3. AMIA. Update on AMIA Inclusive Language and Context Style Guidelines. https://amia.org/news-publications/update-amia-inclusive-language-and-context-style-guidelines. Published March 1, 2022. Accessed March 15, 2023.

SGIM

look good" in reference to a scan that revealed innumerable tumors, then launching into soliloquy on the role of spirituality in hard times. The awestruck patient says little before the visit concludes with the following:

> *I jumped up and shook hands with this man who'd just given me*
>
> *Something no one else on earth had ever given me*
>
> *I may have even thanked him habit being so strong*

That possible *thank you* haunts me. How many patients have thanked me for levelling them with language, and how often have I mistaken their words for praise?

If physicians can be forgiven for lacking insight or for problematic phrasing never intended for patients' ears, it's harder to understand the persistence of so many bizarre and, in many cases, patently offensive terms in our hospital rooms and clinics. In a recent *Atlantic* article,[2] "Please Don't Call My Cervix Incompetent," Rachel E. Gross notes that while medicine has done well in recent years to retire such labels as "sickler" and "drug abuser," the habit of objectifying and blaming patients has been harder to kick when referencing pregnant peoples' bodies. She cites *incompetent cervix, hostile uterus, and habitual aborter* among other examples of this tendency.

This reminds me of the time that my wife's obstetrician warned against excessive weight gain during pregnancy by employing the metaphor of a "ship in a bottle," a phrase he repeated several more times as I scanned the room, making sure that any potential weapons were beyond the petit patient's reach.

I would describe that visit as *unforgettable*. My wife still thinks I'm being too kind.

Speaking of metaphors, the linguist and physician Britt Trogen has written[2] about their utility in helping physicians to better communicate complex ideas. Trogen notes that although physicians who routinely employ metaphors are rated as better communicators, not all metaphors have the intended effects. For instance, patients who embraced the "chemical imbalance" model for depression were found to be more pessimistic about their prognoses, to have lower expectations for treatment, and to be more likely to rely on pharmacology than psychotherapy.

If one oncologist were to describe cancer treatment as a battle while another was to frame the experience as a journey, would a patient's attitude, experiences, and even clinical outcomes differ? It's a hard question to study; it's also safe to assume they might.

If evidence to guide optimal phrasing is lacking, physicians are becoming increasingly aware of how not to speak and write. All manner of labels invites framing biases that distort clinical reasoning and judgement. And it's clear that the use of stigmatizing language, regardless of intent and however subtle, leads clinicians to develop negative attitudes towards patients and can even influence prescribing behavior.[4]

Dr. Julia Raney and colleagues have published a toolkit for cultivating mindful language to limit the transmission of bias in clinical settings. If physicians made a habit of reviewing their five key questions[5] (*Does [this language] cast blame? Does it reinforce a stereotype? Does it include extraneous information? Does it include a pejorative? How would my patient feel if they [heard] this?*), we might also improve the patient experience.

That physicians' words have such power is a function of our status compounded by the vulnerable position in which we encounter our patients. And our words can do more than wound, demoralize, or bias.

When I was 21, I developed seizures caused by a symptomatic arteriovenous malformation in my right temporal lobe. My parents and I sought the best surgeon in our area and connected with a pioneer of endovascular neurosurgery who had a reputation as both a magician with a catheter and a butcher of bedside manner. After multiple procedures and months of recovery, I visited him in his office for follow-up. He burst into the room, muttered a few pleasantries, and performed a brief neurologic exam. Then, he shook my hand and said, "Well, you never have to see me again," hurrying away as hot tears stung my cheeks.

That sentence is more than 20 years old, but I'll never forget it.

References

1. Katz NT, Jones J, Mansfield L, et al. The impact of health professionals' language on patient experience: A case study. *J Patient Exp*. 2022 Apr 7;9:23743735221092572.
2. Gross RE. Please don't call my cervix incompetent: There's no end to the weird ways medicine describes women's bodies. *The Atlantic*. https://www.theatlantic.com/health/archive/2023/01/geriatric-pregnancy-old-outdated-medical-terms/672834/. Published January 25, 2023. Accessed March 15, 2023.
3. Trogen B. The evidence-based metaphor. *JAMA*. 2017; 317(14):1411-1412. doi:10.1001/jama.2016.17219.
4. Goddu AP, O'Conor KJ, Lanzkron S, et al. Do words matter? Stigmatizing language and the transmission of bias in the medical record. *J Gen Intern Med*. 2018 May;33(5):685-691. doi:10.1007/s11606-017-4289-2. Epub 2018 Jan 26. Erratum in: *J Gen Intern Med*. 2019 Jan;34(1):164.
5. Raney J, Pal R, Lee T, et al. Words matter: An antibias workshop for health care professionals to reduce stigmatizing language. *MedEdPORTAL*. 2021;17:11115.

SGIM

SGIM Forum
Society of General Internal Medicine

Society of General Internal Medicine
1500 King Street, Suite 303, Alexandria, VA 22314
202-887-5150 (tel) / 202-887-5405 (fax)
www.sgim.org

BEST PRACTICES *(continued from page 11)*

uating the accomplishments of the applicant. Use of first names should be approached with caution to avoid triggering unconscious biases, even though the intention is to convey a sense of knowing the person well or reducing the appearance of being a generic letter. Beware of and avoid using doubt-raising language, stereotyping, gendered language, and discussion of personal characteristics (unless they predict potential growth and job performance). Consider using a free online bias checker to help. See the extended reference material and links to free online tools that are linked at the end of this article.

Conclusion

We offer readers the full bibliography for this article and additional reading and resources online. Raising awareness of these biases is the first step in addressing them. The second step is to mitigate the use of such language by choosing appropriate evaluators, focusing on the accomplishments of candidates, and leveraging technology (i.e. online decoders). Each of us has a role (as candidates and evaluators) in mitigating these biases. Thus, we are aspiring to a new reality when reading between the lines will no longer be necessary.

References

For the full reference list and resources, please see: Leung TI, Sagar A, Henry TL, Shroff S. SGIM2022: Recognizing and Reducing Bias in Letters of Support and Performance Evaluations in 360 Degrees. SGIM 2022 Annual Meeting. Presentation. *Figshare*. https://doi.org/10.6084/m9.figshare.22093343.v1. SGIM

The ISSN for SGIM *Forum* is: Print-ISSN 1940-2899 and eISSN 1940-2902.