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MEDICAL EDUCATION

THE MILESTONE GAP

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In 2013, the Accreditation Council for Graduate Medical Education (ACGME) introduced the Milestones into graduate medical education as a method to describe competency-based education. The Milestones show promise to provide more accurate assessment of a trainees' progression to autonomous practice. Now 10 years into this project, as we incorporate Milestones 2.0 into graduate training programs, we recognize that there persists a Milestone Gap between theory and practice, between experts well-versed in Milestone language and front-line clinician-educators who evaluate trainees. The Milestones have been a labor-intensive process, mobilizing time and treasure from across the medical education community. The assessment of our trainees is critical. We have a public mandate to train competent, empathic, autonomous physicians. How do we close the Milestone Gap?

Despite growing evidence for content and internal structure, there remains relatively scant evidence for response process validity, the extent to which assessors interpret Milestones in the way intended by the ACGME.[1] A recent qualitative study on response process showed that faculty Milestone scoring was "not always aligned, and sometimes in conflict with, the intended purpose of [Milestone] assessment."[2] Additionally, existing evidence suggests that not only individual Milestone assessments are prone to bias but also there is ongoing confusion about Milestones language.[3] The heterogeneity in assessment is so well known amongst programs that some have begun the process of weighing different inputs during the analysis process via the Clinical Competency Committee (CCC) and are developing continuous quality improvement systems to improve the quality of assessment data on an ongoing basis.[4, 5]

In 2018, the ACGME launched Milestones 2.0 to make them more user-friendly and accessible to clinicians.[3] Medical education experts streamlined the Milestones, simplified the language, and crafted a supplemental guide to provide real world examples for each subcompetency. Assessment requires in-the-moment observation and feedback by trained clinician-educators, thoughtful, collaborative appraisal by CCCs, and global, summative review by trusted advisors. Perhaps the most important purpose of the Milestones is to identify struggling learners early in their training so that supportive action can be taken. This process assumes that the assessment data reflects the actual performance of the trainee. Therefore, assessment requires medical educators who are one-part data scientist and one-part clinician—individuals who understand the validity, consequences, and implications of assessment outcomes.

The clarion call to close the Milestone Gap has been to increase faculty training.[4] While we recognize its importance, isolated sessions often have limited lasting impact. The ACGME is actively combating this issue by providing concentrated training opportunities and setting up a network of Assessment Hubs that serves as training centers for program leaders to learn basic and advanced assessment skills.[4] However, even with this training, the

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BECOMING

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

Sometimes pivotal moments happen invisibly and only reveal themselves for their significance in hindsight. In 2016, I committed to serving the Society of General Internal Medicine as associate editor of SGIM *Forum*. At that time, the more visible pivotal moment was my decision to leave American health care.[1] I felt that I had a lot to experience and reflect about as I embarked on a journey abroad—and SGIM *Forum* offered me a welcoming professional space to share. This was my first step into a routine of scholarly writing, editing, and publishing, especially since my last editorial post was Features section editor of my high school newspaper![2]

The invisible pivotal moment of deciding to serve as an associate editor, and then publishing work in SGIM *Forum* with highly supportive editors-in-chief, such as Joe Conigliaro and Karen Horowitz, eventually led to my becoming editor-in-chief. Handed off squarely in the middle of the COVID-19 pandemic, the newsletter came to me at a time when so many had so much to feel, think, and say. I am endlessly grateful for authors and artists sharing their work over the past three years, including commentary, calls to action, morning reports, preliminary research, art, photography, poetry, and so much more. The previously invisible became brilliantly visible when I was forced to make another pivotal decision[3]—serving as SGIM *Forum* editor-in-chief showed me that a career as a publisher is possible, especially during a time in my life when other options seemed to fade. Simply, I realized that I deeply wanted to keep helping scholars to communicate and publish their best work for any and all of the reasons that they might have something important to say.

Service as SGIM *Forum* Editor-in-Chief impacted my journey. I hope for readers and members, you will find ways for this humble newsletter to impact yours. Thank you for allowing me to *become* editor-in-chief.

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SGIM

GENERAL INTERNAL MEDICINE: WHAT'S IN A NAME?

Martha S. Gerrity, MD, MPH, PhD, FACP, President, SGIM

"We are a vibrant Society with people passionate about [our work]. When collaborating and bringing together our diverse perspectives, skills, and knowledge, we have a better view of a challenge, not unlike our ability to see the whole patient."

I have always believed that general internal medicine physicians have much in common whether we work primarily in the hospital, outpatient setting, or community. It is the breadth of our clinical experience that gives us a unique view of health care, medical education, and research. I was a bit confused when I heard that some hospitalists do not consider themselves general internists. I'm not alone. The public and many of our patients are confused, too. I did a Google search looking for a definition or description of *general internal medicine*. I found a myriad of similar queries and varying descriptions and definitions of general internal medicine. The first known use of the term *internal medicine* was in 1835 and defined as "a branch of medicine that deals with diseases not requiring surgery."[1] Prior to the early 20th century, internal medicine physicians could do little to treat disease but were known for their diagnostic and prognostic capabilities and served as diagnosticians.

As the field of medical research learned more about diseases and developed treatments for these diseases, subspecialities based on organ systems evolved. We then had two categories for internal medicine physicians, subspecialists, and general internists.[2] Subspecialists work within the bounds of organ systems, whereas general internal medicine physicians deal with all acute and chronic diseases of adults. We are not limited to one type of medical problem or organ system, and we extend our view to the social and cultural factors that affect health and provide care that includes health maintenance and prevention of disease. We are specially trained to solve puzzling diagnostic problems and can handle severe chronic illnesses and situations where several different illnesses may be present at the same time. We like a good puzzle.

In addition to providing direct patient care, general internists often work closely with other healthcare professionals in teams—including nurses, pharmacists, social workers, physician assistants, and specialists—to coordinate care and ensure the best possible outcomes for

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Q & A ABOUT PREPARING THE NEXT GENERATION OF ADVOCATES FOR GENERAL INTERNAL MEDICINE (GIM)

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EB: John, why have you devoted so much time and effort to advocacy for better payment of GIM physicians?

JG: Even 30 years ago, the sustainability of primary care GIM was uncertain. There were many practitioners, but workforce projections were worrisome. In the 2000s, I was offered the opportunity to represent SGIM in a multi-specialty committee of the American College of Physicians. I learned that there is a federally managed process for establishing the prices for every individual physician service. After reading the history behind the development of federal price fixing, I discovered that the processes had been corrupted and mismanaged from the beginning. When I personally witnessed a small, self-selected group convened by the American Medical Association and dominated by procedurally oriented specialties with a 90% acceptance by the Centers for Medicare & Medicaid Services, I realized that the premise of fairness within physician service pricing based on the relative intensity of each service had been unduly influenced by those professionals who had no concept of complex care management and continuity. I felt like an investigative reporter getting to the bottom of this story.

EB: What are the keys to your success in being an effective advocate for changes in physician payment?

JG: Finding your people. My passion for advocacy stems from a commitment to service that we all share. I knew that the nation needed a robust primary care internal medicine workforce. Within SGIM, I was exposed to social activists who thought big. They became my people. They provided extraordinary examples of collaboration and relationship building among colleagues and the legislative and executive branches of government.

Effective advocacy has four elements: First, develop an independent understanding of the issue. Second, develop a succinct message. Third, crosscheck to be sure you have the passion to sustain yourself. Fourth, be prepared to present your material at any time and at any place. Opportunities present unexpectedly. Focus on issues of powerful personal importance. Become a trusted source. Know that if you are right now, you will likely be right in 10 years unless things change. Advocacy is a socializing experience and building ongoing relationships is part of the fun.

EB: What do you recommend as top priorities for SGIM's continuing advocacy for the clinical practice of GIM?

JG: SGIM is an emerging professional society with distinguishing characteristics. We all need to celebrate our unique identity. We are a community of practitioners, educators, and health services researchers within academic medical centers. There is no other organization that has our capabilities. Others are starting to recognize that SGIM is a forward moving professional society. Our policy recommendations are based on evidence. Activism has become part of our organizational identity. We need to be skeptical and questioning at all times. For example, the fundamental flaw with many proposed changes in healthcare reimbursement goes back to the legacy distortions of physician service pricing. Unless we change the pricing mechanism to more accurately capture the complexity of our work, we will never be appropriately valued, and the future of primary care GIM will look even worse. Although the Primary Care Collaborative is advocating for a hybrid payment model that should help to provide more support for the services that primary care clinicians provide outside of face-to-face encounters with patients, any model that retains the current federal service pricing within the Medicare fee schedule will fail to properly value the evaluation and management (E/M) services by primary care clinicians.[1] Thus, SGIM must persist in calling attention to the inadequacies of any payment model based on the fee for service rates.

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ASK AN ETHICIST: CARE OF IMMIGRANTS

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For "Ask an Ethicist," members of the SGIM Ethics Committee respond to real ethics cases and questions submitted by SGIM members. Responses are created with input from the Committee but do not necessarily reflect the views of the Committee or SGIM. To submit a case or question, visit: https://www.sgim.org/communities/other-sgim-committees/ethics/ask-an-ethicist, or email the authors of this column.

Case

A 29-year-old woman is admitted to the hospital with sepsis and tuberculous meningitis. She has many complications during her several-month hospital course, including a cardiac arrest, but ultimately her condition stabilizes. Although she is alert and breathing independently, she requires a feeding tube for nutrition and remains delirious, unable to participate in decision-making. When awakened, she cries out for her mother, but can say little more about her background. Her prognosis appears poor.

An investigation by the local police and the Department of Homeland Security indicates that the patient is an undocumented immigrant who may be a victim of trafficking. The house at her address is owned by a local restaurant proprietor. The patient apparently lives there with several unrelated "roommates," all of whom work at the homeowner's restaurants. The patient had been found in similar circumstances in two other US cities before, and both times had been deported to Mexico. Homeland Security and the Mexican consulate believe that the patient's mother lives in Chiapas, a rural part of Mexico, but they have been unable to locate or contact her.

As the patient nears discharge, the hospitalist team considers various options. They could arrange for discharge to a local nursing facility, in which case the hospital would need to assume financial responsibility for her long-term care, and she may not be able to reunite with her family. Alternatively, if an accepting facility can be found in Mexico, the consulate has stated that it can facilitate a transfer. However, due to her condition, she would require a medical flight between facilities at the cost of tens of thousands of dollars, and the team has concerns about the loss of continuity of care and the patient's safety in returning to Mexico. The team requests an ethics consult to assist with this decision.

> **"When discharging any undocumented patient, we need to keep them safe. People in the United States, regardless of documentation, should have the highest quality care. Identification and reporting of human trafficking depend on the rights of immigrants to freely travel."**

Response

The care of undocumented immigrants brings about justified moral distress alongside practical and ethical challenges.[1] These patients are often impoverished, with many avoiding care because it is unaffordable.[2] Further, such immigrants are often separated from families due to federal policy, the stresses of migration, or family choice about who is to immigrate to the United States.[3] Finally, though it is federally mandated and ethically required, language concordant care is often not provided or easily available in our healthcare settings.[4] All these considerations are potentially relevant to this case.

The main question in this case, of course, is how to best care for the patient now, and the destination of the patient after discharge. Can we understand what the best place for her might be based on her wishes (i.e., substituted judgment)? How do we supplement considerations

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THE MUSIC VIDEO: INCORPORATING ARTS INTO MEDICAL EDUCATION

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Like most physicians who supervise a team of medical students and residents on an inpatient internal medicine clinical teaching unit, I have a routine. In March 2020, the COVID-19 pandemic demanded changes. First, we put on masks that prevented us from seeing faces of other team members. Second, we limited the number of team members visiting the bedside of patients to reduce exposure of healthcare personnel to COVID-19. Third, we moved in-person large group meetings, such as Grand Rounds, to Zoom, where most participants turned off their cameras. These changes led to the loss of an important aspect of humanity—face-to-face interaction. In response, I looked for a way to reintroduce humanity into our time together. I stumbled on something from my background in musical theatre production,[1] an activity that I soon called "*The Music Video*".

Every day, our team takes 4-6 minutes to watch a video that contains music. At first, I used the videos as a diversion to lift our spirits, with no other purpose than entertaining the team. But over time, our reactions motivated me to pursue more specific objectives. These include setting a mood for the day (upbeat, fun, mellow, introspective, sad), improving our powers of observation, displaying my passion for this form of art to role model broadening one's horizons, and teaching something about musical theater. As a general theme, these viewings show the power of vocal performance to bring us out of ourselves and into contact with others. We can't see each other's faces—something we dearly miss—but we can all see the facial expressions of the artists.

I have developed a list of favorites. The accompanying table provides a sample playlist with URL links to each of these videos. I always start with upbeat videos, usually either Joshua Lee Turner's Band on the Bus version of "Baby Driver" or the 2018 Tony presentation of *Once On This Island*. The former shows a group of five musicians on their tour bus happily covering the Simon and Garfunkel hit song. It is impossible not to smile while viewing it; it's a toe tapper. The latter is, in my opinion, the best example of a performance on a Tony Award program because it motivates viewers to see the show. Matthew Thomas Grant's "Thank Me Now"

Sample Playlist for Music Video Curriculum

Title	Artist/Source	URL	Mood
Baby Driver	Josh Turner	https://youtu.be/0OxP5nrI6u8	Upbeat
We Dance/Mama Will Provide (medley)	Cast, *Once On This Island*	https://youtu.be/svc26VIJ2pM	Upbeat
Thank Me Now	Michael Thomas Grant	https://youtu.be/4KkuneTLwIk	Angry
Omar Sharif	Chilina Kennedy, *The Band's Visit*	https://youtu.be/MElOrtye4LQ	Mellow, Middle Eastern
I Say a Little Prayer	Kenton Chen and the Scary Pockets	https://youtu.be/bwLkI5Id6cA	Fun, Indie
	Cast, *My Best Friend's Wedding*	https://youtu.be/raEbrKPBoyQ	Karaoke
	Aretha Franklin	https://youtu.be/y1wFX1TPW6E	R&B, Soul
Walking in the Air	*Peter Auty,* The Snowman	https://youtu.be/upH1QZU4Z0Y	Soothing, Evokes Memories
Vincent	Voces8	https://youtu.be/0yamC-NZTgE	Sad, Beautiful
Stand Up	Cynthia Erivo, *Harriet*	https://youtu.be/sn19xvfoXvk	Inspiring
Welcome Home	Christine Hudman	https://youtu.be/Lq8WtBsTBnM	World War II, Big Band

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A BURNING CAUSE OF BACK PAIN: SGIM MORNING REPORT

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Case

We present the case of a 62-year-old man with a prior diagnosis of sciatica who presents with a painful rash of two months on the posterior left leg and lumbar back pain radiating down the left leg. The pain worsened with prolonged sitting, pressure, and walking. Applying a heating pad, oxycodone, and methylprednisolone alleviated his pain. His MRI was normal six weeks ago. Family history includes maternal unspecified thyroid disease, but no other autoimmune history. He lives alone, is independent with daily activities, and is unemployed. He does not use alcohol or intravenous drugs; he has a 30-year smoking history.

> **"EAI should be included in the differential diagnosis for a hyperpigmented reticular rash. Its differential diagnosis includes other reticular rashes: livedo reticularis, livedoid vasculitis, poikiloderma atrophicans vascular, dermatomyositis, malignancies, vasculitis, and bullous disease."**

On examination, the patient was in distress on the table from his pain. Vitals were temperature 37°C, blood pressure 117/81, heart rate 77, and BMI 18. He had Type 1 skin with a lace-like pattern of hyperpigmented brown-to-purple macules on the left posterior leg in the sciatic nerve distribution. It was non-tender and non-blanching. He had an unremarkable neurological exam. The remainder of the examination was within normal limits. CBC was normal. CMP was notable for sodium at 132 mmol/L, chloride at 97 mmol/L, and total bilirubin at 1.1 mg/dL. His INR was 0.93 (low). Autoimmune antibodies, HIV, HAV, HBV, and HCV, were negative. Dilute prothrombin time, thrombin time, PTT-LA, dRVVT, and lupus anticoagulant were negative. The left lower extremity's venous and arterial duplex ultrasounds were without deep vein thrombus or arterial stenosis.

Dermatology evaluated the patient. Upon further questioning, he confirmed using a heating pad for many hours daily for one month before the onset of the rash. A left posterior thigh skin biopsy with Fontana-Masson stain highlighted melanophages within the papillary dermis. Iron staining was negative, and the pathologist identified no vasculopathy changes.

Teaching Points

Erythema ab igne (EAI) is a skin reaction caused by chronic heat exposure through infrared radiation.[1] Historically, EAI occurred with exposure from stoves and coal fires but now results from recurrent heat exposure through electronic devices.[2] The location of EAI may prompt the clinician to inquire about further health problems, such as back or abdomen pain associated with heating pad use. Women are twice as likely to develop EAI.[2,3] The age range varies and can reflect the use of heating devices for chronic pain in elderly adults.

Vasodilation of the venous plexus from heat leads to the classic findings of EAI.[4] EAI initially causes epidermal atrophy and vasodilation as well as hemosiderin and melanin deposition in the dermis.[2] EAI can rarely transform into malignancy, usually taking decades, and a biopsy of the skin is warranted to exclude malignancies that mimic EAI. Severe cases may have telangiectasias, atrophy, and bullae.[4]

EAI should be included in the differential diagnosis for a hyperpigmented reticular rash. Its differential diagnosis includes other reticular rashes: livedo reticularis, livedoid vasculitis, poikiloderma atrophicans vascular, dermatomyositis, malignancies, vasculitis, and bullous disease.[2] EAI will be present only in the setting of chronic heat exposure.

Treatment is removing the heat source. Hyperpigmentation can be treated with topical tretinoin, hydroquinone, laser therapy, or depigmentation creams.[5] Despite this, abnormal pigmentation may remain.[2] EAI has a favorable prognosis with the removal of the

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STEPPING INTO THE TENSION: A REFLECTION ON MY FIRST ADVOCACY EXPERIENCE

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According to the Association of American Medical Colleges, Tennessee has more than 17,000 active physicians. Approximately 43% of those that train in the state stay to practice (AAMC).[1] The Tennessee Medical Association (TMA) is the most active organization representing this state's doctors and student doctors, particularly concerning healthcare legislation. They work through Political Action Committees, empowering physicians to reach out to legislators and organizing advocacy events that place constituents in the offices at Capitol Hill. Known as "Day on the Hill" by those at the TMA and simply as "Doctor's Day" by those in the offices.

> **"I realized that listening to them well had given me real stories to share that would make these issues more tangible. When I can speak with passion, I can speak with conviction, and their stories impassioned my conversations that day."**

When I arrived for my first Day on the Hill, I expected the legislators to be standoffish and unapproachable. Additionally, I thought there would be multiple barriers to engaging in nuanced discussions of health matters. I also thought that, at the least, the politicians we met with would feel that our presence disrupted their already busy schedules. I don't believe I have ever fully understood what happens when the legislators are in session, but I imagined it would be busy. With the recent increase in turmoil over our political climate, I also expected whatever debate we had to become heated. This understanding seemed reasonable, given the outcome of conversations I witnessed among people with differing political views. I was genuinely curious about what I would find but not overly hopeful of a positive experience.

From the moment I walked through the security gates, I found things were not as I expected. The security officer exclaimed, "Oh yay, the doctors must be here today!" as he passed us through. Moving up to the floor reserved for our check-in, I found many welcoming faces confirming why I was there. I arrived early, but a large group was already accumulating at the desk. With the TMA, I was glad to see a mix of faces representing many regions of Tennessee, including OBGYN, orthopedic surgery, family Medicine and Internal Medicine. Medical students, residents, attendings, and those nearing retirement were all in attendance, ready to discuss the issues.

We had scheduled meetings, but as I wore my white coat and ventured throughout the building during my free time, I was likely to be approached by people from my district who wanted to connect with me and find out what I was doing away from Memphis. Instead of acting as if we were a bother, most really enjoyed it when the doctors "came to town," as one said! It made me smile and somewhat inwardly groan when I heard one say, "Oh, I feel healthier already with all these great doctors around. I shouldn't have to go see mine for quite some time". Those casual conversations were surprisingly the most fruitful and collaborative of my day. While in the offices, the groups paired to speak with certain legislators varied. I met people from all over the state, and I loved that they paired inexperienced alongside well-seasoned veterans of such a day. With the groups that they formed, there is a broad range of knowledge amongst all the issues, ranging from independent practice from mid-level providers to complicated insurance policies, that I didn't fully understand. You could choose whether you wanted to speak, but you could be sure you would learn quite a bit from the lively discussion that arose. We encountered some on opposing sides of our stance, and it was enlightening to hear more than one say they were against the bill simply because the opposite side of the political aisle was pushing it. Those discussions tended to last longer, fueled by many ques-

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HOW ANCHORING AND RACIAL BIAS ARE RELATED: A CASE INVESTIGATION

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Dr. Ganesan (veena.ganesan@mountsinai.org) recently graduated from Rush Medical College and will be starting a residency in Internal Medicine at Icahn Mt. Sinai Medical Center in New York City, NY. Dr. Rao (Shobha_Rao@Rush.edu) is an academic hospitalist and clinical assistant professor of medicine, Rush University Medical Center in Chicago, IL.

In clinical medicine, diagnostic decisions are often taught through the context of algorithms. While algorithms are helpful in interpreting information and triaging patients, our column discusses how algorithmic thinking and anchoring bias, or the propensity to rely on one piece of information to inform diagnosis, increases the effect of racial and gender bias. We explore how these patterns of thinking can lead to increased errors in diagnosing and treating patients of color, with this occurring more frequently in female patients.

Case Presentation

A 24-year-old female with a past medical history of tubo-ovarian abscess, surgical abortion in 2019 complicated by uterine perforation and recurrent venous thromboembolism (VTE), presented to the emergency department with severe abdominal pain, emesis, and nausea. Her mood was agitated and tearful and on exam and she was reported to be in significant distress. She had presented for similar abdominal pain one month prior and reported increasingly irregular menses and severe pain. She was treated for pelvic inflammatory disease (PID) during that admission but had no improvement in her pain symptoms. She underwent a CT scan of the abdomen/pelvis which showed mild interval increased size of the complex collection within the endometrial cavity concerning for hematometra or pyometra.

The patient had a history of sexually transmitted infections (STIs) in the past, and her pain symptoms were thought to be from PID-related changes to her cervix and uterus, despite the imaging evidence suggesting pyo- or hematometra as well as ovarian vein thrombosis. Upon further investigation, the patient did not have a recent positive STI screening and was last positive in 2015. The patient had progressive, continuous pain, so specialty consultations were requested from Infectious Disease, Obstetrics and Gynecology, Gastroenterology, and Hematology. All specialists felt that her pain could not be attributed to an etiology related to their specific service. After reviewing the imaging in the setting of her continuing pain, she ultimately underwent a dilation and curettage procedure to remove the hematometra collection. Within 24 hours, the patient's pain had markedly improved and her overall mood and ability to communicate had also changed.

Discussion

We can ask ourselves if our clinical reasoning is affected by omitting the patient's race above. The patient identifies a black woman.

Would it have changed the initial misdiagnosis of PID one month previously? In this case, diagnostic error occurred at two different visits at two different institutions. Was this influenced by the patient's gender, race, and age?

In our case, multiple issues, including anchoring onto PID and racial and gender bias affecting the interpretation of the patient's pain and acuity, had led to initial misdiagnosis and delay in treatment. In several studies, pain levels are noted to be interpreted disparately between patients of different races, as well as description and communication styles. For example, one analysis of 1.8 million records concluded that the language used in clinical notes showed that physicians tend to focus less on the pain, emotions, and physical diagnosis of Black patients as opposed to White patients.[1] This phenomenon is directly linked to the undertreatment of Black patients' pain, which is increased with inclusion of female gender.

"One analysis of 1.8 million records concluded that the language used in clinical notes showed that physicians tend to focus less on the pain, emotions, and physical diagnosis of Black patients as opposed to White patients. This phenomenon is directly linked to the undertreatment of Black patients' pain, which is increased with inclusion of female gender."

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tions and responses from both sides. Despite not starting in agreement, we always left with a sense of being heard fully and understood.

I learned a few things. First, that even my few years of experience caring for patients had established enough of a relationship with them for me to be aware of their struggles. I realized that listening to them well had given me real stories to share that would make these issues more tangible. When I can speak with passion, I can speak with conviction, and their stories impassioned my conversations that day. It was also humbling to have a moment of recognition that I was speaking on behalf of people I hold very dearly in my heart. I wanted to not only speak with conviction but also with clarity and to be equipped with accurate information. As I reflected on the day, I had some retrospective encouragement as I thought about what I learned from men and women that have been representing their patients at the Capitol for many years. I observed some of their styles of speaking and explaining and incorporated them into my own. While I walked in, I was unsure of how I would be able to contribute to the conversation, given my level of training. As physicians, we will continue to experience a feeling of imposter syndrome and inadequacy in different ways. Many acted as mentors who eagerly offered words of advice that emboldened me to speak in these groups that visited legislators' offices. Lastly, I'd like to circle back around to my first point. I may have been able to share some real examples at Day on the Hill because I listened to my patients, but it was not lost on me that I do not come from a place of lived experience. So while I have some awareness of their challenges, the biggest place I need to learn is in my encounters with my community, actively listening. Asking questions so that I may hear about needs that I may not encounter every day. Asking how prescriptions and recommendations I make may or may not be able to happen because of governmental barriers. I hope over time as I gain experience with patients and advocate for them, I'll be able to effect some change to their benefit.

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In a study by Beach et al, physicians are more likely to communicate disbelief of the concerns of Black and female patients. The use of judgment words and evidentials (phrases used to convey a lack of credibility) was significantly higher in Black and female patients, with a statistically significant interaction in the number of evidentials in clinical notes about Black female patients.[2] For example, in our case, clinical notes use language such as "patient reports compliance with PID treatment," corroborating the suspicion physicians had that her symptoms were again due to possible PID. These studies both support the existence of implicit bias, both racial and gender bias, in how physicians interact with and interpret the symptoms of Black female patients. Lastly, the rates of anchoring bias and the process of triaging patients are different across races. In Boley et al, the process of triaging patients in the emergency room is largely influenced by racial bias. The Black patients, across all chief complaints, were rated as low acuity when compared with White patients with statistical significance.[3] In our patient, her symptoms were presumed to be due chronic PID changes in upon presentation despite CT and transvaginal ultrasound evidence of worsening fluid collection. The assumptions made due to her race, gender and age led to a missed diagnosis and delay in treatment, specifically ascribing sexual promiscuity and melodrama to the patient's behavior.

Conclusion

Racial bias further worsens the existing healthcare disparities through physician perception of patients, downplaying the complaints of Black patients, and undertreatment of Black female patients' pain. Our understanding of the role that racial bias plays, especially when first recognizing a patient's symptoms in the emergency department, is essential to correct the differences in the treatment delivered to Black female patients. In the future, acknowledging and identifying racial and gender bias within clinical algorithmic thinking should be performed at *all* stages of medical training to promote equitable delivery of care to all patients.

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for her best interests, that is, where she would be best cared for and safe, where substituted judgment isn't available? Regarding substituted judgment, perhaps we can contact collateral sources of information, family, or friends, to understand what her wishes would be in this case. Those with knowledge of the facilities available near her family might be able to give a sense of what level and quality of care is available there.

How are these options to be carried out? Medical transport can be very costly; perhaps she could be temporarily discharged to a nursing facility in the United States until she can fly on a commercial flight. There are programs and airlines that provide compassionate use discounted fares to fly terminally ill patients or their loved ones—these may be worth exploring. One of our authors (MG) accompanied a terminally ill patient on a commercial flight home to Mexico, which made the institution more willing to cover the relatively minimal costs. Including a representative of the consulate, where possible, might prove helpful.

When we consider discharging any undocumented patient from the hospital, we need to consider how to keep them safe. While there are limits to how and whether clinicians can intervene in violations of employment law, they should confer with legal experts and perhaps law enforcement about employers suspected of trafficking.

In this case, as in so many ethics cases, the best answer depends on circumstances, but the lack of a better answer depends on policies. People in the United States, regardless of their documentation, should have access to the highest quality care. Identification and reporting of human trafficking depend on a system that believes in the rights of immigrants to freely travel; those fearing deportation will not speak up about trafficking. Only governments that welcome immigrants and care for their health and well-being will be able to have the moral authority to prosecute employers for mistreatment.

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from the Los Angeles production of *Emojiland: The Musical* evokes the emotions of first-year residents in the middle of a night on call, complete with the anger and intensity of circumstances when asked to simultaneously handle 10 urgent clinical tasks. I point out Grant's remarkable use of his eyes and hands to convey the song's message. Chilina Kennedy's "Omar Sharif" from the Tony-winning musical *The Band's Visit* is sublime and soothing, with an embracing Middle Eastern mood. I show that one when the team needs to relax.

Sometimes, I show them different versions of the same song. A great example is "I Say a Little Prayer"—a Burt Bacharach and Hal David classic covered by many people. My favorite covers are Kenton Chen with the Scary Pockets and the karaoke-style performance by the cast of the film *My Best Friend's Wedding*. This exercise shows the group how the same stem of material (the music and lyrics) can evoke very different reactions with different interpretations resulting from the cultural context of the artists (see Aretha Franklin's acclaimed pop-R&B cover).

On some occasions, team members bring their own videos. While working over Christmas, a resident from the United Kingdom showed us and excerpt from *The Snowman*; a cartoon about a little boy that people in the United Kingdom watch over the holiday season. While watching the video, I could see both pride and homesickness on the English resident's face, reflecting the capacity of music to evoke powerful memories.

On my last day with one team, I showed them a cover of "Vincent," the haunting song by Don McLean about Vincent van Gogh's mental illness, sung brilliantly by Voces8, a London-based *a cappella* group. The intertwined beauty and sadness left us speechless. All I could say was, "that was beautiful but we can't end on that note". So we watched a second video that day: Cynthia Erivo's uplifting performance of "Stand Up," the theme song from the movie *Harriet*, the story of Harriet Tubman's role in the Underground Railroad. As we left the room to see our patients, I could hear the team singing behind me. I smiled; mission accomplished that day.

> @Adetsky tells us how he used his background in musical theater production to integrate humanities into the daily routine of a clinical team. Each day the team spends 4 minutes to view a Music Video to hone powers of observation and set the mood for the day.

To hone their powers of observation, I ask them specific questions; sometimes before the viewing, sometimes afterwards. Christine Hudman's performance of "Welcome Home" from the musical *Bandstand* is perfect for this exercise. What is this show about? (A returning World War II soldier). What is the message of that song? (Welcome home, I have missed you). What musical or dramatic techniques did they use to engage the audience? (Key change, drum roll, riffing notes.) These exercises complement the way I teach them to use inspection of patients[2]—to really look at them—as a foundational clinical skill. But most importantly, the music video sets a mood for the day and brings the team together.

When I first started doing this, I worried that the residents would resent using their valuable time in a way that seemed tangential to the task of the day. I knew that I had to set the tone to get them to disconnect with the pressing issues on their to do lists. Before showing the first video to a new group, I explain the purpose, ask them to put their phones, lists, and pagers on the table in front of them, and just relax, watch, and listen. Because I sit at the end of the table farthest from the screen, I can tell who is absorbed (they sit very still, eyes glued to the screen) and who is not (they fidget and look at something else). Some of them nod their heads or sway rhythmically; some tap their feet or hands. At the end, they often clap. And while I have not done a formal evaluation, some of them spontaneously tell me it was their favorite part of the day.

This teaching method is not unique. Moniz et al published a scoping review of 769 records of the use of arts in medical education including literature, narrative writing, theatre, film, comedy, and graphic novels.[3] The same authors proposed a theoretical framework for doing so.[4] But I had no such formal structure or evaluation strategy. I was simply looking for something to counterbalance all the sadness we see in our patients—a sadness that was exacerbated during the COVID-19 pandemic. Over time, this activity has grown into something more: a chance to integrate thought processing and skills I learned in my "second career" in theatre into my day job. It occurs to me that many clinicians who teach medicine can do likewise; either by using the "playlist" I have provided or creating a new curriculum that taps into their own interests outside medicine. Doing so requires a teacher to be brave and take risks—the students may not like what we have to offer. But maybe they will.

I look forward to the day we take our masks off in our clinical settings and see each other again. But I am pretty sure that even when that happens, the Music Video will remain an important part of my routine.

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patients. These characteristics span all settings where general internists provide care. General internal medicine is a broad dynamic field that requires ongoing learning and skill development, a feature that attracted many of us into general medicine.

Last year, the American College of Physicians (ACP) launched a campaign to remind the public that "internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment and compassionate care of adults across the spectrum from health to complex illness," are "experts in complexity," and "see the big picture."[2] This campaign is much like SGIM's Proud to be GIM campaign launched in 2015.[3] ACP goes on to differentiate between general internal medicine and internal medicine subspecialties and specifically notes that GIM physicians "lead in diverse roles and settings" and provide care in hospitals, outpatient offices and clinics, long-term care facilities, and other settings. I was relieved to see that ACP viewed general internal medicine as a practice that unites us, even though there are differences based on where we provide care.

Why is this important? First, we care for the same patients. Hospital-based colleagues care for our primary care patients when they are hospitalized. Primary care-based colleagues participate in the transition of patients from the hospital back to primary care to complete the treatment plan started in the hospital. Successful care transitions depend on our collaboration. Furthermore, the lines between where we deliver care are blurring. For example, hospitalists now staff hospital at home programs once the purview of outpatient-based general internists and geriatricians[4, 5] or discharge clinics for patients with severe heart failure or other conditions where close follow-up is important. Patient care and continuity of care are enhanced by close collaboration of general internists across all care settings. As a general internist who works in the outpatient clinic and staffs an inpatient ward team eight weeks a year, I see this in action, and research done by SGIM members addresses improvements in transitions in care between these two settings.

Second, general internal medicine physicians have flexibility in their careers over time. I know many people who have practiced in one setting and later in other settings. One of our former chief residents started in hospital medicine, transitioned to nursing home care and leadership, and is now back in our primary care clinic with a desire to teach residents in this setting. This is an important career advantage that I discuss with residents on the fence between subspecialty medicine and general internal medicine.

Finally, and most important, we are better and more persuasive together. SGIM members are academic general internists, adding education, research, and clinical leadership to our clinical roles. We are a vibrant Society with people passionate about clinical care, education, research, and advocacy. When collaborating and bringing together our diverse perspectives, skills, and knowledge, we have a better view of a challenge, not unlike our ability to see the whole patient instead of one disease. Because of this broad perspective and our diverse viewpoints, we are more likely to find creative ways forward. We need each other as we face the complex challenges of health, health care, and society. I look forward to meeting these challenges together.

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Milestone Gap remains. Frontline clinicians are busy. Many of the Milestones are nuanced, such as "reflective practice and commitment to individual growth" or "the physician's role in healthcare systems," and are difficult to assess amidst the hubbub of patient care. There are many other priorities in medical education: well-being, duty hours, procedural supervision, and patient safety. The reservoir of enthusiasm for Milestones is limited except for the most stalwart amongst medical educators.

While efforts to ground assessment in clinical work using Entrustable Professional Activities (EPAs) has been embraced by a number of specialties, there remains much speculation as to whether this approach improves the accuracy of frontline faculty assessments.[5] Milestones 2.0 is an important step forward—it incorporates 10 years of accumulated experience and feedback—but there remains significant work to be done to ensure valid assessments of trainees. A recent report by Hamstra and Yamazaki stressed the importance of implementing continuous quality improvement (CQI) system to monitor the quality of assessment data to produce summative metrics that can be relied upon for high-stakes decisions, many programs lack the resources to implement such measures.[5]

Assessment and feedback have become an increasingly complex endeavor that now has an alphabet soup of jargon: CCCs, CQI, EPAs, and ILPs (Individualized Learning Plans). Further, significant time and growing expertise are required to ensure high-quality assessment programs.[4] To close the Milestone Gap, we believe an important innovation is for institutions and programs to designate an assessment officer, an individual with advanced training in assessment, validity frameworks, and competency-based education who serves as a local resource for programs. The assessment officer coordinates efforts to implement Milestones, trains clinicians to use them, monitors how Milestones are used, coaches CCCs in effective practices, and works with struggling programs. In addition, assessment officers have training in psychometrics and data analysis to provide ongoing evaluation of assessment data to ensure it is sufficient to make the high-stakes decisions required of residency training. In turn, each residency and fellowship program should identify an assessment officer who should be trained and supported to focus on the specifics of their program.

In recent years, institutions have identified Wellbeing and Diversity, Equity, and Inclusion (DEI) officers. Often, there are leaders in these domains at every level of an organization. At many institutions, each hospital, department, and program has a designated person to support initiatives in Wellbeing and DEI. Given the complexity of assessment and feedback, and the challenges in closing the Milestone Gap, we believe institutions should designate an assessment officer at each level of the organization—from the GME office to each residency and fellowship.

The duties of the assessment officer are manifold. First, they need to design assessment tools that are user-friendly and relevant to the clinical experience. This is no easy task. A surgical theater is very different from a continuity clinic, and the expectations of trainees vary between and across specialties. Tailoring the assessments requires a team approach, deep understanding of required tasks, and expertise in assessment design. Second, while faculty training is important, the assessment officer needs to incorporate assessment seamlessly into the rhythm of clinical duties. This requires innovation and continuous quality improvement. Third, the Assessment Officer needs to assess the overall progress of the programs. Do we have a deficiency in professionalism across all trainees? Are there particular rotations where learners struggle? The big picture view is critical for designing programs-wide improvement initiatives. Fourth, the assessment officer can support the CCCs as they identify struggling trainees. While critics may highlight the cost, we believe there is a greater cost if we do not adequately assess our trainees and give them proper feedback.

The Milestone Gap endures. The resources marshalled by the ACGME to launch the Milestones project need to be met with the support of our institutions.

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causative agent. Patient education is crucial to minimize recurrent heat exposure. Physicians should know the risks associated with heating sources commonly used for chronic pain. EAI is a preventable dermatologic condition that requires healthcare providers to recognize its presentation, acknowledge risk factors, and consider more serious conditions it may mimic.

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In its advocacy work, SGIM must also call attention to the distinctions between GIM physicians and other primary care clinicians. We must find ways to collaborate with other primary care oriented professional societies in demanding increased investment in primary care, while helping policy makers understand the unique role that GIM physicians have in providing comprehensive care to patients with multiple chronic conditions or serious complex conditions.

To be effective, SGIM will need a strong network of members committed to sustained advocacy for an accurate, evidence-based, publicly accountable mechanism for the pricing of all physician services. The individual relationships that each of us develop and maintain will assure our ability to influence health policy.

EB: Mark, what should SGIM do to facilitate further advocacy for the clinical practice of GIM?

MS: To carry on John's extraordinary advocacy efforts, we need to recruit and nurture a new generation of SGIM members that have deep understanding of the history and complexities of physician payment policy, strong skills in health policy advocacy, and a passion for effecting change. Since 2017, the year-long LEAHP career development program has graduated 82 Scholars, with another 19 in the current cohort. SGIM is committed to using the LEAHP Program to train more members in health policy advocacy. The Program is fulfilling its commitments to develop members who are effective health policy advocates and local health policy experts, leaders, and teachers; offer health policy career development resources and opportunities to all members; and develop a national cadre of HPC members and broaden engagement in the Society's health policy efforts.[2]

We want to strengthen the LEAHP Program by launching a new fund-raising initiative that will enable us to offer more support to LEAHP Scholars who are doing projects that will enhance our advocacy for better support of the clinical practice of GIM. In recognition of John's decades of relentless advocacy and inspiring leadership, we propose to establish the John Goodson LEAHP Scholarship Program in time to solicit applications from the cohort of LEAHP Scholars that will start in May 2024. Members may donate to the initiative by contacting SGIM's Development Officer, Liz Davey, at daveye@sgim.org.

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