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IMPROVING CARE: PART I

2024 USPSTF BREAST CANCER SCREENING GUIDELINES: IMPORTANT UPDATES FOR SGIM CLINICIANS

Jennifer L. Michener, MD; Alia Chisty, MD, MS; Megan McNamara, MD, MS

Dr. Michener (jennifer.michener@cuanschutz.edu) is an adjoint assistant professor of internal medicine at the University of Colorado. Dr. Chisty (achisty@pennstatehealth.psu.edu) is an associate professor of medicine at the Penn State College of Medicine and the Chair of the Women and Medicine Commission. Dr. McNamara (megan.mcnamara@va.gov) is a professor of medicine at Case Western Reserve University School of Medicine and the Immediate Past-Chair of the Women and Medicine Commission.

Rationale for the New Guidelines

Recommendations for breast cancer screening in average-risk women have differed widely among clinical societies, ranging from annual screening starting at the age of 40 to biennial screening starting at 50.[1] The United States Preventive Services Task Force (USPSTF), followed by many SGIM members and other generalist physicians, previously recommended biennial screening mammography starting at 50, with individualized decision making for patients in their 40s.[2] These disparate guidelines created challenges for primary care clinicians and their patients as they tried to navigate optimal strategies for breast cancer screening.

Breast cancer is the most common cause of cancer-related death in women and incidence rates have continued to rise in recent years.[3] Overall, breast cancer mortality rates have decreased over the past three decades.[3] However, there are marked racial disparities, with Black women having a 40% higher death rate than White women despite similar self-reported rates of mammography screening.[3] Additionally, disparities in breast cancer mortality for Black women are widest for women under the age of 50.[3] These factors prompted the USPSTF to update their breast cancer screening guidelines.

On April 30, 2024, the USPSTF recommended that women start biennial breast cancer screening at the age of 40.[2] The USPSTF also addressed additional screening for women with dense breasts, and determined there was insufficient evidence to assess the balance of benefits versus harms of supplemental screening.[2]

2024 USPSTF Breast Cancer Screening Guidelines[2]

- The USPSTF recommends biennial screening mammography for women aged 40 to 74 years (Grade B).
- The USPSTF concludes that the evidence is insufficient to determine the balance of benefits and harms of screening mammography in women 75 years or older (Grade I).
- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram (Grade I).

The Evidence

The updated USPSTF guidelines were based on two main sources of evidence: first, a systematic review focused on the effectiveness of different mammography-based breast cancer screening strategies, and how this impacted breast cancer diagnosis, morbidity, and mortality.[4] Second, were modeling studies that provided additional data about the

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THE STATE OF PRIMARY CARE IN THE UNITED STATES

Michael Landry, MD, MSc, FACP,
Editor in Chief, SGIM *Forum*

My professional and personal obligations increased significantly as of late—the end of the academic year, preparing for the 2024 SGIM Annual Meeting, and my work at the VA seem to occupy more of my time. I often feel that I miss out on reading great articles to challenge my thoughts and influence my actions as a physician. Therefore, I am grateful when I discover, or colleagues point out, interesting and thought-provoking articles for me. My editorial this month highlights the state of primary care—a core topic for SGIM members—and I hope it is thought provoking for you as well.

In March 2024, The Commonwealth Fund published an interesting paper that compared the state of primary care across 10 countries including the United States (US).[1] I think most SGIM members recognize the challenges and opportunities for improvement within our national healthcare system. If we stop to reflect, we can identify some aspects of primary care that work well. But how often do we compare our health care to health care delivered in other countries? SGIM has many international members who can provide some insight into their national healthcare. However, many SGIM members probably are not aware of the differences that exist in health care among countries.

The Commonwealth Fund conducted physician and patient surveys in the United States as well as Australia, Canada, France, Germany, the Netherlands, New Zealand (NZ), Sweden, Switzerland, and the United Kingdom (UK).[1] Data was generated utilizing the 2022 International Health Policy Survey of primary care physicians and the 2023 International Health Policy survey of adults aged 18 or older. Specific study components are detailed in the article.[1]

My editorial highlights the key components from this Commonwealth Fund report. Their data and analysis are summarized by the 10 items listed below from their report:[1]

1. *"Adults in the US, Sweden and Canada reported the lowest rates of having a regular doctor or place to go for care."*[1] Range 86-99%. The US is at 87% and the second lowest in ranking. Germany, the UK, NZ, and the Netherlands ranked above 95%.

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BEYOND ROADBLOCKS: NAVIGATING MOUNTING THREATS TO DIVERSITY, EQUITY, AND INCLUSION IN MEDICINE

Jada Bussey-Jones, MD, FACP, President, SGIM

"DEI initiatives are crucial in promoting a more inclusive and equitable healthcare system, ultimately leading to improved health outcomes for all individuals. Medical education must reflect the diverse backgrounds and experiences of patients and train healthcare professionals to provide more just and equitable care."

I wrote this article after an impromptu hallway conversation at the SGIM 2024 Annual Meeting with our beloved past-president, Thomas Inui. He encouraged me to embed stories and narratives into my presidential columns to introduce myself and my ideas to SGIM members. This column has deep significance for my life and career, so it seemed appropriate to try this narrative approach.

I often share with learners how my childhood experiences in a rural Georgia town, where a railroad track served as both a physical and metaphorical divide between races, provided the passion that drives much of my work. A legacy of structural racism meant my grandparents only received a grade school education—the highest possible education in this racially segregated town. They went on to die too soon from preventable social and health conditions. It is this legacy, impacting these conditions, that has driven much of my work—from providing clinical care in safety net settings to implementing research, educational, and professional interventions designed to promote broad changes to improve care for diverse populations. I have held positions and implemented many of the very programs that are now at risk from current efforts to dismantle diversity, equity, and inclusion.

In parallel with my own journey, over the past two decades, medical schools and residency programs have increasingly implemented diversity, equity, and inclusion (DEI) initiatives and curricula. DEI describes values and practices used by institutions to address historic

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Q & A WITH SGIM'S CEO AND IMMEDIATE PAST PRESIDENT ON NOTABLE ACHIEVEMENTS OF 2023-24

Eric B. Bass, MD, MPH; Martha S. Gerrity, MD, MPH, PhD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Gerrity (gerritym@gmail.com) was the President of SGIM in 2023-24.

The last few years have been very stressful for SGIM and our members. Yet, we have continued to pursue an ambitious agenda in pursuit of our mission. Now that another year has flown by, I wanted to ask our immediate past president, Dr. Martha Gerrity, about her reflections on the Society's achievements during her presidency.

EB: Which achievements of the last year give you the greatest sense of pride in SGIM's members?

MG: I am extremely proud of the Program Committee, led by Drs. Zirui Song and Jennifer Schmidt, for pulling off a fabulous Annual Meeting. The meeting achieved record-breaking attendance of 2,877 registrants and represented 90% of our 3,132 members. The meeting content was inspirational and at times heart rending, thereby reinforcing the importance of our mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine (GIM), leading the way to better health for everyone.

When I reviewed the summary of SGIM's notable achievements in 2023-24,[1] I felt enormous gratitude for the time and energy that so many members devoted to amplifying SGIM's voice on important issues that affect our patients, trainees, and colleagues, including:

- *Telehealth Policy, Practice and Education Recommendations: A Position Statement of SGIM*, developed by the Education, Clinical Practice, and Health Policy Committees (published in JGIM);[2]
- *Building Climate Change into Medical Education: An SGIM Position Statement*, developed by the Environmental Health Interest Group and Education Committee (published in *JGIM*);[3]
- *The Expert Adaptive Clinician Educator: A Framework for Future Educational Leaders in Academic Medicine*, developed by the Education Committee (submitted for publication);
- *Incorporating Anti-racist Principles Throughout the Research Life Cycle: A Position Statement from SGIM*, developed by the Research Committee and Health Equity Commission (submitted for publication);
- *Considerations for Technologists and Healthcare Organizations on the Development and Deployment of Generative Artificial Intelligence in Medicine: A Position Statement of SGIM*, led by the Clinical Practice Committee in conjunction with the Education, Health Policy, Research, and Ethics Committees and Health Equity and Academic Hospitalist Commissions (submitted for publication); and
- *Opposition to Reporting Immigration Status for Persons Accessing Medical Care*, developed by the Ethics and Health Policy Committees (posted on SGIM's website).[4]

I am grateful for the collaborative efforts that produced a record number of position papers and statements endorsed by SGIM's Council in one year.

EB: What else stands out about the work of SGIM's committees, commissions, and interest groups in the last year?

MG: Our Health Policy Committee was very active working on physician payment reform to improve payment for the cognitive work we do in providing continuous, comprehensive, coordinated care to our patients.[5] Much of this work was done in collaboration with the Primary Care Collaborative and American College of Physicians. The committee also worked on ways to support members in state and local advocacy. This work led to skill building workshops and symposia at the Annual Meeting and a section on our new website where members can find resources for advocacy as well as SGIM's position statements.

With philanthropic support from members and the Hess Foundation, we expanded career development opportunities for members and trainees. We increased the curricular scope and number of participants in the Unified Leadership Training in Diversity (UNLTD) Program. We launched the new Medical Education Scholarship Program for members who want to strengthen their skills in education-focused scholarship. We

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PRACTICING EXCELLENCE IN HEALTH CARE

Nikhil Sood, MD

Dr. Sood (Nikhil.Sood@bannerhealth.com) is a hospitalist at Banner Gateway Medical Center in Arizona, affiliated with MD Anderson Cancer Center in Houston, Texas.

It is imperative that the healthcare system focus on the well-being of its physicians and clinical teams involved in providing high-quality patient care. In 2023, the nationwide clinician burnout rate exceeded 50% for physicians and advanced practice providers.[1] Burnout costs the healthcare system an estimated $5 billion annually due to reduced clinical productivity and increased physician turnover.[2] In 2013, Dr. Stephen Beeson, a family practice physician in California, founded Practicing Excellence (PE)—a novel concept born out of the necessity to revitalize, engage, and empower clinicians by connecting, collaborating, and leading organizational change in healthcare delivery.

What Is Practicing Excellence (PE)?

Built on the concept of "Learn, Try, and Share," Practicing Excellence (PE) provides healthcare coaching for clinicians through a video-based learning app called *Clinician Experience Project* (CEP). Spending just five minutes a week, clinicians can share their experience with their teams, colleagues, and leadership to drive positive innovation. Utilizing PE, skill mastery is pursued at the individual and group level.

The Mission

Use video app-based coaching to help clinicians, nurses, leaders, and teams develop skills to improve patient and organizational outcomes while amplifying purpose and contentment. Participating healthcare professionals become inspired to perform at their highest potential and connect more effectively with patients and each other. This, in turn, translates into high-quality patient care and improved patient outcomes.

What Is the Clinician Experience Project (CEP)?

The Clinician Experience Project (CEP) is the brainchild of PE that demonstrates how a diverse range of video content using an app-based learning platform can contribute to excellence in health care. It uses the "micro-learning" approach in which clinicians spend five minutes per week learning coaching tips. These videos can also be shown in meetings or "huddles" to engage the clinical team in learning and development. Clinicians can track their progress in the app, share insights with their colleagues by commenting on videos, collaborate with hospital leadership, and implement effective organizational and policy changes. It has revolutionized patient care and safety and improved healthcare workers' mental well-being through videos focused on issues that matter in daily patient care and workflow. Over the years, CEP has earned the trust of many of the nation's largest health systems (e.g., Kaiser Permanente, Northwell Health, and Corewell Health).

How Does This Apply to Patient Care?

I work in a cancer hospital caring for vulnerable and terminally ill patients. The stressful environment, coupled with the increasing workload, complicated electronic health record systems, and mounting administrative metrics, can make clinicians feel overwhelmed, fatigued, and undervalued. Under these circumstances, it can be challenging to empathize and connect with patients and their families if the clinician cannot effectively engage in patient care. This creates a domino effect, resulting in ineffective engagement of clinical teams, low-quality patient care, and poor patient outcomes. It translates into lower job satisfaction and feelings of burnout among clinical team members.[3]

I remember watching *First Impressions*, a video series emphasizing the power of listening and its contribution to healing.[4] Afterwards, I took care of a young patient with metastatic cancer who had failed all treatments and whose oncologist had recommended hospice care the day before I met him. It had been a long, stressful night for the patient and his wife as they grappled with their harsh reality. I entered the room and observed a young cachectic patient sitting in bed with tears rolling down his cheeks. Leaning onto his shoulder, I saw his wife, with fear and sadness in her eyes, hoping for a miracle. I sat down, and we talked about their life and their cancer journey. At the end of our conversation, I asked them, *"How can I help?" The wife hesitantly responded, "Can you order something for us? We have not eaten in more than 24 hours." I replied, "I most certainly can."* As I walked away, I reflected on the difference I made through this small act by showing empathy, making them feel heard, connecting with them, and relating to their

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SCALING AGE-FRIENDLY HEALTH SYSTEMS IN A LARGE INTEGRATED HEALTH SYSTEM: LESSONS AND OPPORTUNITIES

Shivani K. Jindal, MD, MPH; Kimberly Wozneak, MS; Laurence M. Solberg, MD;
Andrea Wershof Schwartz, MD, MPH, AGSF

Dr. Jindal (shivani.jindal@va.gov) is an associate professor-clinical affiliate at the University of Cincinnati College of Medicine, Director of Transition of Care at the Cincinnati VA Medical Center and Clinical Consultant to the VHA Office of Geriatrics and Extended Care. Kimberly Wozneak (kimberly.wozneak@va.gov) is the National Lead for Age-Friendly Health Systems in the VHA Office of Geriatrics and Extended Care. Dr. Solberg (laurence.solberg@va.gov) is a professor of internal medicine of the University of Central Florida, College of Medicine, and Associate Director for Clinical Innovations at the Gainesville, FL Geriatric Research Education and Clinical Center at the North Florida/South Georgia VA Health System. Dr. Schwartz (andrea.schwartz@va.gov) is associate professor of medicine at Harvard Medical School, Associate Director of the Harvard Medical School Multicampus Geriatrics Fellowship, and Associate Director of the New England Geriatric Research Education and Clinical Center at VA Boston Healthcare System.

More than 3,800 health systems have joined the Age-Friendly Health Systems (AFHS) movement, an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI).[1,2] AFHS aim to provide reliable, evidenced-based care to older adults guided by the 4Ms—What Matters, Medication, Mentation, and Mobility—without causing harm and using "What Matters" as a central core of care alignment.[1]

In the Department of Veterans Affairs (VA), nearly 50% of Veterans enrolled in VA health care are 65 years of age or older, compared to under 20% in the general population, driving the need for Age-Friendly care across a broad continuum of services. To engage VA teams in providing Age-Friendly care, the VA hosted a national Age-Friendly Action Community initiative. From October 2022-April 2023, 186 teams participated in the first VA Age-Friendly Action Community, representing many types of care settings including outpatient clinics, inpatient units, emergency departments and Community Living Centers (analogous to nursing homes in the VA). Action Communities provide a series of monthly webinars, office hours, and coaching calls to support teams and health systems to scale-up, spread, and work towards the reliable practice of the 4Ms. Through these Action Communities and strategic planning, VA is transforming into the largest integrated health care system in the United States to be recognized as Age-Friendly by the IHI.[4]

VA followed the IHI's Action Community model, using the 4Ms as a framework for the monthly webinars presented by interprofessional experts. Coaching calls, with the addition of an introductory 4Ms workshop, taught application of the 4Ms and basic concepts of quality improvement. Participants were encouraged to review their current processes in the delivery of 4Ms care and taught how to build a team for this endeavor. The Action Community also featured sessions on how to set an aim and how to apply their knowledge of the 4Ms in learning and action periods between webinars through Plan-Do-Study-Act cycles. By the end of the VA Action Community, more than 50 of the 186 participating teams earned Level 1 AFHS Participant recognition from IHI, by submitting a robust plan to deliver 4Ms care. This Action Community has helped the AFHS movement grow to more than 100 facilities across VA.[4]

Lessons Learned and Recommendations

Through experience from local facility implementation of AFHS and during the action community our team has learned the following pearls. We highlight this advice during the action community webinars and coaching sessions to aid teams in their Age-Friendly journey. These learning points can be utilized across all healthcare systems and clinical settings.

1. The 4Ms are intended to be practiced as a set. There are evidence-based tools to "assess and act on" each individual M, but the teamwork and care alignment that comes from the interaction of the 4Ms with each other is what achieves the goal of delivering Age-Friendly care.
2. Take time to understand your current process in delivering 4Ms care. Depending on the clinical setting, dive into that "M" that needs the most improve-

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ment. This approach can help to identify what the team is already doing while giving the opportunity to recognize effective delivery of care and opportunities for improvement without being overwhelming.

3. Institution-specific Age-Friendly resources and guides contribute to the culture change that comes with implementing the 4Ms. We found that tailoring some of the language and materials to VA terminology, electronic medical records, and unique structures has been helpful for the groups to implement at local facilities.
4. Providing coaching and sharing success stories enhances the experience of participating in the Action Community for frontline clinicians. Learning which approaches have worked at other VA facilities helps to reduce the need to "reinvent the wheel" thereby reducing the burden of implementation. Lastly, teams learning from each other convey that AFHS is valuable and doable for their clinical setting.
5. Interprofessional leadership is important to the success of AFHS implementation. Having champions that are experts in each 4M can help with buy in and distribute the assessment and act on workloads of AFHS.
6. AFHS is a team approach—include all interested parties and interprofessional colleagues. Identify a champion to pull the team together. Teams may also include a leader/sponsor in a higher leadership position who can work to remove barriers and communicate across care settings.
7. Everyone on the team has a role not only to provide guidance on clinical practice but also to demonstrate communication and coordination—showing the effectiveness of a shared language.

When asked to share their experience in the VA Action Community, participants said that this "was a great learner experience and I will continue to implement this into my practice" and the VA Action Community "was so much fun to be a part of and I learned so much!" They also expressed gratitude for the tools, knowledge, and resources shared during each webinar.

Conclusion

AFHS is a framework to reduce cognitive load to help clinical teams deliver evidence-based care to older adults, with complex care needs, across the healthcare continuum. SGIM is a leader in general internal medicine which encompasses care for older adults and is able to champion this framework. In addition, Medicine trainees see value in implementation of AFHS on inpatient medicine services and see this as a tool to help care for hospitalized older adults.[5] SGIM members supporting this mission in academic medicine can consider incorporating the 4Ms framework into their teaching to aid in the spread of the framework.

Having the 4Ms of AFHS practiced in all patient care settings can demonstrate that the healthcare system is "speaking the same language" with the goal of aligning care with "What Matters" to the patient, their family, or caregiver.

For other health systems committed to the AFHS movement, participating in and/or leading an Action Community may serve as a tool to overcome challenges to implementation. Action Communities can facilitate a positive, peer-to-peer learning experience and create a space to share innovative best practices through small groups and coaching sessions. Due to the success of the first Action Community, the team is now running a second VA Action Community from January-July 2024 that has more than 400 VA teams participating.

Any frontline clinician can become an Age-Friendly champion, and joining an Action Community is just one way of getting started.

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SPEAKERS BUREAU: A GRASSROOTS EFFORT TO SUPPORT ACADEMIC PROMOTION

Jennifer Koch, MD

Dr. Koch (jennifer.koch@louisville.edu) is a professor of medicine at the University of Louisville School of Medicine where she serves as Vice Chair for Faculty Affairs & Education.

Achieving academic rank promotion is a rigorous process for all physicians, but generalists face additional challenges.[1] Many full-time clinicians or clinician-educators have less time and fewer opportunities for scholarship, especially those leading to publication. In turn, this leads to lower rates of advancement to full professor among generalists as compared to medical specialists, surgeons, and basic scientists.[2] Some medical schools changed their promotion criteria to better accommodate the types of scholarly activity most frequently contributed by clinicians and clinician educators; however, the promotion process remains daunting for many.[3]

While academic promotion is based on the achievements of an individual, the truth is that having a network of colleagues is an important prerequisite for scholarly productivity. This can take many forms—for example, being invited by a colleague for a speaking engagement, banding together for a multi-institution workshop submission, or performing multi-institutional research that leads to publications. In this sense, academic promotion is more of a team sport than it might first appear. How can we better help clinical faculty find their "teammates?"

In 2006, I was completing my first year as an Assistant Professor, and I was (erroneously) "certain" about two things: first, everyone in my professional societies seemed to know each other, except for me. I did not yet feel connected to my potential teammates—colleagues and mentors outside of my institution. Second, it would be nearly impossible for me to ever reach the rank of Full Professor as a clinician educator. It was very uncommon to do so in my department at the time, so internal mentorship in this area was scarce.

I am happy to say that I overcame my imposter syndrome, learned the importance of as well as best practices for networking, found my niche in scholarship, and reached the rank of Full Professor. This happened in large part through meaningful collaborations with many of my SGIM colleagues. Several years ago, I saw the opportunity to facilitate this process for others and pursued it.

I posted on a discussion board asking for speakers for a faculty development series, presenting it as a wonderful opportunity for junior faculty willing to give a virtual talk without monetary compensation. In return, the volunteer speakers would earn an invited speakership to list on their CV as well as expand their networks via this virtual interaction. My e-mail inbox was flooded with responses. With only six speakerships to offer and more than 50 volunteers, the situation revealed a clearly unmet need. By simply offering up an electronic form to sign up as a speaker and granting access to a spreadsheet listing those names, the Speakers Bureau was born. In its first year, 173 faculty from across the country signed up as potential speakers. By retiring the list annually and starting anew, speakers need to recommit and revise the topics they are willing to present, and users are assured that the information is up to date. In its third year, 285 speakers enrolled within the first two weeks.[4]

As a single volunteer maintaining this effort, tracking usage is not possible, but anecdotal feedback has been both robust and positive. Dr. Katherine Schafer, Associate Professor at Wake Forest University School of Medicine, offered this perspective: "Participating in the Speakers Bureau created opportunities for me to present at academic institutions across the country where I may not have been invited otherwise. The Speakers Bureau facilitates speaking opportunities for faculty outside of the traditional approach of inviting people who publish in certain areas of expertise."

I am currently working to populate a third faculty development series at my institution by recruiting from the list of speakers. For a couple of sessions, in previous years, I was able to match up two speakers from different institutions who wanted to speak on the same topic. For these faculty members, the intangible benefits of the Speakers Bureau were multiplied, as their CVs now reflect a collaborative speakership, and by working together, they have expanded their own networks. Several speakers subsequently asked me to write letters of evaluation for their promotions, revealing an additional advantage of the networking achieved by using this simple tool. (Kudos to the Promotion Support for Women in Medicine [PSWIM] initiative which has led an amazing grassroots effort to help educators get the letters of evaluation they need for promotion![5]) I am also hopeful that tools such

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BOB MARLEY: BUILDING PATIENT TRUST THROUGH A FAMILY-BASED APPROACH

Aprotim C. Bhowmik, EdM

Aprotim Bhowmik (abhowmik1@pride.hofstra.edu) is a fourth-year medical student at the Zucker School of Medicine at Hofstra/Northwell in New York City.

"*I'm not taking it. That shit is going to fuck up my body.*" His glazed eyes sluggishly focused on my notes. "*Is that my journal? Why are you reading what I wrote?*"

I assured him that my papers were chart notes, but the 21-year-old patient wouldn't have it. "*I make videos on YouTube and need to get back home to paint my room for Valentine's Day. I need to talk to my mom. Can you check on that van outside? I don't like the look of it. Tell them not to mess with me.*"

I glanced over at the medicine attending and psychiatry consult team. They nodded, and I told the patient that we'll talk to him again later, monitor his COVID-19 symptoms, and do our best to keep him safe.

Despite having taken valproic acid for seizures in childhood, he did not want to take it again for mood stabilization. Risperidone was not even in his purview. He didn't feel impaired—rather, he felt ready to go out into the world and grab his opportunities by the scruff of the neck. Psychiatric medication—from his perspective—would hold him back.

"*We can put him in therapy, but we'd like to avoid meds. We know him well.*" The parents made it clear that they would take care of their son. "*We know about valproic acid from our time in Trinidad, and we don't think it's needed at this time.*"

Each following day, I would drive to the hospital from Jamaica, Queens—a hub of Caribbean and Indian culture. I knew from my personal background and the experiences of friends, how certain cultures frowned upon and strictly avoided conversations about mental health. To that point, medications indicated for mental health treatment (e.g., valproic acid) are often met with opposition, even when those same medications may be welcomed for other clinical indications.

Day by day, the 21-year-old aspiring videographer got worse. "*I told you to take care of that van! They're messing with me. I'm not safe here.*" The nursing staff relayed to us that on multiple occasions, he had picked up his stool from the toilet and placed it in the sink, had accused other patients of spying on him, and had broken down in the hallway in tears.

"*Other patients keep trying to sabotage me. They don't want me to leave the hospital.*" We reassured him that he would be safe, and over the phone, his parents tried to comfort him: "*We'll go see the new Bob Marley movie together, son. We know you've been looking forward to it.*" But with the lack of improvement in his symptoms, it was clear that his parents were beginning to lose hope.

Later that evening, during visiting hours, as I walked around the floor, I caught a glimpse of the patient, tears in his eyes, head resting on his mother's chest, her fingers massaging his forehead.

I relayed what I had seen to my attending and the consult team. We decided to request a family meeting, in-person, the following day. When his parents came into the hospital, we spoke to them candidly.

"*We're all rooting for him,*" we told his parents. "*He's such a sweet young man. And we really think that these medications can help him feel better, but without them, his prognosis is not as promising.*" In response, to our surprise, the parents engaged with us with alacrity. They had been researching valproic acid and risperidone and were concerned, but hopeful. They wanted to know about its side effects, risk of addiction, whether the medications would alter his personality—the whole nine yards. We answered every question, one-by-one, until they understood.

We walked to the patient's room together.

"*Son, how are you feeling?*"

"*I love you, mom. I love you, dad.*" Tears rained down his cheeks.

"*We love you, too. And we really will see that Bob Marley movie together. But before we do, we want you to feel good, to feel like yourself again. You'd like that, wouldn't you?*"

He nodded, sniffling and reaching out for father's hand.

"*Son, the doctors say that the meds will help, and we believe them. Can you try taking them for us? We think you will feel like yourself again.*"

In many cultures outside of the West, trust is in community, in family—to an extent that we might not

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inequities and support healthcare workforce representation that meets the needs of our increasingly diverse society. Many of these efforts followed the landmark 2003 Institute of Medicine "Unequal Treatment" report documenting widespread bias and racism contributing to disparate health outcomes for certain populations.[1] Efforts further intensified in the racial reckoning that followed the murder of George Floyd in 2020. By 2022, an Association of American Medical Colleges (AAMC) survey found that 96% of US and Canadian medical schools reported some integration of DEI into their curricula.[2]

Threats to Diversity, Equity, and Inclusion (DEI)

As new roles, programs, and investments in DEI were emerging, so were the threats to undermine these efforts. On June 29, 2023, the U.S. Supreme Court ruled that race-conscious admissions violated the Equal Protection Clause of the 14th Amendment.[3] Several schools with fledgling and established programs cited this ruling as reason to halt or dismantle DEI efforts, often with stronger restrictions than called for by the ruling. Several states have gone even further to ban DEI efforts in higher education by limiting funding that necessitates state-funded universities to close their DEI offices.[3] As of May 2024, there are more than 30 bills across the country targeting DEI initiatives. A more recent bill targets medical education specifically. On March 19, 2024, Rep. Greg Murphy, MD, introduced the Embracing Anti-Discrimination, Unbiased Curriculum, and Advancing Truth in Education (EDUCATE) Act.[3] If passed, this bill would stop medical schools that adopt certain DEI policies and practices from receiving federal funding, including federal student loans.

Impact

These attacks on DEI efforts have already had tangible negative results. Many DEI faculty have lost their jobs, were compelled to shift their careers, or move their families for additional opportunities. In addition, many faculty with DEI focused academic careers have been faced with limited ability to present their work and engage at academic conferences as their institutions no longer fund DEI related travel and scholarship. Importantly, DEI leaders have faced increasing scrutiny along with threats, harassment, and intimidation. Beyond DEI leaders, these consequential decisions will harm our country's health for generations—widening the ongoing diversity gap among physicians. Physicians may avoid training and work in states with these limitations, further restricting healthcare access.

Case for Supporting Diversity, Equity, and Inclusion (DEI)

In the face of these threats, the case for DEI remains strong. Academic general internal medicine physicians have the unique privilege of preparing physicians, researchers, and other healthcare professionals to provide high-quality care in a diverse society. Engaging diverse perspectives and backgrounds in classroom, clinical, laboratory, research, and community settings, enriches the educational and work experiences of our learners and colleagues. Diverse learning and clinical environments are important to provide future physician leaders with skills needed to interact, engage, and lead change across complex health systems.

To be clear, DEI efforts are not only about historically marginalized groups—a growing body of research demonstrates the benefits of DEI efforts in maximizing organizational performance. Diversity cultivates creativity and discovery and enhances financial performance.[4,5] Diverse scientist teams have also been associated with better patient outcomes and higher impact of scientific findings.[4] For learners, increased student diversity strengthens skills needed to care for diverse patient populations, and stronger endorsements for equitable access.[5]

Ultimately, legislators and politicians cannot tell us how to be clinicians or define what is important in our profession. Accrediting bodies like the Accreditation Council for Graduate Medical Education (ACGME) and Liaison Committee on Medical Education (LCME) should "override" this legislation. Healthcare professionals and medical schools are in the best position to determine how to prepare our learners to meet societal healthcare needs. DEI initiatives are crucial in promoting a more inclusive and equitable healthcare system, ultimately leading to improved health outcomes for all individuals. Medical education must reflect the diverse backgrounds and experiences of patients and train healthcare professionals to provide more just and equitable care.

The Role of SGIM

SGIM is well-positioned to lead on this issue. At my first SGIM meeting more than two decades ago, SGIM's commitment to health equity for patients and diversity and inclusion among our learners and colleagues was evident. Our organization and its members prioritized and led innovations in DEI well before it became a popular trend or the product of mounting scrutiny. DEI has been a long-term core value, and that will not change.

Even with these national and statewide challenges, SGIM is committed to diversifying our physician work force. We have started by publicly reaffirming our support for DEI in medical education. SGIM signed on to a joint letter to Senator Murphy along with several other societies in strong opposition to any efforts to ban DEI programs in medical education. We further endorsed a resolution introduced by Rep. Joyce Beatty and Congresswoman Kathy Castor recognizing the importance of DEI in medical education and push-

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2. *"In all countries surveyed, only two countries report more than 10% of primary care physicians having high telehealth use."*[1] Range 0-28%. The US is at 2% and ranked the fourth highest among the 10 countries, while NZ and the UK were the only countries greater than 10%.
3. *"US adults are the least likely to have access to home visits by a primary care provider, with less than a third offering this service."*[1] Range 29-100%. The US ranked last at 29% while Canada was next at 67%. The other eight countries were greater than 75%. It is noteworthy that Germany and Netherlands were both at 100%.
4. *"Less than half of adults in the US and Australia reported having a longstanding relationship with a primary care provider."*[1] Range 43-76%. The US ranked last (43%) while eight of the 10 countries exceeded 50%.
5. *"Over half of primary care physicians in the majority of countries reported that their practices had arrangements for patients to be seen outside of normal hours."*[1] Range 16-91% with the US ranked as fourth lowest at 52%. Of note, Sweden, and the Netherlands both were at 16% while France was the highest ranked (91%).
6. *"US, German and French primary care providers are the most likely to screen their patients for social needs."*[1] Range 8-32%. The US and Germany ranked highest while the Netherlands ranked lowest. The shocking part of this statistic is that two out of three patients were not screened at all for social needs in any national healthcare system.
7. *"More than half of physicians reported at least one challenge with coordinating their patient's care with social services."*[1] Range 55-85%. The US ranked fourth lowest at 63%.
8. *"Over 90% of physicians in every surveyed country said their practice was prepared to manage their patient's behavioral health needs."*[1] Range 90-99%. The US ranked second lowest at 91% while the Netherlands and Australia ranked highest at 99%.
9. *"More than two-thirds of adults reported their regular doctor has helped to coordinate or arrange care from other doctors or places."*[1] Range 27-68%. The US ranked fifth highest at 66% while Sweden and the UK ranked lowest at 27% and 49% respectively.
10. *"Less than half of primary care providers in Sweden, the US, the Netherlands and Germany report adequate levels of coordination with specialists and hospitals about changes to patient's care plans."*[1] Range 20-72%. The US ranked third lowest at 41% while Germany (20%) and NZ (72%) were lowest and highest in ranking.

What did The Commonwealth Fund conclude were the common systemic issues affecting primary care in the United States? SGIM members in the United States are acutely aware that our patients lack access to care, continuity of care, and after-hours care—they may also be forced to see different providers to meet their healthcare needs. There are fewer trainees entering the field of primary care due to lower salaries, higher administrative burdens, decreased visit time, increased inter-visit care coordination, and decreased support staff. These were all themes supported in The Commonwealth Fund report.[1]

The Commonwealth Fund proposed five solutions in their article.[1] Reading these solutions reminds me of themes I have heard at many SGIM meetings and in discussions with SGIM members:

1. *Invest in primary care.*[1] A striking statistic in the article references that the US spends 4.7% of its total healthcare spending on primary care in 2021 compared to 14% average spending in peer high income countries. Think what a 10% increase in spending on primary care could do to improve the health of our patients and the satisfaction of our physicians.
2. *Grow the primary care workforce.*[1] High tuition leading to exorbitant medical student debts and low primary care salaries disincentive trainees from considering primary care as a viable career. There are some programs within the US and other countries to incentivize practice in rural and underserved areas and the VA has recently implemented a medical school tuition payment program to recruit physicians with a longer-term vision. The first Native American affiliated medical school, in conjunction with Oklahoma State University and the Cherokee Nation, graduated 46 students with 20% being Native American. Kaiser medical school in Pasadena, California, graduated an inaugural class in 2024, and new medical schools are planned in Colorado, Bentonville, Arkansas (funded by the Walton family), and the HBCU Xavier University in New Orleans, Louisiana, over the next few years, to name just a few. It will be interesting to see if these new medical schools unaffiliated with traditional academic centers assist in filling the gap for primary care providers since the focus of many academic medical centers is on high revenue generating specialty care.
3. *Reform payment for primary care.*[1] Specialty physicians have higher salaries than primary care. The SGIM Health Policy Committee has advocated for payment reform for many years to increase payments for critical

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benefits and harms of different breast cancer screening strategies.[5]

The systematic review, published in *JAMA*, did not find sufficient evidence to determine when to start or stop screening.[2,4] Collaborative modeling suggested that lowering the start of screening to age 40 rather than 50 resulted in fewer breast cancer related deaths, with Black women benefiting most.[5] Given this modeling study, the increase in breast cancer incidence rates, and the high mortality rate for Black women, the USPSTF concluded there was sufficient evidence to lower the screening age to 40 for all women.[2,3,5]

Lowering the screening age to 40 does increase the rate of false-positive findings on mammography and results in increased biopsies of benign lesions.[2,5] This was determined to be an acceptable risk given the associated reduction in breast cancer related deaths.[2,5] Annual mammography increases the rate of false positive findings without any decrease in mortality, prompting the USPSTF to recommend biennial rather than annual screening.[2] However, this decision has been met with controversy by some experts.[2]

Hot off the Press! Read about the Updated USPSTF Breast Cancer Screening Guidelines!

Collaborative modeling demonstrated a decrease in cancer related deaths for women age 74-79, but the trial emulation study did not show a reduction in the hazard ratio or the absolute breast cancer mortality, and this underlies the rationale for not extending the recommended cancer screening to age 79.[2,5]

Discussion

While the updated USPSTF guidelines do not add much clarification for primary care physicians about when to stop screening or the optimal screening modality for women with dense breasts, they do provide an important update on the age to begin screening for average-risk women.[2] These recommendations are now more in line with other society guidelines,[1] though public comment demonstrates that some experts are still calling for annual rather than biennial screening.[2] Public comment also revealed controversy over the decision not to include additional MRI screening for women with dense breasts and not to extend the screening age to 79.[2]

> **"As SGIM members, it is essential that we begin thinking about ways to improve breast cancer screening rates for women in their 40s."**

These guidelines highlight a significant practice change for all clinicians who treat women patients. As SGIM members, it is essential that we begin thinking about ways to improve breast cancer screening rates for women in their 40s. We should address the new USPSTF guidelines with our patients during scheduled office visits. However, it is also imperative that physicians address breast cancer screening, diagnosis, and treatment on a systems-based level.

As clinicians and health systems leaders, SGIM members should be keenly aware that access to mammograms will likely be impacted by these expanded screening guidelines. It is critical that Internal Medicine clinicians work with Radiology colleagues to address equal access to screening mammography for all women, and to ensure those with abnormal screening mammograms and exam findings have timely access to diagnostic studies. Finally, we must remind ourselves that a major aim of these guidelines was to improve disparities in breast cancer mortality for Black women.[2,5] The modeling studies that inform these guidelines make assumptions that approximate reality: breast cancer treatment effectiveness is lower for Black women for a variety of factors, many of which are rooted in sustained and systemic racism.[5] To achieve equity, screening is not enough. We must ensure timely, accessible, evidence-based diagnostic studies and treatment for all.

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enrolled the second cohort of participants in the Veterans Affairs Partnered Research Program. We also established the John Goodson Leadership in Health Policy Scholarship Fund. The fund will be used to assist participants in our Leadership in Health Policy (LEAHP) Program with projects related to clinical practice or physician payment reform. Finally, we gave 65 scholarships to fellows through the Investing in GIM Membership Program, and 60 scholarships to medical students and residents through the National Young Scholars in GIM Fund.

EB: What stands out about the work done by SGIM's staff during the last year?

MG: I enjoyed working with a talented group of staff that shares our passion for SGIM and our vision of a "just system of care in which all people can achieve optimal health." After 18 months of hard work by staff to conduct focus groups with members and renovate content, SGIM unveiled its redesigned website in February 2024. The site should enhance member engagement by offering streamlined navigation, improved search features, and enhanced accessibility options. Initial feedback has been extremely positive, with a significant increase in site traffic and user satisfaction since the launch. The staff also worked closely with members to make new educational content available to members through our learning management system known as *GIMLearn*.

I hope members will read the posted summary that provides more details about the Society's recent achievements.[1] I thank the leaders and members of SGIM's committees, commissions, interest groups, and regions for their outstanding work in advancing our mission!

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as these contribute to closing gender and race/ethnicity-based gaps in promotion rates.[1]

I look forward to the day when an organization (perhaps SGIM) requests to take over and make the Speakers Bureau an official resource. In the meanwhile, I am pleased to do my part to assist SGIM colleagues who may feel the same way I did back in 2006. Creating a method of providing far-reaching sponsorship to my junior colleagues has broken down some of the barriers for them to find their "teammates." Academic promotion for clinicians and clinician educators should remain appropriately rigorous, but with a little creativity, we can find ways to turn networking into teamwork, and teamwork into success in the promotions process.

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situation. These were important concepts that I learned from the *First Impressions* videos.

How Can CEP Be Helpful to Clinicians and Their Teams?

In January 2024, I attended an educational session presented by Dr. Beeson at my hospital. Following this, our hospital initiated a pilot project for the physicians and nursing staff. This project involved watching a weekly video on the CEP app and providing constructive feedback during nursing huddles and hospitalist team meetings to improve patient care. The topics included first impressions with patients, team positivity, bringing cheerfulness to work, patient experience, partnering with a nurse, efficient rounding, quality and safety, value-based care, telehealth, conveying respect for each other as team members as well as patients, how to approach goals of care and end-of-life discussions. In the first three months, we have seen steady improvement in the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) patient experience scores, which we attribute to this pilot program.

What Are Banner Health's Initiatives for Practicing Excellence in Health Care?

CEP was initially introduced to Banner Health hospitalists' teams as part of value-based care. The impact it made throughout the system by engaging physician teams has been substantial. The video discussions and experiences were echoed by clinical teams throughout our healthcare systems, influencing patient care positively and contributing to better patient experience, shorter length of stay, better physician satisfaction, and mental well-being.

In 2019, Banner Health implemented another program called Cultivating Happiness in Medicine (CHIM), aimed at reducing burnout, building resiliency in clinicians, and allowing them to bring their best selves to work. The physician led CHIM strategy provides specific opportunities to ensure the creation of valuable resources and effective tactics to support clinicians. The program involves supporting clinicians from "hire to retire," beginning with a robust onboarding program and ongoing professional development through individual and group skill building. It also provides a peer support program offering a confidential outlet and support for struggling clinicians. The advanced leadership program, reward and recognition programs, and social community are other aspects of the CHIM program. As one of the pillars of CHIM, Social Community helps build relationships and improves team camaraderie, engagement, and trust. It is an opportunity for clinicians to support one another as peers by sharing their experiences as providers with someone who shares their challenges. All these programs and activities roll into the CHIM strategy and support the provider's experience at Banner Health, impacting over 10,000 healthcare providers and helping improve our burnout results.

The CHIM program and CEP initiative combined have culminated in a record-low 7.6% total burnout for physicians at Banner Health via the Maslach Burnout Inventory (MBI) survey in 2023, well below the industry average of 9.9%. Based on the effects of CHIM on burnout, Banner Health was recognized as a 2023 American Medical Association Joy in Medicine organization.

Why Should SGIM Members Consider Practicing Excellence?

Burnout in health care threatens the health and well-being of individual clinicians and team members. It increases the risk of medical errors, resulting in suboptimal quality of care for our patients and poor patient outcomes. Burnout has contributed to early physician retirements and clinicians choosing to leave medicine altogether, resulting in an unprecedented physician shortage and healthcare crisis.[5] SGIM members can advocate for the well-being of physicians and clinical team members by providing education through webinars and podcasts, collaborating with programs like CEP and CHIM, and establishing physician advocacy focus groups to develop effective solutions to make healthcare easier for patients and healthcare providers. SGIM members are in prime positions to address the well-being of clinicians so that they can continue to do what they do best- care for our patients and the community.

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ing back against efforts to restrict federal funding for medical schools with DEI programs.

As SGIM looks for a way forward, a focus on these threats and SGIM's response will be a key component of our summer Council retreat and a priority for SGIM this year. In addition to reviewing our own programs, advocacy, and education efforts, there may also be opportunities to support research documenting the impacts of anti-DEI legislation on the education and careers of students, trainees, and faculty. DEI is not only important but also essential in health care to ensure equitable access to care, address inequities, create inclusive environments, and drive innovation in the delivery of healthcare services. SGIM can play a vital role to drive positive change in the healthcare landscape by advancing diversity, equity, and inclusion for patients, faculty, staff, and learners.

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fully understand in the United States. Embracing this communal approach to life is essential to caring for a diverse population of patients, especially when cultural barriers to medication use are present. Furthermore, these barriers do not come out of a vacuum: long histories of deceptive vaccination,[1] disparagement of non-Western medicine,[2] and medical experimentation on Black populations[3] have contributed to the skepticism regarding certain medical practices.

Understanding these histories and engaging in culturally competent medical care are essential steps for SGIM members to take when engaging with patients. Cultural competence can involve holding family meetings with patients, hiring more Black/Brown healthcare workers, connecting with representatives from cultural/religious groups in the surrounding community, and developing educational materials (e.g., online pamphlets) about commonly used and misunderstood medications.[4] Just as pastoral care is offered at many hospitals, other cultural and religious outreach can and should be available to patients. To adequately care for a diverse patient population is to offer all patients an equity of resources.

For this aspiring YouTube artist, having our team embrace a family-based approach meant that he took his medications, had a few ups and downs, but left the hospital a couple of days later with his parents on either side of him. He was grinning from ear to ear as he walked out, as were his parents. As Bob Marley famously said, "Don't worry about a thing, every little thing is going to be alright."[5]

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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

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services provided by primary care physicians. Recent changes in coding that benefit primary care are a step in the right direction, but more is needed.

4. *Facilitate better coordination between primary care and other physicians.*[1] Electronic Health Records (EHR) and interoperability across healthcare systems was viewed as a critical step in improving communication during handoffs and transitions in care. Primary care providers are often the drivers behind many of the communication efforts. The data presented here though shows that only two in three patients report this is done effectively.
5. *Reduce the administrative burden on primary care physicians.*[1] Documentation, billing, phone calls, portal messages, nursing shortages, EHRs are a sample of the administrative burdens that lead to burnout among current physicians and lead trainees to consider opportunities outside of primary care. These burdens can and must be reduced.

The Commonwealth Fund report was an important read for me. Understanding that other countries are also plagued by similar issues offers some solace, but also shows that health care across these 10 countries have significant opportunities for improvement.

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