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MEDICAL EDUCATION

# EXPECTATIONS AND CHAMPIONS MATTER IN MEDICINE

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I first read George Bernard Shaw's *Pygmalion* in high school. Shaw's play tells the compelling story of a flower girl, who, with the guidance of a phonetics professor, learns to adopt the language of upper society.[1] *Pygmalion* may be a humorous commentary on class in early 20th-century England, but lessons from the play and the Greek mythology that inspired it remain relevant today. *The Pygmalion effect*—i.e., the idea that we rise to the expectations placed upon us—is a term that has played a key role in my medicine journey, and it is time that we as physicians recognize its power in medical education.

> "It is time that we as physicians recognize the power of expectations in medical education."

## Expectations in Early Education

Psychologists Robert Rosenthal and Lenore Jacobson coined the *Pygmalion effect* in the 1960s to describe a phenomenon among school teachers, who, when prompted to believe certain students were more capable than others, appeared to treat their students differently.[2] These students, who were categorized at random, had outcomes more in line with their teachers' expectations at the end of the academic year.[2] Rosenthal and Jacobson's work was fundamental for later research on childhood education.[3]

As a child, I was fortunate to have two loving parents. Although not doctors themselves, they recognized my interest in medicine early and encouraged me to pursue opportunities in health care. Their positive reinforcement was needed as it helped to counteract less positive classroom experiences.

Some teachers met my aspirations with encouragement, while others received me with doubt. The teacher champions prevailed, and I successfully completed secondary school, followed by college, medical school, and even internal medicine residency. Despite my good fortune, I sometimes wonder where I might have landed had I not *had* the support of my parents and insightful teachers. I have seen many peers—from children of physicians to first-generation college students—question the same.

## Expectations in Medical Education

Upon graduating from medical school in 2020, I felt that I had officially "made it." But this feeling quickly faded on the wards, working in a pandemic that would ultimately define my residency training.

The hospital was an unpredictable place, and COVID-19 posed new challenges. As interns, we lacked the typical social interactions of prior classes. Developing our identities as physicians proved challenging when interactions with others were limited. Our team dynamics were also a sharp departure from prior dynamics I had observed as a student.

Upon reflection, I realized that we were operating in an environment that lacked established relationships and expectations. I say this because the clarity I received after identifying role models much later in residency was profound. Some individuals I met with once, others multiple times, and only a select few became mentors. Each of

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# THE IMPACT OF EMOTIONAL INTELLIGENCE: WHAT I WISH I KNEW EARLIER


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


*"Emotional intelligence is the single most important influencing variable in personal achievement, career success, leadership, and life satisfaction."*[1]

In preparing for a career in medicine, pressure grows and intensifies within us as we advance in our education. The pressure starts in college (if not in high school) with a focus on GPA and MCAT scores for acceptance to the "best" medical school. Once in medical school, the pressure rises for GPA, USMLE scores, class rankings, etc., to achieve highly rated residencies and fellowships. What is the common thread? These are all measurable "scores" that are based upon the Intelligence Quotient (IQ) scale. We all need a significant "IQ" to be good doctors.

But what is emotional intelligence (EI), a term sometimes referred to as *Emotional Quotient (EQ)*? "Emotional intelligence refers to the ability to perceive, understand, and manage one's own emotions and relationships. It involves being aware of emotions in oneself and others and using this awareness to guide thinking and behavior. Emotionally intelligent individuals can motivate themselves, read social cues, and build strong relationships"[2] How does EI/EQ relate to IQ? We learn through medical school and post-graduate training to treat medical conditions (IQ); but, over time, we learn to treat people (EI/EQ). Daniel Goleman postulated "our level of emotional intelligence is not fixed genetically, nor does it develop only in early childhood. Unlike IQ, which changes little after our teen years, emotional intelligence seems to be largely learned, and it continues to develop as we go through life and learn from our experiences."[3]

Once I recognized the importance of EI/EQ, I thought "Why didn't someone teach me this earlier?" EI/EQ, unlike IQ, can't be taught; EI/EQ is learned through cumulative experiences. We become better physicians as we experience the highs and lows of treating patients and from our own personal experiences. We learn to treat our patients, colleagues, and employees as people. We meet them where they are in their life's journey. We develop and invest in


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# UNLOCKING LEADERSHIP: DEVELOPING A TRANSPARENT LEADERSHIP PATHWAY PROGRAM TO EMPOWER SGIM'S FUTURE

Jada Bussey-Jones, MD, MACP, President SGIM

*"This initiative presents a unique opportunity to make SGIM leadership pathways more transparent and to intentionally support our members' leadership journeys. The successful implementation of a robust Leadership Pathway Program will enrich our members, boost their engagement, and secure the long-term success of SGIM."*

My pathway to leadership in the Society of General Internal Medicine (SGIM) began when my mentor, Giselle Corbie, MD, MSc, introduced me to SGIM by sharing her experiences and their significant impact on her career. Following her advice, I attended my first annual meeting where, although the people captivated me, I felt unsure of how to engage them. I hadn't fully grasped the nuances of academic medicine, so this meeting of academic general internists felt unfamiliar to me. I expected the conference discussions to focus on clinical management as they did in other meetings. Instead, I was inspired by the groundbreaking innovations I encountered in education, clinical practice, and health services research.

Later, I completed a fellowship in General Internal Medicine at the University of North Carolina, Chapel Hill, which solidified my commitment to SGIM. The program director, Sam Cykert, MD, was a longstanding SGIM member who encouraged us to submit our work to the Southern Regional Meeting. While I was a passive attendee at that initial national SGIM meeting, my second experience at the regional level was more intimate, interactive, and engaging. This meeting offered my first opportunity to present an oral abstract. I would go on to chair the Southern Regional Meeting and participate in other opportunities within SGIM—from serving as

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# Q & A WITH SGIM'S CEO AND DR. JOHN GOODSON: REFLECTIONS ON A CAREER IN GENERAL INTERNAL MEDICINE

Eric B. Bass, MD, MPH; John D. Goodson, MD

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After learning that SGIM Forum received enough articles to span two issues for the theme "Lessons I Have Learned in My Career I Wish Someone Had Taught Me Earlier," I also learned that long-time member John Goodson has written three books reflecting on his career in general internal medicine. I invited John to share his reflections in this interview.

**EB: Do you consider yourself to be a writer?**

JG: Hardly. I know good writing and I try to be a good writer, but I am not nearly as good as true authors. However, ever since college I have cared about how well I write. I believe in "Medical Haiku," expressing everything essential with as few words as possible. No one likes long notes. Even those who write them have trouble finding what they need. I have journalled occasionally, which I find a helpful way to achieve thoughtful resolution.

**EB: What can you tell me about the first book you published?**

JG: Through the years as a primary care internist, I had innumerable conversations with patients around their health, personal issues, and lifestyle. With time, I honed my messaging. As in advocacy, "find your message and stay on message." I jotted these down when I thought I had the most succinct wording. As a read aloud parent, I appreciated well written and illustrated books. These were the ones I enjoyed rereading.

With the pandemic, I created an illustrated adult read aloud self-help book in the format of a children's book, *Longevity*.[1] I found an illustrator with the right sense of whimsy. As the pandemic receded, and I returned to in-person care, I gave each patient a copy. You can imagine how surprised a patient is when they get a gift. Of course, many were familiar with my messages. For some, it became a coffee table book.

**EB: But you also write poetry. Tell me about the process.**

JG: There are moments in life that are particularly intense. As a primary care doctor, the continuity of the relationships spans decades. We have a privileged companionship that can create a strong bond. Such moments came unexpectedly in my 45 years of primary care, many after the death of a long-time patient. I was able to reach closure through poetry. Each was written at a single sitting. Generally, I would grab a piece of paper and write. I didn't think much about structure, but I cared about content. There was something I had to capture and in doing so, created something unique. At the completion of every poem, there was a sublime sense of satisfaction. I never showed these to anyone. When I was diagnosed with amyotrophic lateral sclerosis (ALS), I began an extended wrapping up process. This included recovering, editing, and assembling poems into books of poetry.

> **"When I reread my poems, I reexperienced the darkest days of my life and the moments that helped me survive."**

**EB: What happened with your first book of poetry, *100 Poems*?[2]**

JG: In 2005, my personal world fragmented. I needed space to grieve. At the same time, as a primary care internal medicine physician, I had commitments to patients that demanded focus. I needed a way to detach from all the thought channels to maintain clear thinking. So, I wrote poems, 100 of them. With each, I found a moment I could capture. Some reflected patient care (with names changed) while others reflected unique moments previously unnoticed. Later, I could only find ninety-nine. Did I write the last poem and lose it? Or had I achieved the balance I needed to move on? I do know that those 100 days became the foundation for a different life.

When I was diagnosed with ALS a few years ago, I reread these poems for the first time in 15 years. I assembled

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# LEADERSHIP LESSONS SHARED BY ACLGIM MEMBERS

Michael Klein, MD

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For this special theme issue of SGIM Forum, members of the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) tackled the question "Lessons I Have Learned in My Career I Wish Someone Had Taught Me Earlier." The following answers are from General Internal Medicine (GIM) leaders from across the country. Dominant themes of leadership philosophy, opportunity, culture, and guidance emerged.

One theme was the importance of understanding your leadership style and identity:

- *"Read about leadership philosophy and decide on what kind of leader you want to be. Make your leadership philosophy known to those who report to you and whom you report to. As a servant leader, my team is aware that I will serve their needs before mine. When disappointing news is handed down from up high, the team knows that I represented their interests to the best of my ability."* –Sunil Sahai, MD
- *"Great leaders know their own leadership styles and tendencies but are prepared to adapt different behavioral styles when the situation calls for it. Flexing into a different style does not make us less authentic; instead, it makes us adaptable which is so important in our ever-changing academic health-sciences environment."* –Elisha L. Brownfield, MD
- *"One lesson I have learned is to truly understand who you are as a person—your core values, your preferred leadership and conflict styles, your 'true North.' Over the years, this has helped guide me in deciding how and when to bend without breaking, how to move the work forward without compromising my integrity, and when to stand firm in the storm."* –Rita Lee, MD

Understanding the value of opportunity was also a notable theme, including self-advocacy, networking, mentorship, and keeping options open:

- *"Start with maybe. There's always time for no and rarely a reason to rush to get there. Be generous with opportunities and credit. Your contributions will be apparent enough on their own, and your value is best measured in the success of the people you support. Love the people you work for, even when they forget to return the favor."* –Mark Earnest, MD
- *"Earlier in my career, sponsorship was happening around me, and occasionally, for me, but the concept had not been explicitly identified as key to career advancement. I wish that someone had made me aware of the power of sponsorship, and the importance of building a diverse network of both mentors and sponsors to support my career advancement."* –Mitchell D. Feldman, MD
- *"Build a solid network of mentors, coaches, and sponsors to navigate career decisions. Rather than waiting until someone 'taps' you or until you feel you've accumulated the necessary skills, use your network and your values/mission to determine which opportunities to pursue. Don't be afraid to do it scared!"* –Eliana Hempel, MD

A third notable theme was culture, including the value of synchronous communication, whether over the phone or in-person interaction:

- *"Culture is critical. Fostering an environment of collegiality, mutual respect and support among the team is invaluable and sustains you through the difficult times. While technology allows us to connect in different ways, don't underestimate the value of meeting face-to-face such as scheduled meetings with your admin, team member socials, monthly updates, and annual check ins."* –Nancy M. Denizard-Thompson, MD, and Kirsten Feiereisel, MD
- *"Every time you meet a peer or leader ask if you can exchange cell numbers. The power of sending or receiving a text stating 'do you have 5 minutes to talk about XXX' is enormous. The ability to have an immediate synchronous conversation, whether it is to build a coalition, ask for a favor, or solve a crisis cannot be underestimated."* –Eric Green, MD

Finally, there was a theme of clinical guidance and presence, including emphasizing interdisciplinary care collaboration:

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# THE LUXURY OF TIME: A GERIATRICIAN'S REFLECTION ON LIFE'S MOST VALUABLE RESOURCE

J. Isaac Pena, MD, FACP

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*One hour… six months… 100 years*. These may seem unrelated, but they share a common denominator: they are units of time, undoubtedly one of the most valuable resources we have. As a mid-career physician, I learned that these disparate units of time are more and more connected. I aim to explore the significance of time in geriatric care, highlighting the benefits of extended patient visits, the importance of recognizing hospice eligibility, and personal experiences with aging and loss.

Office visits last on average 18 minutes.[1] However, in Geriatrics, new patients still have one-hour initial visits. I wish now that I had applied for a geriatric rotation as a medical student so I could better appreciate the roles of a geriatrician. I would have enjoyed learning how to perform a comprehensive geriatric assessment and review the patient's concerns without major time constraints. The privilege of these extended visits facilitates answering a possible barrage of questions and, most importantly, connecting with patients in a more impactful way. For instance, this extended time helps me understand their goals for the next 10 years, analyze their social network and even learn the names of their furry loved ones. It is one of the perks of taking care of this vulnerable population.

One of the expectations of a geriatrician is to identify patients properly who might qualify for hospice services, defined as having less than six months to live. I learned this quickly during my first months as an attending physician. The knowledge and skills to recognize a patient at the end of their life were acquired during my fellowship training, but I wish more primary care doctors had a hospice rotation to better understand how they can assist older adults who qualify for hospice care. The question "Will I be alive in six months?" can be intimidating but can arise during that first visit. Sharpening this skill takes practice but helps to set up realistic expectations.

It becomes a challenge to identify if a centenarian woman has six months left to live, but it is more difficult when that person is your grandmother. Having a close relationship with my 100-year-old *abuelita* (grandma) helped me witness her decline first-hand. She was a forward-thinker, courageous, energetic, and had a younger-looking appearance than other people her age. I learned from her that age is just a number. My heart saddened the last time I saw her and said, "I will see you again on your birthday." Unfortunately, she passed away a few months later.

After spending half a decade as an attending geriatrician and understanding the value of time a little better, I am thankful to connect at a deeper level with my patients by having one-hour visits, assessing patients needing hospice at the beginning of our healthcare journey, and honoring my deceased centenarian grandmother.

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SGIM

## PRESIDENT'S COLUMN *(continued from page 3)*

an abstract, workshop, and vignette reviewer to serving on committees, commissions, and Council. These experiences culminated in my current role as SGIM President.

My mentor, fellowship, and early experiences provided the roadmap and sponsorship for leadership and engagement in SGIM. However, I recognize that this journey is not the same for everyone. In a previous SGIM Forum article,[1] I highlighted that our members' voluntary service and leadership represent our greatest strength. It also poses a significant challenge, as SGIM, like many organizations, has experienced a decline in volunteer leadership.[1, 2] To address this concern, I proposed a proactive and transparent Leadership Pathway Program to create clear avenues and support for those aspiring to SGIM leader-

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# PARENTING IN MEDICINE: NAVIGATING YOUR WAY TO WORK-LIFE INTEGRATION

Emily Podany, MD; Namrata Patel, MD; Rakhee K. Bhayani, MD

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Doctors face unique challenges when starting a family and balancing parenthood with work. In a study of more than 1,000 female physicians, 75% delayed starting their family due to training or work, more than a third experienced the challenges and heartbreak of infertility, and, after having children, the women reported taking on a larger portion of the household and family duties than their significant other.[1] Another study found that among physicians with children, women six years out of training were significantly less likely to be employed full-time than men.[2] It is clear that despite increasing equity in medicine, we must create effective support systems for physician parents, especially female physicians. The authors created a moms and caregivers initiative in the Department of Medicine at Washington University to foster a supportive environment for physician caregivers and keep them informed, connected, and empowered. Our mission is to create community, share strategies for work-life integration, and advocate for policies that increase institutional support for caregivers. From this perspective and as physician moms ourselves, we share lessons we have learned over the years through this initiative to help others navigate this challenging but deeply rewarding path.

## Create Your Own Village

Humans were never meant to parent in a vacuum; historically, parents have been surrounded by extended family, friends, and community members. As technology advanced, society became more insular, and that sense of community is often lost. We learned that it is up to us to find a community of people to help shoulder the mental and physical burdens that come with parenting children, especially if we have traveled away from our immediate families to train or work. Building a village requires reaching out and being open to connecting. For example, plan a playdate with your co-worker's kids, strike up conversations at day care's drop-off line, commiserate with a parent of your daughter's friend about last-minute school project assignments, join online groups to find students looking for babysitting jobs, or make plans with co-residents even if they don't have children. As you create this network, you will find it is easier to ask for help and offer help to other parents in need.

## Ask for Help

There are moments in parenting that are particularly difficult, including illnesses, new medical diagnoses, school transitions, moving homes, the arrival of a sibling, and financial struggles. It is important to remember that you do not have to face these alone. You can and should reach out to your village, but you should also have trusted mentors to help navigate these moments without the sense of drowning at work. These mentors can help you prioritize, cut back, and even adjust your schedule, if it is flexible. When choosing a workplace, it is reasonable to consider how family-friendly it is, how they treat parents, and whether you would have access to these types of mentors.

## Say "No" and Put Aside Time to Recharge

In your early career, it feels as though you must say "yes" to every opportunity. What we have learned is it is key to consider how each opportunity will further your career, if it will be available later, and how much time it will take away from your life balance. As Dr. Podany's mentor once said, "You don't have to complete 50 years of work in five." Your career and patients are deeply important, but so is this time with your family. If you find yourself compulsively checking work e-mail or refreshing the EMR while at home, it is time to carve out family-only and solo time. The act of being present for family requires practice, but it is worth it. You will return to work more refreshed and ready to tackle the next day of challenges.

Although the above advice is aimed at improving individual experiences with parenting and medicine, we want to emphasize that work is required at the system level to adequately support women and, more broadly, parents in medicine. Systemic change can improve work-life integration and job satisfaction, thereby decreasing the attrition rate of female physicians, and should include

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# RESIDENCY IS A SHORT TIME IN THE SPAN OF WHAT I HOPE IS A LONG CAREER

Miriam Robin, MD

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*"Residency is a short time in the span of what is I hope a long career."*

This was the advice given to me as an intern who found herself mismatched with her top med/peds residency program. Multiple factors, all exacerbated by the COVID-19 pandemic, made me realize that I was not where I belonged. The mismatch led to extreme burnout, and I found myself disconnected from my patients, apathetic, and dreading going to work.

I thought back to my medicine sub-internship where I worked similar grueling hours. Yes, I was exhausted, but I also felt deeply connected to my patients. Baltimore's best doughnuts tasted so much sweeter when they were shared with my patient transitioning to hospice.

Well-intentioned advice from various mentors included "stay put, you'll get through it," "tough it out!," and "take some time off to manage the burnout." These comments reflected genuine concern for my well-being, but didn't address the underlying cause of burnout—I knew the cause was a poor fit between me and my program.

Although I was a resident in good standing, my choice felt like an ultimatum: either leave my program or leave medicine altogether. I had a tough conversation with my program director, explaining that I wanted—needed—to transfer. With his support, I arrived at my new home in my current program.

For a long time, I carried shame regarding the transfer. No one I knew had even whispered about transferring residency programs. I felt like an imposter—I hadn't matched here. I struggled with learning about a new system and a new city. But over time, I realized the unique perspective gained from attending two residency programs was an incredible strength. I was able to build my program's first-ever anti-racism curriculum based on my prior program's extensive social justice curriculum.

When a patient needed a transplant, I was uniquely prepared to advocate for a transfer to my prior institution. That critically ill patient received the specialized care he required, something I was only able to accomplish because I understood the intricacies of two very different institutions.

Because my new program was the right fit for me, I was able to effectively manage burnout by simply doing my job in a way that rekindled my joy in being at the bedside. Such softness is strength. On the fun days, it's leaning into the thrill of being the first person selected to sign my six-year-old patient's lime green cast. Sometimes it's lingering in my patient's doorway as we laugh about their questionable lunch tray or discharging a patient just in time for prom. On the more serious days, it's leaning into the visceral sadness I feel at the loss of a patient. At one patient's memorial service, I read the 100-word love story I had written in her memory.[1] Alongside her loved ones, I found myself grateful for moments that transcend our roles as physicians and have allowed me to once again practice medicine with my whole heart.

These meaningful connections with my patients bring levity to the heaviness we all experience in medicine. I recognize the innovative work by SGIM, and other organizations committed to fostering these connections during medical training and beyond. I was proud to have been awarded an ACGME Back to Bedside grant, combining my passion for health equity with cultivating meaning in medicine. I am now serving as an Internal Medicine Chief resident, giving back to the program that allowed me to truly thrive as a resident. I wish I knew back then what I can so clearly see now: transferring was the bravest and best decision I ever made. So yes, residency is a short time in the span of what is I hope a long career. Don't waste it.

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# TOUCHING THE FUTURE: A PERSONAL REFLECTION ON MAKING AN SGIM BEQUEST

Tom Inui, MD

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My last conversation with my father took place at his bedside in a small community hospital near Kissimmee, Florida, where he had been hospitalized after the last and most severe of his brainstem strokes. It wasn't easy for him to talk, but there were things he wanted to say to me. First, "*Tom, I am not afraid to die.*" Then, "*Take care of your mother.*"

Predicting the future is rife with uncertainty. Nevertheless, I can confidently predict that the day will come when I too die. I don't know what that experience will be like, but I do know that I will have already thought about the people and institutions I love—to whom I owe a debt of gratitude—and will have made some provisions for them in my will. In fact, the beneficiaries in the joint will that my wife Nancy and I have created are few. Members of the family come first, but a few institutions will also benefit after our deaths, including the Society of General Internal Medicine.

Why SGIM? Here are a few more forecasts! After we die, the arc of history will still be long, especially:

- Health justice and inequities will still need work;
- Health workers with a broad gaze on all the determinants of health will need to be active participants in the crafting of health and social policy;
- Generalists will still be needed who can embrace complexity and use a moral compass to navigate the tipsy and high-stakes worlds of medicine, public health, healthcare policy, organizational leadership and the health marketplace; and
- Research findings, including inquiry into the "inner world" of doctors, will be important to keeping our balance.

The increasingly diverse community of SGIM will continue to benefit from meeting together, hearing about new ventures, appreciating discoveries, debating varied opinions, leaning into the community's questions and finding common cause for science, caring, advocacy, teaching, learning, leading, and mentoring.

Nancy Inui and I want SGIM—my professional home for these activities—to endure and prosper and to continue being a fighter for justice and health rights. We are aware of the many existential threats that generalism in medicine faces today and will continue to face going forward. To flourish, SGIM must have sufficient financial resources to weather any storm that might loom on its future financial horizons. Our organization must have adequate resources to respond with agility to the ideas and passions of its membership. A resilient SGIM should continue to host interest groups, regional and national meetings, healthcare policy initiatives, publications, scholarships, mentorship, awards and other recognitions for its terrific members.

Acknowledging these hopes, Nancy and I have named SGIM among the beneficiaries in our will in the hopes that these funds will be used as part of the larger SGIM Legacy Fund. With this action, we believe we have touched the future.

SGIM members, do likewise: Take care of your professional mother. SGIM

## SIGN OF THE TIMES *(continued from page 7)*

adequate parental leave policies. We recommend striving to create policies and a culture of equity that allow physicians to navigate successfully the difficulties of parenthood while thriving in their careers. We hope our advice will help physician parents in the short term and inspire increasing advocacy for long-term solutions.

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# HOW TO REDUCE HARM AT DISCHARGE: WHAT I WISH I LEARNED SOONER

Sydney Katz, MD

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*An elderly patient with a PEG tube on tube feeds is readmitted from a nursing home with hypernatremia. The discharge summary didn't document the free water boluses the patient was receiving inpatient.*

*"What do you mean you want him to go home tomorrow? Absolutely not!" A patient stays two more days after being deemed medically stable so the family can set everything up at home for discharge.*

*A patient with malignant bowel obstruction s/p venting PEG tube and TPN initiation, is now readmitted two days after discharge with an obstructed venting PEG. The caregivers were never educated on how to take care of the venting PEG.*

Sadly, I was the attending hospitalist responsible for these discharge failures.

The hidden curriculum in our medical training tells us that an admission is much more important than a discharge. In medical school, we spend hundreds of hours practicing the art of the history and physical exam. In residency, we structure attending rounds to focus on new patient admissions. Then, suddenly, we become attendings and the onus is now on us to seamlessly lead the interprofessional team to coordinate complex discharges, decrease length of stay, discharge before noon, and lower readmission rates. What gives?

We learn to care about discharge planning the hard way—through failure, or at least the failures we do manage to hear about. However, the failure that comes with a discharge gone wrong is not only a blow to our ego, but more importantly represents potential harm to our patients. A study which evaluated the outcomes of patients discharged from a medical service at an academic center found that nearly 20% experienced adverse events after discharge and roughly 30% of those were preventable.[1] Despite discharge being a vulnerable transition of care, the skills required to effectively discharge a patient are infrequently taught to trainees.[2]

Besides learning the hard way, I also learned from my colleagues. During my first years as a hospitalist, I spent my clinical time at our community hospital where most of our patients follow with doctors in the neighborhood. While working in our shared office I heard my coworkers calling their patient's primary care doctors on admission and discharge. I saw them ask families to bring in pill bottles and call the pharmacy to verify home medications. I saw them faxing discharge summaries to outpatient offices and giving frequent updates to family members to discuss the plan of care and plan for discharge. I read many discharge summaries and began to recognize the commonalities which made it easier to assume a patient's care. I began to pick up my colleagues' best practices and my practice evolved.

Now, I aim to teach my learners the skills they need to effectively discharge patients and reduce harm at a high-stakes transition of care. I've transformed the way I run attending rounds to emphasize the importance of discharge preparation. I set it as an expectation that residents and medical students give a "discharge presentation" on the day of discharge instead of a S.O.A.P. presentation. We review the discharge plan and ensure the patient receives discharge counseling. When we have a re-admission, we analyze what led to the re-admission and how we can change our practice in the future. I go to the bedside with learners to observe them give discharge counseling to their patients and give them feedback on this skill. I closely review every discharge summary and medication reconciliation prior to a patient leaving the hospital. In my work as an undergraduate medical educator, I've developed workshops on the approach to discharging a patient, including writing an effective discharge summary, and an Objective Structured Clinical Exam (OSCE) curriculum which teaches the clinical skills to approach premature discharge, also known as discharge against medical advice.[3] I'm known as the attending who is obsessed with discharge. And I'm ok with that.

Despite my change in practice, I continue to be humbled. With every readmission, I hope that my patients are not harmed and that I may continue to learn and do better next time. Though I do wish that someone had told me sooner...

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# THE GREATEST LESSONS LEARNED DURING MY CAREER

Christine M. Stoltz, MD

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Twenty-five years ago, I was a naive clinician-educator fellow when asked to contribute articles to SGIM Forum. I recall wondering whether my words would be meaningful to others. After all, I had not come close to mastering clinical medicine and my life experiences were limited by long work hours and a meager trainee's wallet. My articles centered on issues relevant to me at the time: making house calls, the apathy felt when transitioning from intense to relaxed clinical rotations (affectionately called *deceleration injury*),[1] patient moments, and fellowship. I strived to master the clinical knowledge required not only to be someone's doctor but also a *good* doctor. I wanted to jump ahead magically five years, thinking that it would all be figured out by then. Little did I realize that the greatest lessons learned during my career were not about clinical medicine but about *myself*—and it took longer than five years to get there.

Now, 25 years later, I still don't have it all figured out. What is clear is that learning clinical medicine allowed me to become a physician, but learning about myself allowed me to continue to be a physician. Some lessons were harder to learn than others. Here are the top 10 lessons I have learned in my career that I wish someone had taught me earlier:

1. **Listen to your patient's backstory.** Listening to a patient's backstory can foreshadow your own future. Patients' experiences underscore the fragility of human existence, including the excitement of marriage and emptiness of divorce, the joy of having children and frustration of infertility, the challenge of being a parent and the sadness of losing one, the complexities of strained relationships, financial insecurity, the tendency to overindulge or deprive ourselves during stressful times, the fear of moving and changing jobs, and the importance of resilience.
2. **Growth happens when you step (or are shoved) out of your comfort zone!** Sometimes, we take calculated steps outside of our comfort zone, like giving lectures or writing grant applications. Other times, we are shoved there without warning, such as having to take taking a work hiatus for health reasons. Develop a growth mindset: believe that your intelligence (and talents and patience) can be developed over time and are not fixed.[2] By giving yourself permission to grow, you allow yourself to stumble, ask for help, take detours, and learn from others along the way.
3. **Self-talk can be sustaining or destructive.** It's easy to see failures as opportunities to shame ourselves into doing better next time, but real success doesn't work that way. Address yourself with the same compassion as you would comfort a good friend. Resist seeing life through a lens of perfectionism.
4. **Learn to process your emotions.** Even if you choose to suppress your emotions now, they will bubble up later, often unpredictably. Whether individually or with professional guidance, take time to feel your feelings. Learn to recognize the signs of burnout and imposter syndrome when they come to visit, so that you can support yourself and others. Asking for help shows strength, not weakness.
5. **Self-care is not selfish.** This took a while for me to believe. In medicine, self-sacrifice and delayed gratification are common, as we are taught to place the patient's needs above our own. However, physically and emotionally caring for ourselves can lead to greater satisfaction with our job, our life, and our relationships. Effective caregivers take time to care for themselves. Examples of self-care can include breath work, meditation, getting a haircut, walking in nature, connecting with friends, exercising or enjoying the arts.
6. **Perception can distort reality.** Our feelings about a situation are influenced by the thoughts that we have about it. You are only "stuck" in your current situation if you do not notice the opportunity to change your thinking about what is possible. Even if you are not where you planned to be right now doesn't mean that you missed the opportunity to get there. View setbacks as setups for future success.
7. **There is power in community—find your tribe.** Identify at least two trustworthy people (e.g., colleagues, friends, or family) with whom you can connect on a regular basis. They will inspire you, celebrate your successes, and support you through disappointment.

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# STANDING UP TO MISTREATMENT FROM PATIENTS: LESSONS LEARNED FROM MR. M

Sally Namboodiri, MD

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On morning rounds a few years ago, I went with my trainees to see Mr. M, a new patient admitted to the hospital overnight with heart failure exacerbation. I said, *"Good morning"* and started to introduce myself as the attending. Mr. M cut me off, pointed to the door, and snarled, *"Get out! Go back where you came from!"* Shocked, I stood frozen while my team looked on helplessly.

Little did I know that this brief encounter would be a watershed moment for me. Until this incident, I focused solely on getting my job done. Disrespectful comments from patients never gave me pause; I ignored them or politely laughed, telling myself they were mere distractions. But as Mr. M's words rang in my ears, several other uncomfortable incidents with patients flooded my memory, ones that I previously dismissed as unimportant. I realized that Mr. M had gone one step further than the other patients: he refused to accept me as his physician because of my ethnicity. Although I had no idea how to handle his racist rejection, I knew I could no longer pretend that mistreatment was an acceptable part of my professional life.

When mistreatment goes unchallenged in the workplace, insidious feelings of anger, self-doubt, and burnout consume recipients, while sources of mistreatment gain tacit approval to further perpetuate disrespectful behavior. Over the past decade, social movements, such as #MeToo, Time's Up, Black Lives Matter, and Stop Asian Hate, illuminated incidents of violence, harassment, and discrimination in the workplace and beyond. Workplace dissatisfaction grew rampant, and, due to the COVID-19 pandemic, health workers were inordinately affected. The U.S. Surgeon General's report noted large increases in burnout among health workers in 2022 compared to 2018, with a mass exodus of physicians and nurses from the workforce during the COVID-19 pandemic.[1] Health workers cited long hours and infection risk as reasons for leaving their jobs. However, mistreatment also played a role. The prevalence of reported harassment of health workers more than doubled in 2022 compared to 2018.[1] In a study of more than 6,400 physicians surveyed at the end of 2020, mistreatment by patients and families was commonly experienced, especially by female and ethnic minority physicians, and was associated with feelings of burnout.[2]

What did I do about Mr. M that day? I left the room immediately and reached out to colleagues for help; no one offered a clear solution. I decided to go back and speak with Mr. M. I let him know that there was no other doctor available. I suggested to him to accept me as his physician and treat me with respect. Since he was not critically ill, he could seek care elsewhere if he was unhappy with this plan. Mr. M decided, albeit begrudgingly, to treat me respectfully. This interaction solidified my belief that patients of sound mind who reject physicians solely based on prejudice should not be accommodated. Assignment changes should be initiated, however, if physicians feel uncomfortable continuing to care for such patients.

When I tell my "Mr. M" story to trainees, I stress that disrespectful comments by patients are unacceptable. We need to talk openly about uncomfortable encounters and how to address them. I encourage trainees to report any incidents of mistreatment both directly to their supervisors and electronically, via our medical center's disruptive behavior reporting system, to ensure that sources of mistreatment are educated and held accountable.

My experience with Mr. M stripped me of my rose-colored glasses and galvanized me to address mistreatment in my teaching hospital. When I surveyed some residents, they reported high rates of mistreatment, especially by patients and families, and did not know how to respond. They felt reporting the incidents would reflect badly on their performance evaluations. To bridge this gap, I worked with colleagues to create curricula on approaches to mistreatment by patients in real-time, including upstander interventions. We held upstander workshops for medical educators that reviewed ways to address the source of mistreatment directly. As upstanders, we can debrief with a trainee who experiences mistreatment and offer to address the incident. If the trainee agrees, we can ask the source of mistreatment to clarify what was said and then explain how the comment affected the trainee, review the mission of our teaching institution, and emphasize that mutual respect is expect-

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ship roles. Council enthusiastically supported this proposal. This article presents an update on our progress.

## The Charge

After Council endorsement, a work group was selected to lead this initiative. Council clarified the program's intended purpose and outlined the group's responsibilities. It is important to note that SGIM and the Association of Chiefs and Leaders in General Medicine (ACLGIM) already provide exceptional leadership programs that prepare our members for leadership roles in clinical and academic settings outside of SGIM. The Leadership Pathway Program will develop and implement welcoming, transparent, inclusive, and accessible programs and pathways to regional and national leadership within SGIM and ACLGIM.

## The Goals and Objectives

To establish the Leadership Pathway Program and achieve the intended outcomes of inclusive and transparent leadership trajectories, Council recommended the following key goals:

1. **Enhance members' understanding of the organization and the pathways to leadership within it.** This includes fostering awareness of SGIM's structure, mission, and strategic priorities. It also includes creating transparent avenues for involvement at all career levels, including trainees. SGIM offers several potential entry points for participation and leadership. The work group is tasked with exploring ways to highlight these opportunities among our members. Additionally, the group will also consider metrics of success for the program and its participants.
2. **Support an SGIM Leadership Mentor Program.** The work group is dedicated to developing a mentorship framework that pairs emerging SGIM leaders with current and former SGIM leaders. Additionally, the group will provide recommendations for opportunities where mentees can receive tailored guidance aligned with their SGIM leadership aspirations at regional or national meetings.
3. **Implement governance training.** The Leadership Pathway Program would educate current SGIM leaders and those in the pathway to leadership on responsibilities associated with governance roles, including fiscal oversight, ethical considerations, and compliance with regulatory standards. Governance and board leadership training is not a part of medical education, making such expertise rare among physician leaders. This training would enhance effective decision-making, strategic planning, and ethical leadership.
4. **Review and catalog existing SGIM and ACLGIM Leadership programs.** The work group would review existing programming to identify relevant content for the new SGIM Leadership Pathway Program. The group will then determine whether and how current related offerings can be integrated into the new program. The goal is cohesive and comprehensive programing. This approach will leverage existing resources while addressing any gaps, ultimately fostering a framework for developing future SGIM leaders.

## The Team

SGIM assembled an outstanding team chaired by Andrea Sikon, MD, and co-chaired by Ryan Kane, MD. Dr. Sikon brings years of experience and a deep knowledge of professional development, coaching, and mentorship in academic medicine. Dr. Kane is at the outset of his career, currently completing a General Internal Medicine fellowship at Duke University Health System and serving as an associate member on SGIM Council. His insights as an "end-user" of the planned programming will be invaluable in creating content for members who are just beginning their careers and exploring their leadership pathways within SGIM. Jillian Gann, SGIM's Director of Leadership and Mentoring Programs, will enhance this initiative by providing staff support and assistance. Members from various regions, institutions, and backgrounds have graciously accepted the invitation to join the work group, including Elisha Brownfield, MD, Marshall Chin, MD, Utibe Essien, MD, Eric Green, MD, Anuradha Paranjape, MD, and Jennifer Schmidt, MD. I am also thrilled to participate in meetings in an ex-officio capacity.

I am excited about the potential of this new Leadership Pathway Program. While members have historically found their way to success within SGIM, this initiative presents a unique opportunity to make those pathways more transparent and intentionally support our members' leadership journeys. The successful implementation of a robust Leadership Pathway Program will enrich our members, boost their engagement, and secure the long-term success of SGIM.

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them in my first book of poetry, *100 Poems*.[2] I now confront the darkness of an incurable disease. When I reread my poems, I reexperienced the darkest days of my life and the moments that helped me survive. I am reassured that I had recovered then, that my soul had carried on in the most wonderful ways, and that I came to be surrounded by love and compassion over the decades that followed.

### EB: How did you assemble your second book of poetry?

JG: My life has been filled with many planned encounters of unexpected content. As a primary care physician, my routine was laid out in blocks of time divided into smaller segments for each patient on my schedule. Before office hours, I rounded on hospitalized patients. At the end of the day, I completed my records, reviewed lab results, checked with my staff, answered messages, and made calls (yes, even house calls). Days were comprised of countless contacts with patients, many in person, others by phone or message, and still others represented by a lab result or a consultant's note. For each contact, I had to fully engage. This is the nature of medical practice, intense focus on the moment, no distractions, gather, assess, decide, act, close, move on. Office encounters were the most precious interactions, I with my medical knowledge and each patient with a story, not just of illness, but of life, family, relationships, commitments, personal events, and much more. From these elements, I constructed my understanding of those in my care, who they were and what they faced. Over 45 years of practice, I had many opportunities to reflect on those lost, some I commemorated with poetry to ensure remembrance. Other seminal events triggered the need to write poetry. I assembled these in my second book of poetry, *Experiences: Reflecting on Certain Fate, I Breath.*[3] My favorite poem—"Obama"—was recognized in a personal letter from President Obama himself!

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- *"I advise my colleagues that they are not a judge, the police, or a patient's guardian. They are the patient's chosen health advisor. Their role is to apply knowledge of health and disease to the patient's lived experience, then do their best to guide them."* –Jennifer Shiroky-Kochavi, MD
- *"Early in my career, I thought doctors and nurses viewed patients similarly. However, Medicine and Nursing emphasize different reasoning: doctors focus on 'cure,' while nurses emphasize 'care,' considering patients' preferences and contexts.*[1] *As a leader, I now foster collaboration between them, leading to shared decision-making with patients."* –David Willens, MD, MPH
- *"If you would like to remain a respected clinical leader then don't drop your clinical footprint to lower than 20% clinical FTE. The clinicians you supervise need to know that you struggle with similar barriers to practice as they do and understand the challenges of the changing clinical landscape."* –Mohan Nadkarni, MD

The wide range of answers to this question demonstrates the expansive skills and experience that go into leadership. Consider membership in ACLGIM if you are a leader seeking opportunities for management training and networking with other GIM leaders across the country. Advantages to be a member include being able to attend the ACLGIM Winter Summit and the Hess Institute at the annual SGIM meeting.

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them contributed to my vision of the ideal career and helped to inform my next steps. They had high expectations for me and challenged me to think big and explore new opportunities. With these individuals, I learned important lessons:

- **Lesson #1: Find Your Champions.** I credit my persistence in primary care to interactions with key individuals throughout residency. These champions—some local, some remote—had the perspective of being further along in their careers and made me aware of important opportunities. Graduate medical education programs should ideally create supportive environments for trainees to identify their champions early in training. But as I learned during the pandemic, trainees need to take an active role in shaping their team. Champions can be at any career stage—from fellow co-residents to senior faculty. All that matters is that they stoke your passion and help you succeed in your chosen pursuits. We also live in a virtual world where relationships and resources are no longer restricted to one's location. As such, residents and fellows should feel empowered to utilize any resources—e.g., search engines, affinity groups, medical societies—to find additional support.
- **Lesson #2: Be a Champion.** As much as I benefitted from the champions in my life, I also benefited from championing others. It is never too early to champion someone else, even your peers. Serving as a champion can provide personal satisfaction and opportunities for self-reflection. Championing experiences have led me to reflect on past challenges and reevaluate my values, goals, and relationships. Watching individuals grow and succeed has also been rewarding. As a champion, you can positively impact others' lives and careers.

## Conclusion

As I reflect on my journey in medicine, I recognize the important role that champions have played in my career. Although we may not have control over our early childhood, we can have some degree of control over our training environment. Residents and fellows should feel empowered to look within and outside their institutions for the support they need to advance their careers.

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relationships that span more than the one-month duration of a residency rotation or a three-year continuity clinic. We learn about our colleagues and what is important to them and those they depend on. As a leader, our employees tell us about their priorities by their actions often more than their words. These experiences all contribute to our emotional intelligence.

But why should we care? Why is EI/EQ greater than IQ? As Theodore Roosevelt stated, "No one cares how much you know, until they know how much you care."[4] I wish someone had told me this earlier in my career. But I guess now, I should be the one to tell others, "It's all about the care."

As we conclude this second SGIM Forum theme issue on "Lessons I Have Learned in My Career I Wish Someone Had Taught Me Earlier," I want to thank Dr. Alfred Burger, SGIM Forum Associate Editor, who served as Co-Editor in Chief as well as Drs. Shanu Gupta and Lubna Khawaja, SGIM Forum Associate Editors, who served as Primary Editors for these theme issues. Without their dedication and assistance, these issues would not be possible. The Editorial team would like to thank the SGIM members who shared their stories, exposed their vulnerabilities, and revealed the lessons they have learned that will help SGIM members in all stages of their careers.

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## PERSPECTIVE: PART II *(continued from page 11)*

8. **Speak up, but also listen.** Sometimes, the best ideas come from the most junior person in the room. You may be that person or may need to listen to that person. Get a mentor or be one. We have much to learn from one another.
9. **Charting efficiency is essential.** The transition from paper charts to the EMR has come with extensive documentation requirements. Simultaneously, the explosion in electronic messaging infringes on our time outside of work. Identify opportunities to streamline your workflow and partner with others to create more efficient systems within your organization.
10. **Your impact is not based solely on your CV.** We are more than our titles. In addition to being a physician, if it is important for you to be a chef, golfer, at-home parent, musician, volunteer, or skydiver, then do so. Engaging in meaningful activities will nourish you, so that you can continue to care for yourself and others.

As you look ahead, consider working on some of these lessons that resonate with you. Remember that success takes practice, intention, and repetition. As physicians, we are privileged to determine our own path. While I still have room to grow as a clinician and person, I find myself being more patient in getting there. Maybe you will, too.

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## BREADTH: PART II *(continued from page 12)*

ed in every interaction. Patients who persistently disrespect health workers should be reported to medical center leadership and face consequences for their behaviors.

Although I wish I had been taught earlier in my career to expect respect in the workplace, stand up for myself when I experience mistreatment, and support others when I witness mistreatment, my introduction to these lessons as a seasoned attending was likely more impactful. Mr. M became one of my greatest teachers, whose racist rant allowed me to look mistreatment in the eye and pay it forward. I share Mr. M's lessons with my trainees, and when they become attendings, they pass the lessons along to their trainees. I hope that over time, more health workers will learn from someone like Mr. M. We may even reach the point where respect for health workers is widely acknowledged as a right worth fighting for.

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