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SGIM FORUM

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LEADERSHIP AND HEALTHCARE ADMINISTRATION

LEADERSHIP LONELINESS IN HEALTH CARE: EXPLORING THE CAUSES, CONSEQUENCES, AND SOLUTIONS FOR A CONNECTED FUTURE

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In the post-pandemic environment, evidence suggests a sustained challenge exists in health care: leadership loneliness and the resulting organizational languishing. To address this, connected leadership demands a thorough understanding of leadership loneliness and its effects on the system, particularly in relation to patient safety and clinician burnout. This insight is essential for enabling meaningful interventions that restore humanity to medicine.

The Language of Loneliness

Connection is a basic human need; without it, we suffer. As defined by U.S. Surgeon General, Dr. Vivek Murthy, loneliness is "a subjective distressing experience that results from perceived isolation or inadequate meaningful connections."[1] While this definition captures the essence of loneliness, it overlooks the self-perpetuating loop that often characterizes the condition. Described by social neuroscientist Dr. John Cacioppo, this loop illustrates the paradoxical nature of loneliness—it traps individuals in a state of hypervigilance where they expend energy constantly scanning for potential social threats, rather than building meaningful connections. This heightened threat awareness triggers a cycle of increased self-centeredness and self-devaluation compounded by the one-two punch of high-level productivity expectations and insufficient sleep, leading to deeper personal and professional isolation.[2]

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The impact of loneliness is staggering. As discussed by Dr. Murthy, statistics demonstrate that loneliness carries a 25% increased risk of premature death for impacted individuals—a risk equivalent to smoking 15 cigarettes a day.[1] More broadly, a 2020 survey performed by CIGNA Group demonstrated that employers are estimated to have sustained a nearly $154 billion loss due to loneliness related absenteeism.[3]

Loneliness and the Practice of Administrative Medicine

Many healthcare leaders, specifically those who entered leadership from the clinical side, receive no formal training or mentorship in the development of their administrative practice. Further shaped by the singularity of leadership roles (i.e., there is only one Chief Medical Officer, Chief of Medicine, Chair of Surgery, etc.), complexity of responsibilities, and ever-changing personal and professional relationships, loneliness in healthcare leadership reflects the dysfunction of the social infrastructure at the system level.

The loneliness burden of the leader manifests across the leader's team, as the perception of decreased psychological safety shifts team behaviors to adapt to the leader's stressed state. The ripple effect becomes rampant. The consequential organizational languishing slowly crushes the propensity to innovate, and, if unrecognized, it can lead to disastrous outcomes. The slightest challenge can precariously tip a languishing organization into a burnout culture of firefighting and survival, risking the consequences of administrative harm and systemic collapse.

The Opportunity: Energy, the Power of Connected Leadership

In 2021, the National Taskforce for Humanity in Healthcare (NTH) published findings of a pilot study demonstrating the significant success of combining "processes and methodologies that deliver highly efficient and effective care with systems and infrastructures that restore human connection and empathy."[4] Systems that were engaged with this work prior to the COVID-19 pandemic were better equipped to handle the competing demands for sustainable adaptive solutions and needs for immediate technical fixes. The leaders of these socially connected systems were able to sustain a level of systemic energy to "fulfill [their] oaths as administrators to create the conditions that allow the healers to heal and the patients to thrive."[4]

Built on the work of the NTH, the Institute for Healthcare Excellence has developed sustainable solutions rooted in breaking the loneliness loop by equipping leaders and their systems with skills to create a sustainable energetic environment of trust, respect, and compassion. This new work has demonstrated success with a three-part approach—values alignment, communication, and positive organizational design:[5]

1. *Values alignment*. The positive energy work of Seppälä and Cameron defines the sustainable energy of a connected leader as the "most underutilized" predictor of leadership success. Further, this energy "is not the superficial demonstration of false positivity…Rather, it is the active demonstration of values."[5] Anchored in aligning the organizational core values with what matters most to their people, connected leaders emit a self-renewing energy source for themselves and others resulting in thriving organizations.
2. *Communication*. Sustainable communication remains an essential component of purposeful organizational connection. Effective communication strategies enhance work-life experience, improve outcomes of safety, decrease turnover, address clinician burnout, and promote professional thriving.
3. *Positive Organizational Design*. The science of positive organizational design is rooted in the work of social psychologist, Barbara Fredrickson. Innovative experience mapping and catalytic human-centered design sessions create deep learning where leaders train to maximize opportunities for deliberate connection. The resulting workflows generate safety, collaboration, and work-life harmony within clinical delivery systems to harness the power of connected leadership.

Shaped by values alignment, communication, and positive organizational design, these early efforts have strengthened organizational culture, reduced clinician burnout, and enhanced patient care. From this integrated approach, connected leadership emerges as a vital force of stability and positive energy that sustains and nurtures thriving healthcare systems.

A Call to Action

As an extension of the interdependent evolution of patient harm and clinician burnout, leadership loneliness has been an insidious phenomenon contributing to the dehumanization of medicine experienced over the last quarter century. In an environment already seeking new alternatives to re-humanizing care for all involved, this additional loneliness layer is both a symptom and potential compounder of a system in distress. However, current evidence suggests a clear antidote. Connected leadership and its commitment to trust, respect, and compassion energizes system infrastructures where leaders and their teams are assured of a more humanized future. SGIM and ACLGIM members, positioned at the intersection of academic institutions, hospital authorities, and provider

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groups, are uniquely suited to lead this effort. Through purposeful connection at both the individual and systemic levels, and by naming the problem of leadership loneliness, they can create lasting change and foster systems of care where patients, providers, *and* leaders can all thrive.

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SGIM

FROM THE EDITOR

THE HAPPIEST PLACE ON EARTH: OBTAINING MY ANNUAL "FIX"

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Editor in Chief, SGIM Forum

"You are braver than you believe, stronger than you seem, and smarter than you think."[1]

"Wait, what did you say?" my colleague stammered. *"Did I hear you correctly?"* The incredulous tone echoed in the empty exam room as her voice reached a crescendo. *"You are going to fly to Florida, to your 'happiest place on earth,' and you will only be there for a total of 29 hours. You are crazy! What are you thinking?"* I realized that as a non-member, she would never understand.

Sorry to those Disney fans who think this column is about their happiest place on Earth (Disney World); but the 2025 SGIM Annual Meeting in Hollywood, Florida, will be my happiest place on Earth over the four-day meeting. Attending the Annual Meeting is a validation of my decision to pursue academic medicine more than 25 years ago. The SGIM Annual Meeting is my chance to teach, learn, present, and network with like-minded colleagues. It is also my opportunity to catch up with old friends and make new ones. It is a feeling that is hard to put into words and I am always sad when the meeting ends. However, I leave with a reinvigorated passion and purpose for the year ahead, just as Gusteau inspires Remy when he says: "You must be imaginative, strong-hearted. You must try things that may not work, and you must not let anyone define your limits because of where you come from. Your soul is your limit."[2] As I head home, I feel like I am ready to go "To infinity and beyond."[3] I recognize that this sense of renewed energy will be unappreciated by many colleagues who are not SGIM members.

SGIM has held two meetings in Hollywood, Florida, during my more than 25 years as an SGIM member (#SGIM16 and #SGIM25). This beautiful meeting venue holds a personal vendetta against me as my attendance at both meetings has been challenged. In 2016, my oldest son was receiving the highest award at his grammar school graduation. I chose my personal family over my SGIM family, and this remains the only meeting I have missed during these years. This year, my attendance at #SGIM25 is impacted by the same son graduating from Tulane University on Friday, May 16th, with his unified commencement on Saturday, May 17th. Again,

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a tough decision to make; but I conceived a new plan for #SGIM25. I will fly to Hollywood, Florida, on Wednesday May 14th and arrive mid-afternoon for the SGIM Council meeting. On Thursday, I will present two workshops and lead an Interest Group before flying home Thursday evening. Somewhere in this melee, I hope that my Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) LEAD mentee and I can find time to get our yearlong mentoring started.

Why suffer through this madness you might ask? SGIM is that important to me! "Sometimes the right path is not the easiest one."[4] I survive on the energy that the Annual Meeting offers to carry me through the year until the next SGIM meeting. I am aware of the virtual option of attending #SGIM25 that is being piloted this year. It is wonderful that SGIM members who are concerned with the political environment in Florida as well as those with concerns over large meetings and the impact on the environment have this option. I respect their reasons for attending virtually. But I cannot lead or participate in a workshop via the virtual process, and I need the comradery and networking that comes with in-person attendance.

> **"Serving as the Forum Editor is an amazing opportunity to meet SGIM colleagues whom I would not have met otherwise. The Editor role affords me a role to assist in sharing the scholarly work that our SGIM members contribute to medicine."**

As SGIM Forum's Editor in Chief, it is important to attend this Annual Meeting as it kicks off the final year of my three-year Editor term. The SGIM Forum Editor position is a non-voting member of SGIM Council and is actively involved with SGIM members via their published articles. The Editor collaborates with SGIM staff, SGIM Forum Associate Editors, and authors submitting to the Forum. The SGIM Forum also works with the *Journal of Internal Medicine (JGIM)* and SGIM committees, commissions, task forces and interest groups. As I enter my final year, it is important to engage with applicants interested in serving as the next Editor in Chief. The workshops that I will be participating in (WG13 "Scientific and Scholarly Writing for Beginning Researchers: A Collaborative Workshop from Editors of *JGIM* and SGIM Forum" and WC10 "How to Write High-Quality Peer Reviews of Scientific and Scholarly Writing: Crafting Professional Critiques Using Contemporary Tools and Paradigms") offer insights into the Forum from the viewpoint of an author and a reviewer respectively. If you are interested in working with the Forum editorial team as an Associate Editor, please stop by the Forum Interest Group meeting (ITA17) on Thursday, May 15th at 7:00 am—grab breakfast and a big cup of coffee as you chat with Forum colleagues. If you would like more information about the Editor in Chief position, please find me at the meeting so we can arrange to meet after the Annual Meeting. If you miss me in the chaotic 29 hours I will be in Hollywood, please contact me at SGIMForumEditor@gmail.com to discuss details regarding the editor position.

Serving as SGIM Forum Editor is an amazing opportunity to meet SGIM colleagues whom I would not have met otherwise. The Editor role affords me a role to assist in sharing the scholarly work that our SGIM members contribute to medicine. I am happy to have accepted the position two years ago. As someone who considered themselves a hesitant writer, I would have to describe my three-year leap of faith as "Venture outside your comfort zone. The rewards are worth it."[5] I look forward to seeing all of you at the Annual Meeting-in person or online. A great meeting awaits us!

If you can identify the five Disney movie quotes above without peeking at the references, you are a true Disney fanatic, and we know why you consider Disney your happiest place on Earth.

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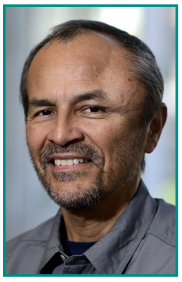
SGIM

STARTING A NEW CHAPTER, BUILDING COMMUNITY, AND MOVING FORWARD

Carlos Estrada, MD, MS, FACP, President, SGIM

"SGIM will continue efforts to promote and support the work of our members through active advocacy and coalition work with other organizations of similar values. SGIM remains committed to keeping members informed and engaged in these critically important advocacy efforts. While we adjust, advocate, and plan for the year ahead, I call on SGIM colleagues to support each other and continue the noble call of the medical profession."



I have a confession. I struggled writing my first column as SGIM President in mid-March 2025 for the May 2025 issue of SGIM Forum—we live in an evolving world, and I have both fear and hope. As I talk to people at my own institution and elsewhere, I recognize that I am not alone. I don't want you to feel alone either. SGIM is a wonderful community to be a part of and is there to support its members.

SGIM has been my professional home since my GIM fellowship years in the early 1990s. During my many years of SGIM membership, I have come to recognize items that are important to SGIM members. As SGIM President, I will continue SGIM's work to advocate for increased funding for primary care, expanded representation and inclusivity, and diversified professional development.

Re-reading my platform re-invigorated me for the work that lies ahead. I remain committed to supporting clinician-educators, both clinic- and hospital-based. As clinical and administrative demands continue to grow, SGIM must work to decrease the burden of the practice of medicine and increase the meaning to have a thriving career in academic GIM. SGIM offers multiple career development opportunities to foster professional fulfillment and advancement—both at the regional and national levels.

I remain supportive of the professional development of underrepresented minority groups in medicine. As a foreign medical graduate from Universidad Peruana Cayetano Heredia (Lima, Peru), I feel privileged and honored to serve as SGIM President.

SGIM as a Community of Like-minded Individuals

As president-elect, I attended my first regional meeting for the newly formed Southwest region held in San Francisco on January 25, 2025. The energy, enthusiasm, and excitement were palpable. Individuals from both small and large institutions participated. I saw presentations that characterize the SGIM community—clinical vignettes with pearls for clinical practice, research presentations as well as practice and educational innovations.

It was refreshing to meet and get to know new members and faculty. Each one had a story to share. For example, Dr. Miriam Robin created a database that could help faculty in her center connect with potential mentors for research projects and scholarly opportunities. All institutions would benefit from such a list, leveraging local resources and interests, and making them available to all faculty, including those from groups under-represented in medicine. After meeting Dr. Robin, I also learned of a prior experience that shaped her career path, I encourage you to read more about it.[1]

I met Dr. Alisah Parada, SGIM member and current American College of Physicians (ACP) Chapter Governor (New Mexico), who helped me find a primary care doctor for my daughter who lives in Albuquerque. Her kindness is emblematic of the generosity of SGIM members.

I met Dr. Saloni Kumar Maharaj, the Leadership in General Internal Medicine (LGIM) awardee, who had an army of people cheering for her during the announcement. In our brief conversation, and after reading her online bio, I was impressed with her passion for GIM, dedication to trainees and the profession, and career path. After serving as President of the SGIM CA-HI Region (2023-24), she now serves as President-Elect, Society of Hospital Medicine—Bay Area Chapter (2024-present).

Dr. Eric Bass, SGIM Chief Executive Officer, introduced attendees to the many SGIM educational offerings. While I was familiar with most of them, I decided to complete a learning module from the GIMLearn series. I selected *Managing Up*.[2] Why? I recognize it is an important skill, and this is the advice that I have both received and given. I am also aware that I have failed more times than I am willing to acknowledge and

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need to revise my own approach. I met the authors years ago through SGIM regional and national meetings. Drs. Nancy Denizard-Thompson and Kirsten B. Feiereisel (Wake Forest University School of Medicine) did an excellent job in the design and delivery of the educational module. How could SGIM members use a module like this? You can use this material to guide faculty development at your institution. The worksheets and suggested in-person discussion with a partner will foster sharing experiences and learning.

SGIM members were eager to learn from others and find the networking and 'ad-hoc' exchange of ideas energizing. The regional meetings help build the community of academic internists; the examples above illustrate the importance of strategic connections and networking.

New Administration: First Weeks of 2025

The past few weeks have been unprecedented given the reach and impact of the executive orders. To deal with the uncertainty, I focus my attention on medicine as a profession and general internal medicine, in particular. During these challenging times, SGIM remains committed to its core mission: "To cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone."

SGIM leadership, Council, and multiple groups within the organization have been managing and prioritizing the vast number of national changes to support SGIM members while navigating through their local political environments. The policy changes affect patient care, academic medicine, and medical research, including vital organizations in health care, such as the National Institutes of Health (NIH), Department of Veterans Affairs, and Centers for Disease Control and Prevention (CDC).

I repeat the guidance provided in recent SGIM communications. Get involved and talk about these issues with your local leaders and government representatives. Use the following key points and modify them to fit your own priorities:

- Medical research saves lives and drives economic growth
- Support for research infrastructure is critical—without it, labs would go dark[3]
- Academic medicine leads national health progress[4]
- Health systems with robust comprehensive primary care achieve better health outcomes and are less costly.

SGIM will continue our efforts to promote and support the work of our members through active advocacy and coalition work with other organizations having similar values. SGIM remains committed to keeping members informed and engaged in these critically important advocacy efforts.

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In closing, while we adjust, advocate, and plan for the year ahead, I call on my SGIM colleagues to support each other and continue the noble call of the medical profession.

Disclosures: The opinions expressed in this column are those of the author alone and do not reflect the views of any of his employers.

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SGIM

FROM THE SOCIETY

Q & A WITH SGIM'S CEO ABOUT DISCUSSING POLITICS WITH A LIFELONG FRIEND

Eric B. Bass, MD, MPH; Andrew Theodore Fischer, DVM, DACVS

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Fischer is the chief surgeon at Chino Valley Equine Hospital.

I recently strayed into politics in an exchange with my best friend from high school. Our friendship was forged during the grueling seasons we had as members of the wrestling team that went undefeated for two of our three years on the team. I was the skinniest guy on the team. My friend was a naturally gifted athlete with about 40 more pounds of muscle mass than me. When my friend casually mentioned in an e-mail that he was "enjoying the DOGE (Department of Government Efficiency)," I initially attributed it to a warped sense of humor. I debated whether to ask him about it. We had never discussed politics before. I decided to ask because I had recently resolved to make greater efforts to talk with friends and family members whose political views differ from mine. Here is a summary of the discussion that ensued.

EB: I hope you're facetious about enjoying the DOGE. I am extremely upset about the executive orders calling for devastating reductions in funding of medical research as well as the extraordinary censorship of research.

ATF: First off, we have been friends for a long time, so let's skip politics. I think we need governmental accountability. DOGE is bringing that in. Please listen to "out of the bubble" news. I look at left- and right-wing news sites. Look at CNN, Fox, Breitbart, Whatfinger, or the *New York Post*. Check out the *(Real) Coffee with Scott Adams* podcast. I do not want this to hurt our friendship, but I think it's important for people to expand their sources of information.

EB: You're stuck with me as a friend even if we disagree on political issues. I took the risk of mentioning politics because I want to talk more with people who have different views than most of the people I work with. If we don't talk about politics with people we know and respect, we cede the political realm to polarizing forces. I hope you won't mind engaging. You're not likely to get angrier than when I applied that cross-face in a wrestling drill when you were still wearing a mask while healing from a broken nose. I was lucky to escape that incident without permanent harm.

ATF: Always willing to engage and stir the pot. I figured what your leaning might be (being in academia, in the Beltway and a physician). Listen to *(Real) Coffee with*

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Scott Adams (the cancelled Dilbert cartoonist). He is interesting and calls out both sides. I have been on research boards and found we were funding research proposals I knew were already completed, yet they were approved. How is this impacting you? Did you see the *Wall Street Journal* article about funding at Johns Hopkins?[1]

EB: Thank you for sharing the link to the article which I hadn't seen yet. The administration's policies on research funding are having a devastating impact at Johns Hopkins, with direct impact on me and my colleagues. I feel like I'm living in a nightmare that gets worse with every additional policy that targets the work to which my colleagues and I have dedicated our careers. I attended a *Stand Up for Science* rally recently because I feel I owe it to my patients to stand up for the science that enables us to offer the best possible care to everyone.[2] I'm sure there are ways to improve how the National Institutes of Health and other health agencies operate but gutting everything makes no sense. What do we need to do to help people understand how much they benefit from federal support of medical research and what they will lose if we can't stop the huge disruptions of research? Don't you want access to the latest advances in medical care when you or a family member have a serious illness?

ATF: We desperately need good research, but it seems that a lot of questionable things get funded, or funds get diverted away to questionable nongovernmental organizations doing projects that are not in our national interest. Hopefully, this will just be a pause for a while and legitimate research gets funding restored. I do agree that total gutting is not the right path.

EB: I also have patients who are losing their jobs. I saw one of them on Wednesday. He worked for the United States Agency for International Development and devoted decades of his life to humanitarian efforts in some of the most dangerous countries in the world. American citizens who risked their lives to help people in other countries deserve to be treated with respect even if the administration doesn't care what happens in other countries.

ATF: I totally agree with supporting your patient. They are heroes, but there are a lot of nongovernmental organizations that wasted or squandered a lot of money and caused this examination by DOGE. Once again, I hope that your funding gets restored. Please listen to at least one of the *(Real) Coffee with Scott Adams* episodes. It will open your eyes. Enjoying the exchange and appreciate our friendship.

EB: I listened to two of the *(Real) Coffee with Scott Adams* episodes.[3,4] I know you recommended listening to him because he's against "experts" who provide biased information about controversial topics to keep getting funded for their research. What I learned from his podcasts is that he believes that the chain saw approach to cutting the government is appropriate because that strategy has worked in the business sector and many people agree that the federal government is too bloated and inefficient.

I also noted his disdain for "academics" which may be related to his concern that the accreditation system allows existing institutions to prevent new institutions from being credentialed. I did not hear any mention of the value of the clinical, research, and education missions of academic medical centers. In his podcast on March 15, 2025, he makes the argument that colleges and universities are bad, especially the big ones, because they depend on the federal government for so much of their money.[4] He goes on to say that the only way to fix universities is to let them fail and start over without the "crazy stuff." His argument ignores the history of how relationships between universities and government have evolved to serve the public. As the President of the Johns Hopkins University said in a recent letter to the university's community about the eight-decade partnership with the federal government, "The funds allocated by the federal government on a competitive, meritocratic basis to us and other American research universities have extended and improved the quality of human life, driven innovation, educated the next generation, created new industries and jobs, ensured the safety of the nation, and fueled the remarkable success and productivity of the American economy."[5]

I hope we can continue the conversation even if we disagree about a lot of what is happening. I hope others will join us in making greater efforts to have these kinds of difficult conversations. I will close with the point you asked me to emphasize—that we have been driven into separate camps by the news bubbles and that is why there is so much angst and why people need to expand their sources of information and be more cautious about trusting their usual media and expert sources.

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SGIM

IMPROVING CARE

MEDICAL GASLIGHTING: UNDERSTANDING AND ADDRESSING THE PATIENT'S PERSPECTIVE

Nikhil Sood, MD; Anthony D. Slonim, MD, DrPH, FCCM

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Introduction

For patients seeking medical care, the physician-patient relationship is central to ensuring an accurate diagnosis and effective treatment. However, challenges can arise in these interactions if patients feel that their symptoms or concerns are not acknowledged, a phenomenon referred to as *medical gaslighting*.[1] This dynamic can contribute to delays in diagnosis, inappropriate treatment, and increased stress for patients.

Internal medicine physicians regularly manage complex, chronic conditions, and are positioned to address medical gaslighting and improve patient outcomes. In this column, medical gaslighting is explored from the patient's perspective, by examining its emotional, psychological, and physical impacts. Strategies are offered for internal medicine physicians to foster a more compassionate and patient-centered approach.

> **"Medical gaslighting occurs when a patient perceives their symptoms to be dismissed, minimized, or misinterpreted by a healthcare provider. This negative experience can undermine a patient's trust in their self-awareness and the healthcare system."**

What Is Gaslighting and How It Happens

Medical gaslighting occurs when a patient perceives their symptoms to be dismissed, minimized, or misinterpreted by a healthcare provider; such dismissal or minimization leads them to question the validity of the interaction. This negative experience can undermine a patient's trust in their self-awareness and the healthcare system, leading to delays in necessary care or hesitancy in accepting future diagnoses.

A patient reporting persistent fatigue or pain might be told their symptoms are "all in their head" or attributed to "stress" without a thorough investigation into potential underlying causes. While psychological factors may play a role, prematurely attributing symptoms to them without sufficient investigation can leave patients feeling invalidated. Other contributing aspects (such as the power imbalance in doctor-patient relationships or the time constraints of busy clinical practices) may inadvertently foster conditions where medical gaslighting occurs. By implementing a collaborative and comprehensive approach to patient care, internal medicine physicians can mitigate these risks and maintain trust within the physician-patient relationship.[2]

Although it is unintentional, medical gaslighting may arise from unconscious biases, gaps in communication skills, or assumptions based on patient characteristics,

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such as gender, race, or age. Recognizing how these personal biases can influence clinical interactions is essential in reducing the risk of medical gaslighting.

Impact on Patients: Emotional, Psychological, and Physical Consequences

Medical gaslighting can profoundly affect patients, influencing their emotional, psychological, and physical health. From the patient's viewpoint, this dismissal undermines trust and can worsen health disparities, particularly among marginalized groups that already encounter discrimination in healthcare environments.

For individuals with chronic or complex conditions, such as fibromyalgia, autoimmune diseases, or mental health disorders, this lack of validation can exacerbate their health challenges. These conditions are often misunderstood or misdiagnosed, and instances of medical gaslighting may delay their diagnosis and treatment, prolonging the patient's suffering. Sometimes, patients may avoid seeking care, fearing their concerns will not be taken seriously.

Physically, the consequences of gaslighting can be severe. When symptoms are overlooked or minimized, patients face a heightened risk of misdiagnosis, missed diagnoses, or delayed treatment.[3] The failure to consider the range of potential diagnoses can result in delayed interventions, potentially worsening their condition or leading to preventable complications.

Patient Cases

A 38-year-old woman sought medical care for chronic joint pain, fatigue, and digestive issues. Despite her insistence that something more serious was wrong, the doctors for months attributed her symptoms to stress and anxiety. Initial testing included routine labs and a trial of acid reflux medication. No further diagnostic testing was done on her follow-up visit. Instead, the focus remained on her stress and work challenges. As her symptoms progressed, she visited a rheumatologist a few months later and was diagnosed with rheumatoid arthritis. The delay left her feeling unheard and doubting her own experiences.

A 55-year-old man of African descent presented with severe headaches and dizziness. His physician attributed the symptoms to high blood pressure without conducting additional diagnostic testing. Subsequent visits focused on managing his blood pressure and adjusting the medications while the underlying etiology of his presenting symptoms remained undiagnosed. Eventually, he was diagnosed with a brain tumor. While routine imaging for all patients presenting with headaches is neither practical nor recommended, a more in-depth conversation and investigative approach regarding his symptoms and response to treatment might have led to an earlier diagnosis.

These patient cases illustrate how medical gaslighting can disproportionately affect certain groups, including women, patients of color, and individuals with chronic illnesses. Beyond the immediate health impacts, these experiences can erode trust in healthcare providers and the healthcare system, highlighting the need for a more inclusive and patient-centered approach.

Addressing Medical Gaslighting

SGIM members have a unique opportunity to combat medical gaslighting by fostering a more open, empathetic, and collaborative environment. Addressing medical gaslighting requires awareness and active steps to improve communication, care, and understanding.

1. *Listen Actively and Validate Patients' Experiences.* Active listening involves more than simply hearing what a patient says, it requires attentively processing and responding to their concerns with empathy. Physicians should validate their patients' experiences by acknowledging the emotional impact of their symptoms. Phrases like "I understand that must be difficult for you" or "Let's work together to find out what's going on" can help reassure patients that their concerns are being taken seriously.
2. *Ask Open-Ended Questions and Explore Symptoms Holistically.* Rather than jumping to conclusions or making assumptions, physicians should encourage patients to provide detailed descriptions of their symptoms. Open-ended questions like, "Can you tell me more about when the pain started?" or "What seems to make your symptoms better or worse?" allow patients to fully express their concerns. This can lead to a better understanding of the patient's condition and may prevent rushed judgments.[4]
3. *Foster a Collaborative Environment.* Patients should feel empowered to participate in their care. By engaging patients in shared decision-making, physicians can build trust and demonstrate that patients' opinions are valued. Encouraging patients to express their preferences or concerns can also ensure that patient's voices are heard and respected throughout the diagnostic and treatment process.
4. *Recognize and Address Biases.* Unconscious biases can significantly influence how a physician interprets a patient's symptoms. Internal medicine physicians should be mindful of these biases when dealing with diverse patient populations. Regular self-reflection, participation in bias training, and cultural competency workshops are valuable tools for mitigating these biases and ensuring equitable care.
5. *Prioritize Patient-Centered Care.* Internal medicine physicians should adopt a patient-centered approach

IMPROVING CARE *(continued from page 10)*

Patient Statements and Behavior of Feeling Gaslit and Suggested Physician Responses

Patient Statement Examples	Suggested Physician Response
"Do you think I'm just imagining these symptoms?"	"Your symptoms are real, and I believe you. Let's work together to figure out the best way forward to address what's going on."
"I've been told this is all in my head."	"That must have been difficult to hear. I take your concerns seriously and explore both physical and emotional factors that could be contributing."
"I looked this up online, and I think I might have [condition]. What do you think?"	"Thank you for sharing your thoughts. Let's discuss your symptoms and the condition you read about so we can evaluate whether it might be related to what you're experiencing."
"I've tried everything, and nothing seems to work."	"I hear how discouraged you're feeling. Let's revisit your treatment history and see if there's a different approach or combination we haven't explored yet."
"Why can't you just order more tests to figure this out?"	"I understand your desire for more answers. Let's review what we've done so far and discuss the benefits and limitations of additional tests to make an informed decision together."
Patient Behavior Examples	**Suggested Physician Response**
Seeking out multiple providers for the same issue	"I notice you've seen several providers for this issue. Let's take a comprehensive look at your history to better understand what's going on and ensure nothing is being overlooked."
Having frequent visits with the same provider for unresolved symptoms	"I see you've been coming in often for the same concerns, which tells me this is really impacting you. Let's work together to get to the root of the problem."
Asking for second opinions frequently	"I respect your need for additional perspectives. Let's ensure all your questions are answered and collaborate on how we move forward together."
Bringing up past negative experiences with healthcare providers	"I'm sorry you had those experiences. I want to make sure you feel heard and respected here, so please let me know how I can best support you."
Showing reluctance to engage in treatment due to past experiences of feeling dismissed	"I know past experiences might make it hard to trust the process. I'm here to work with you and ensure your voice is a key part of our approach to your care."

that emphasizes holistic care rather than just treating a disease or symptom. Consider the patient's complete medical history, mental health, and personal circumstances when making decisions about care. Ensuring that each patient feels seen, heard, and respected is essential for combating medical gaslighting.

When these steps are combined with open yet focused communications, internists can address medical gaslighting and foster a collaborative and therapeutic relationship for their patients. Additional examples of patient statements regarding feeling gaslit with suggested physician responses are provided in the table.

Conclusion

Medical gaslighting is a significant issue with the potential to impact patient well-being and trust in the healthcare system. By prioritizing active listening, validating patient experiences, and adopting an integrated approach to care, SGIM physicians play a significant role in addressing this challenge and enhancing care.

Effectively combating medical gaslighting requires a commitment to patient-centered care, empathy, and an awareness of how biases may influence clinical decisions. When patients feel heard, supported, and respected, they are more likely to engage in their treatment and achieve better health outcomes. SGIM members have a responsibility to ensure that every patient's voice is valued and their concerns approached with compassion.

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REVAMPING A COMMUNICATION CURRICULUM: EMPLOYING AN EVIDENCE-BASED PATIENT-CENTERED INTERVIEW MODEL

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Nearly 30 years ago, medical communication scholars achieved a long sought-after feat: they developed evidence-based patient-centered interview models based on a biopsychosocial framework. Each component of these interview models, known as *The Four Habits Model*[1] and the *5-Step Patient-Centered Interview*,[2] could be observed as present or not present, and thus taught, assessed, and studied. Controlled trials have shown that these models are easily learned[3] and associated with improved patient health outcomes.[4,5] Nonetheless, awareness of these interview models across educational institutions is incomplete.

At the University of Massachusetts (UMass) Chan Medical School, teaching patient-centered communication has been an educational priority for decades. Only in recent years, however, has the Early Clinical Learning (ECL) leadership team fully aligned the communication curriculum with evidence-based patient-centered interview models.

In the 1990s, a group of pioneering leaders and educators at UMass Chan established an innovative, longitudinal small-group discussion and workshop-based communication curriculum for first- and second-year medical students. This curriculum was nationally recognized for teaching patient-centered skills like listening and empathy and has been previously cited by students as their most impactful medical school experience.

As specific patient-centered interview models accumulated evidence supporting their association with improvements in patient mental functioning, physical ability, and satisfaction, UMass Chan had yet to update its curriculum. While patient-centered skills were endorsed and promoted by the curriculum, the interview template and grading rubric directed students toward a clinician-centered style of interviewing. For example, the first eight checklist items on the grading rubric corresponded to obtaining the chief concern and the seven cardinal features of the chief concern, leading students to open the medical interview by asking a series of targeted questions. Only later in the checklist were there items that corresponded to asking about the patient's perspective on the etiology of the chief concern, acknowledging their stress and discomfort, and providing them reassurance. In 2022, the need for a teachable and testable step-by-step method for integrating patient-centered with clinician-centered interview skills was recognized as part of a school-wide curricular redesign. To address this need, the ECL leadership team set about to revamp the communication curriculum by employing an evidence-based patient-centered interview model.

In reviewing these models, the ECL leadership team recognized three gaps in the communication curriculum: the teaching of agenda-setting skills, the operationalization of open-ended questioning, in addition to emotion-seeking and response skills. Where agenda-setting was entirely missing from the curriculum, open-ended questioning and empathy skills were emphasized but not clearly incorporated into the interview templates and grading rubrics. Using the *5-Step Patient-Centered Interview* model as the basis, the leadership team revised the curricular materials (i.e., syllabus, session guides, preparatory readings and assignments, practice and assessment standardized patient cases, and interview templates and grading rubrics). Students are now taught and assessed based on the initial agenda-setting, open-ended questioning, and emotional inquiry steps.

Initial Agenda-Setting

- Welcome the patient and make social small talk
- Indicate the time available
- Forecast a clinician agenda

MEDICAL EDUCATION *(continued from page 12)*

- Elicit a complete patient agenda
- Negotiate a shared visit agenda.

Open-ended Questioning

- Elicit the story of the chief concern using an open-ended question. (e.g., "Please tell me *all about* the [chief concern]. Start from the very beginning and bring me up to the present in as much detail as possible.")
- Use open-ended skills to learn as much as possible about the chief concern (e.g., silence, continuers, echoing, open-ended requests such as "What else did you notice about the [chief concern]?").

Emotional Inquiry

- Elicit the emotional story (e.g., "You mentioned feeling [emotion]. How has this been for you, emotionally?")
- Respond to the emotion with a reflective statement and with statements of understanding, respect, and support.

Only after taking these key steps are students taught to transition to a clinician-centered style of questioning and obtain the rest of the medical history via targeted questioning.

During academic years 2022-23 and 2023-24, the ECL leadership team trained more than 28 small-group faculty facilitators in the revised curriculum. They taught and tested 175 students in the class of 2026 and 200 students in the class of 2027.

Six of the 20 faculty facilitators with active clinical practices reported changing their practice to align their interview style with the updated evidence-based model. The standardized-patient trainer conveyed that the standardized patients found the model allowed for a more natural and conversational exchange with students at the beginning of the interview. Specifically, they noted the use of the phrase "Please tell me *all about* the [chief concern]. Start from the very beginning and bring me up to the present in as much detail as possible" enhanced the patient-centeredness and efficiency of the interview. Some faculty and students expressed concern that the interview model was too scripted and could sound robotic or cold. However, the ECL leadership team found that students gradually altered the suggested wording over the course of their preclinical years, adapting it to their personal styles, and thereby enhancing its authenticity.

Student evaluations were unchanged compared with previous years, with 45-53% of first-year medical students rating their overall experience with the curriculum as "Excellent" on a 4-point Likert scale. Further, consistent with student performance in the prior curriculum, all students achieved a passing grade of 70% on the communication portion of the five objective structured clinical examinations.

All medical degree-granting United States medical schools accredited by the Liaison Committee for Medical Education are required to teach communication. Many strive to teach a patient-centered interview. Just as the field of medicine demonstrates its commitment to fact-based truth via its regular updating of educational materials in cardiology, genetics, and biochemistry, a similar dedication should be made to updating communication curricula.

SGIM leaders and educators involved in developing medical school communication curricula can similarly replicate the *5-Step Patient-Centered Medical Interview* or *The Four Habits Model*. Anticipated challenges may include updating a breadth of curricular materials, training faculty in a new curriculum, and navigating concerns about impact on student evaluations and exam pass rates. However, our experience showed that the revamped curriculum was straightforward to implement, accepted by veteran and novice faculty alike, adopted by students, and had no impact on student evaluations or exam pass rates.

Overall, we were pleased by the uptake of the evidenced-based patient-centered interview model by faculty and students. We invite SGIM leaders and educators to consider making such a change at their institutions and are available for support and further information.

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UNEXPECTED BONDS: HOW NON-MEDICAL STAFF SHAPED MY RESIDENCY AND MADE ME A BETTER DOCTOR

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I remember the early days of my intern year, and the emotions that came with it. I was a 30-year-old Dominican woman and proud first doctor of the family. Eager to become an ideal physician for my community, I pursued medical training at a top program in the country. I prepared for the challenges ahead, including stressful situations, long hours, and variable schedules. What I did not anticipate was the initial difficulty connecting with my new environment. In this column, I reflect on how I navigated that early sense of isolation and the unlikely friendships I found in non-medical colleagues. These relationships transformed my experience, reminding me that the support we need can come from unexpected places.

Residency programs are not bursting with young, Hispanic women of low socioeconomic status, or first-generation immigrants who took the scenic route to medicine because of the need to support their family. Yes, I felt happy to become a doctor and take care of the sick. Yes, I gained a hundred-plus new brilliant and kind co-interns. But I was overwhelmed by the amount of medicine still to learn and afraid to fail those who had supported me. I was lonely, having left my family and greatest source of support to pursue a dream. While my co-interns and I had similar hopes and fears about the training ahead, we had little else in common. Casual conversations in the workroom were often about things I had only heard of. When discussing weekend plans, for example, my co-intern Katie shared that she was going hiking, something I loved to do. Before I could share about my walks on local trails, the conversation drifted to favorite types of hiking boots (I wore sneakers), national park experiences, and best winter gear. Turns out I didn't even really know what "hiking" was! Outside of medicine, I felt inadequate, inexperienced, foreign.

Over the next four years, I adapted and learned more than just medicine. I found myself supported by an unlikely crew during the best and worst times of residency. This was the community my intern self couldn't have foreseen finding, the community they don't teach you about in medical school. I coped with my loneliness by "going to the bathroom," finding refuge near the service elevators, where the housekeeping team would often hang out. Their laughter, work gossip, and stories in loud Dominican Spanish, the language I grew up with, were music to my ears. I wanted so badly to join them, share my own tales, and tell them about my family—of whom they reminded me. However, intern checklists were long and the service was busy. I settled for taking the long way to the bathroom to make sure I saw them, walking slowly to maximize the experience, and greeting them in Spanish so they knew I knew. Their presence made me feel like I belonged.

One morning, I stopped by a patient's room after rounds. She had a mass in her chest and a constellation of symptoms that was concerning for cancer. She was sad, afraid, and alone. I sat with her for a while, listening and trying not to make things worse while navigating the many questions we had no answers to. This was my first conversation of this nature. When I left the room, my insecurities surfaced (as they often did in those early days), and I worried that maybe I could have done a better job. Later that morning, Carlos, the janitor for the unit, approached me and admitted he overheard some of our conversation while he was cleaning that patient's bathroom. "*I have been around here for 15 years, and you are very good.*" His words were the encouragement that I needed in that moment, the words that would stay with me for years to come.

Friendship is essential in enduring the kind of work we do in medicine. Carlos is one of the many friends I made in the hospital. There was also Jane, the information desk lady who told me, "*Tomorrow will be better*," whenever I felt defeated. There was Andy, who restocked the patient snack pantries throughout the hospital. He once left me a cupcake with a note that said, "*You got this, have a nice day.*" Then, there was Adriana, the 10A unit secretary, and the first person from work with whom I shared the news about my pregnancy; she had been encouraging me for years to "*have kids soon.*" Devon, the grill guy at the cafeteria, and Pedro, the pizza guy across from Devon's station,

PERSPECTIVE: PART I *(continued from page 14)*

once gave me a cardiovascular anatomy mug from the gift shop with a note in Spanish, "*It is lovely to know that we have phenomenal people near, willing to share friendship with a big, beautiful heart. It's a gift from life. Thank you.*" I cried and drank too much coffee out of this mug.

My dearest friends at the hospital were "non-medical." My loneliness in the physicians' workroom forced me to seek other places of belonging. I don't recall how these relationships became so important, but I know their conception required noticing and acknowledging the people around me, people I'd otherwise walked past; it required granting myself permission to slow down and work with them instead of around them. These relationships expanded my view of who constitutes the care team to include those who couldn't drop a note in the chart. My non-medical friends were essential to patient care, and to the care of all of us who worked in the hospital. They transformed my residency experience, sprinkling it with unexpected encouragement and kind gestures. They made me more present and intentional. They made me a better doctor and a better colleague.

I am now done with residency and starting my career close to family. I miss my old workplace; it was nice to know and be known. But as I step into my new hospital as a total stranger, I am overcome with joy and excitement for the friendships ahead—in all spaces!

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PERSPECTIVE: PART II

REMEMBER THEIR NAMES: DOCUMENTING THE DEATHS RESULTING FROM ABORTION RESTRICTIONS

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Are you aware that just days before the 2024 Presidential election, Porsha Ngumezi and Naveah Crain suffered preventable deaths in Texas?[1,2] Porsha left behind two young sons. Naveah was just 18 years old.

They died because they were pregnant and had uncontrolled hemorrhage and sepsis in the state of Texas. Both had nonviable pregnancies for which they sought and were denied medical care because of Texas' anti-abortion laws. It is shocking to learn many people are not aware of the tragic and preventable loss of these young woman's lives.

More preventable deaths will likely follow. As of March 2025, at least nine states (Georgia, Idaho, Indiana, Kentucky, Missouri, North Dakota, Oklahoma, South Carolina, and Texas) have proposed classifying and prosecuting abortion as homicides.[3] In addition, there are now some states with restrictions on abortion that are suing healthcare providers practicing in states with abortion protections for providing medication assisted termination.[4] This will increase fear and lead pregnant people to delay seeking care and physicians from providing life-saving abortions.

Since the Trump administration came into power, an effort is underway to systematically erase history and data from government websites, scrub datasets of variables (such as race and gender), and prohibit the collection of data (such as race, gender, and socioeconomic status). Project 2025 calls for the tracking on abortion related metrics (including abortion, miscarriage, stillbirth, and incidental pregnancy loss) and reporting this data to the federal government.[5] The goal is not to demonstrate the impact of restrictive abortion laws on women's health, but rather this is about restricting access to abortion and punishing those that perform or receive abortions. This is demonstrated by the point that Project 2025 states "OCR [Offices of Civil Rights] should withdraw its Health Insurance Portability and Accountability Act (HIPAA) guidance on abortion."[5]

This appears to be our future:

PERSPECTIVE: PART II *(continued from page 15)*

1. To stop data collection that would demonstrate the deadly impact of restrictive abortion laws on the lives of people who can become pregnant
2. To reverse privacy restrictions to potentially punish women and their healthcare providers for seeking evidence-based life-saving care.

This is even though many Americans support access to abortion to save the life of the parent who is pregnant. If the government does not collect or share data about the morbidity and mortality that directly follows from restrictions on abortion care, they can continue to further restrict and even ban access to abortion.

I write this not to discourage SGIM members but to remind you that we have power to advocate for data collection and the provision of evidence-based abortion care, and SGIM members can amplify that power collectively. SGIM can create communities and networks in which members document, preserve, and share the memories and stories of those who have lost their lives because of these policies. These efforts provide SGIM members the opportunities to replace the false narrative that abortions occur in the third trimester to healthy, viable pregnancies, with the reality that people who are pregnant are dying because they lack access to abortion services.

I respect everyone's choice when it comes to abortion. But I hope we can all agree that when a pregnancy is non-viable and a threat to a person's life, abortion should be provided.

I encourage SGIM members to join me in collecting and publicizing information about how people who can become pregnant, and their loved ones are harmed by restrictive abortion policies.

Let's memorialize Porsha and Naveah, the two little boys left without a mother, the parents left without a daughter, and honor Porsha and Naveah's shortened lives by protecting the lives of others.

Remember their names.

**Note: The opinions in this column do not purport to reflect the opinions, views, or positions of SGIM or any other entity.*

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SUPERWOMAN VS. LIFE: THE PATH TO BECOMING A CHAMELEON

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There are three lessons I have learned in my career: first, Superwoman does not exist; second, life happens; and third, it is all right to be a chameleon.

Superwoman, the fictional character of DC Comics, is invulnerable, with superhuman stamina, strength, and speed.[1] She can do anything with little vulnerability, except for her weakness to Kryptonite. Prior to college, I lived overseas for a year and returned to the United States with gratitude for endless opportunities to pursue my dreams! The "You can do anything and everything" philosophy was instilled in me. Going to medical school was my top priority. During medical school, I got married, and after residencies and fellowship, my husband and I started our family. I believed I could do it all! I had been indoctrinated by culture to take my maternity leave, find the best day care, practice full time, and be a loving wife to my equally super busy physician-husband.

It soon became clear that I did not fit into the Superwoman mold. Having a newborn along with a spouse working more than 100 hours a week, combined with maternal instincts, changed my perspective on my first lesson. I learned that I was not Superwoman. In my world, Superwoman did not exist.

This leads to my second lesson—"Life happens!" (*The original expletive used here was replaced for decorum.*) You never know what situations in life are going to come and how they will affect you until they happen: It could be something as beautiful as having a baby, or tragedies like death, war, or a disabling physical or psychological state that occurs to a family member.

Suddenly, the straight-forward regimented and structured path of college, medical school, residency, and the practice of medicine hits a bump in the road. This is hard to accept for a young, career and goal-oriented, high-achieving person early in their career. I learned for the first time as a young physician that I needed to prioritize my family over medicine. It was the right choice for us.

My third lesson is "It is alright to be a chameleon." To be a chameleon, you don't have to have zygodactylus feet, acrodont dentition, or venom glands.[2] I have learned in my career that the ability to adapt and change is fundamental to survival, particularly as a woman in medicine, who also happens to be a spouse, a mother, a daughter, a sister, and a friend. Just as chameleons can change their color in response to environmental factors, so do I.

This has required taking different paths to suit the needs of my family and at times putting my medical career on hold. This was not always easy to accept. There was guilt in leaving my patients. I did what I was called to do as a mom and wife, family caregiver, school board chair, and soccer coach, all the while keeping my hands in medicine as county Medical Society president, an Alabama Free Clinic volunteer, and maintaining board certification. I waited for my environment to change so that I could change colors to reflect the practicing physician that I am today.

These three lessons I have learned in my career have led me back to my roots in academia and the Society of General Internal Medicine (SGIM). I love this Society and the opportunities it affords its members! I love that I can use my God-given and hard-earned developed skills to help educate this next generation of physicians. I am very thankful for the journey; despite wishing I had known the lessons earlier in my career.

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