

CAREER GUIDE for RESIDENTS



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- Finding new ways to teach procedures
- 10 tips for well-being amid COVID-19
- Training meets pandemic
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2020 Fall Career Guide for Residents

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Finding new ways to teach procedures

Simulation is part of the current model for procedure training

By Mollie Frost

Procedures remain essential to internal medicine training, but the ways residents learn to do them have evolved as the American Board of Internal Medicine's (ABIM) procedural requirements for board certification have changed.

"There are so many different learners, so many different learner types, and so many different interests, and I think it's hard to train a monolithic internal medicine resident," said May M. Lee, MD, a clinical associate professor of medicine at the Keck School of Medicine of the University of Southern California in Los Angeles.

within a program [could do so] would be very helpful in facilitating these types of skills development."

Doing procedures early on is especially helpful for residents who are considering entering a procedurally based subspecialty after residency, she said. As a pulmonary and critical care fellowship director, she said she looks favorably upon applicants who've done a lot of procedures. And for those who want to become hospitalists, Dr. Lee noted that procedurally competent hospitalists are potentially valued and compensated more than those who don't do procedures.

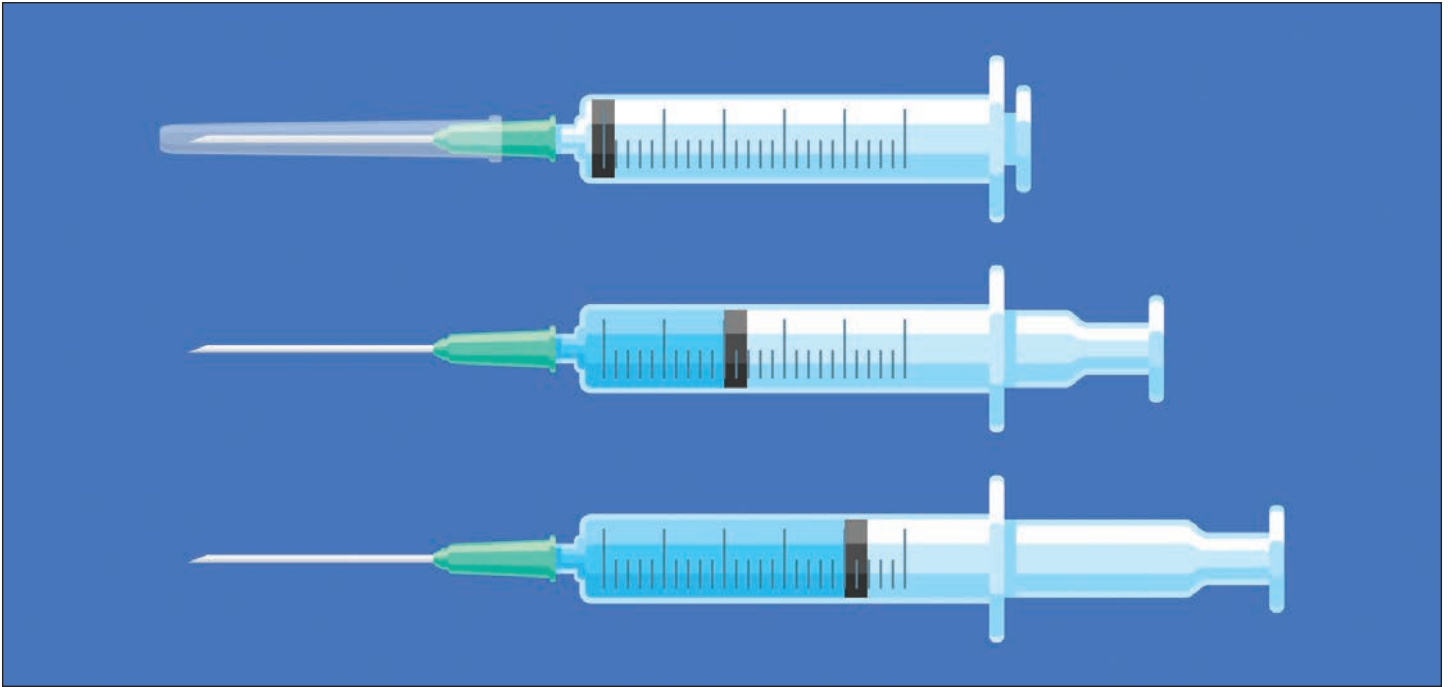


Image by Getty Images

As of the 2019-2020 academic year, ABIM still required all residents to perform procedures during training. However, the certification requirements state that "Not all residents need to perform all procedures," as the specific procedures they complete will vary based on their subsequent subspecialty or choice of an inpatient or outpatient career path. In other words, procedural training for today's trainees may be customized to the individual.

The most recent requirements, which ABIM established after seeking input from program and fellowship directors, recent graduates, health systems, and medical societies, also give program directors more discretion in how they evaluate procedural skills. "This may vary from resident to resident depending on interest," said Dr. Lee. "I think building avenues where people who are interested in getting procedural training

Plus, residents are still the workhorses of the hospital on nights and weekends. At some institutions, they may even be called upon to do procedures out of necessity, said Joshua D. Lenchus, DO, RPh, FACP, regional chief medical officer at Broward Health Medical Center in Fort Lauderdale, Fla. "They may not do [them] when they get out of training, but certainly in training, there is a need to have residents perform these procedures because they're not being performed by attendings in many of the training institutions around the country," he said.

Residents have the benefit of more attending supervision than in the past and increasing use of simulation-based training. Although ABIM isn't requiring as much procedural expertise as it used to, some residency programs have been going a cut above the requirements by using simulation and establishing procedure service rotations.

Going beyond requirements

In the early 2000s, ABIM required residents to successfully perform a minimum number (three to five) of certain invasive procedures, such as lumbar puncture, abdominal paracentesis, central line placement, and thoracentesis.

Historically in the U.S., residents performed procedures at the bedside without attending supervision, said Grace C. Huang, MD, FACP, an associate professor of medicine at Harvard Medical School and a hospitalist at Beth Israel Deaconess Medical Center in Boston. "Back then, there was very little supervision, and if it occurred, it was the person the next level up," she said.

Then, in 2006, ABIM changed its requirements for certification to state that residents are expected to understand and be able to explain (but no longer perform a certain number of) such procedures. Instead, residents are required to safely perform a smaller subset of procedures, including advanced cardiac life support as well as more outpatient-based procedures, such as drawing blood and doing Pap smears.

Under the most recent requirements, program directors can customize their procedural evaluations using direct observation and simulation as appropriate, according to ABIM. Given the evidence supporting simulation and competency-based approaches (such as mastery learning) for teaching procedures, such as a systematic review and meta-analysis published in the April 2016 *BMJ Quality & Safety*, more residency programs are using these techniques.

At the University of Miami Miller School of Medicine, Dr. Lenchus created a simulation-based invasive bedside

procedural curriculum that uses mannequins and an ultrasound machine to teach trainees. The main procedures include lumbar puncture, thoracentesis, paracentesis, central venous catheterization, and knee arthrocentesis.

To standardize the way procedures are taught, Dr. Lenchus trained a handful of attendings in performing the procedures, supervising the residents, intervening when necessary, and providing feedback. "We used a critical skills checklist to assess the performance of the procedure, both in the sim lab and at the bedside, and every procedure was directly supervised by hospital medicine attendings," he said.

Northwestern University Feinberg School of Medicine in Chicago also uses simulation to "go above and beyond the ABIM guidelines," said Jeffrey H. Barsuk, MD, MS, professor of medicine and medical education and the director of simulation and patient safety. Residents learn how to do procedures through a simulation-based mastery learning curriculum and must reach mastery before doing them at the bedside.

"Before the end of training, all learners are required to reach a very high level of skill that's determined by an expert panel to be safe for independent patient care. Residents have to demonstrate this level of skill on the simulator before they are even allowed to perform the procedure supervised on patients," Dr. Barsuk said.

Hands on patients

Residents who, due to career plans or general interest, want hands-on experience in invasive procedures often must learn while rotating through the ICU or a procedure service (if the hospital has one), said Dr. Lee. But in the ICU, the ability to

Teaching hospitalists to do procedures

It's not just residents who have been doing fewer procedures. There has also been an overall decline in hospitalists' procedural skills, said Joshua D. Lenchus, DO, RPh, FACP, regional chief medical officer at Broward Health Medical Center in Fort Lauderdale, Fla.

"Because it has been abandoned in residency for a while now, residents who get out and then become attendings now lack the skill and confidence in order to perform and supervise these procedures," he said.

The Society of Hospital Medicine's 2017 core competencies for hospitalists do include five procedures: arthrocentesis, central venous catheter placement, lumbar puncture, abdominal paracentesis, and thoracentesis.

But for many hospitalists, procedural skills wane as a result of low procedural volume, and hospitals may lack established mechanisms to ensure that they maintain their skills, according to a perspective published in May 2019 by *Annals of Internal Medicine*.

Grace C. Huang, MD, FACP, an author of the perspective, has observed that hospitalists less experienced with performing procedures in her group will consider having interventional radiology do procedures instead. "There are many specialties that can do these procedures now, and as a result, I'm no longer gaining skill from my own volume and experience," said Dr. Huang, who is an associate pro-

fessor of medicine at Harvard Medical School and a hospitalist at Beth Israel Deaconess Medical Center in Boston.

To train the hospitalists to do procedures, her group used a simulation-based mastery learning approach and shared their insights in the *Annals* paper. At baseline, the hospitalists reported only moderate levels of comfort performing lumbar punctures and paracenteses and poor comfort teaching them. Only half achieved passing scores when practicing on mannequins.

The group did master procedures during the training. But when reassessed a couple of months later, their skills had naturally regressed, said Dr. Huang. "I think what's scary is the fact that most hospital credentialing processes across the country allow physicians to do these procedures, but they may be neither comfortable nor proficient," she said.

That may change, however, according to Jeffrey H. Barsuk, MD, MS, professor of medicine and medical education and the director of simulation and patient safety at Northwestern University Feinberg School of Medicine in Chicago. He sees more institutions launching medical procedure services, as well as more hospitalists jumping on board through "train-the-trainer" opportunities. "I think, if anything, it's starting to make its way back," he said. ■

do procedures is restricted. "Residents don't always get to do them. Sometimes it's the fellow or the attending because, if the situation is dire enough, it just needs to get done," she said.

A procedure service can help interested trainees get intensive hands-on experience while offloading procedural work from their resident colleagues directly caring for the patients, Dr. Huang noted, adding that her colleague C. Christopher Smith, MD, FACP, started one of the first procedural service rotations in the country in 2004 at Beth Israel Deaconess.

"This allowed residents to do a one- to two-week rotation where all they were doing was procedures. . . . This essentially became a consultative service so that residents who cannot pause their workday for a few hours to perform a procedure could request the procedure team to manage the whole process. This involves independently reviewing the indications, obtaining consent, monitoring for complications, and following up on results," she said. "That educational structure has been in place here for more than 15 years now and I think has basically been propagated around the country as well."

At the University of Miami, residents who complete simulation training move on to a procedure service rotation that Dr. Lenchus created in 2007 to give them a critical mass of experience. The four-week rotation began as an elective and has since become a mandatory rotation for all internal medicine and medicine-pediatrics residents, he said.

Calls to the service come from any service in the hospital, such as the ED and the ICUs. "Anyone could call our team to perform the procedure like they could call interventional radiology . . . In fact, we took over the education of procedures for most of the hospital," Dr. Lenchus said. For example, the service team trained surgeons how to put in central lines and trained neurologists how to do lumbar punctures, he said.

Northwestern has also been planning to start an elective procedure service rotation and will require residents to

complete the simulation training beforehand, according to Dr. Barsuk. "My guess is that residents who are going to be more procedure-based will want to do it," he said.

For hospitals that want to start a procedure service, the most resource-heavy component will be arranging for direct supervision in addition to equipment like mannequins and a portable ultrasound machine, said Dr. Lenchus, who has shared his program with several other institutions. "The financial resources in getting this off the ground in the beginning is getting the equipment that's needed, and then having some semblance of a 'train-the-trainer' session," he said.

The decision of which clinicians should train others on the service will depend on the skill level of staff, said Dr. Lee, who created and served on a procedure service at Mount Sinai Hospital Medical Center in Chicago. "I think it can be owned by internal medicine if you have procedurally based hospitalists, or it can be owned by pulmonology/critical care or even a surgical service," she said.

But not every institution is ripe for a team-based service, as opposed to one or two trained individuals who can supervise and train other people, Dr. Lenchus said. "In a large hospital . . . having a team is warranted because the volume is so high, and you could actually carve out a dedicated attending to supervise the performance of those procedures," he said. "But a hospital that has 100 or 200 beds may not have the volume to warrant a full-blown team."

Nonetheless, Dr. Lenchus said that standardized procedural training should be manageable for any hospital that wants to move beyond the old training model of "see one, do one, teach one." "I think it's absolutely doable for every institution, regardless of size, to conduct the training," he said. ■

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10 tips for well-being amid COVID-19

The global pandemic has professional and personal consequences for physicians, so experts offer their advice on coping during COVID-19

By Mollie Frost

Well-being as an internist is never easy, let alone during a global pandemic.

"I know that I personally have struggled with a lot of frustration, and anger, and fear, and grief," said ACP Member Elisabeth Poorman, MD, MPH, a clinical instructor and primary care physician at the University of Washington in Seattle. "And those feelings are totally valid."

Especially in medical education, physicians may believe they need to know everything in order to be competent, said Dr. Poorman. "But it's not possible to know everything in medicine, and it's certainly not possible right now in a pandemic. Information is rapidly changing."

From patients dying to financial uncertainty, the consequences of COVID-19 for physicians are both professional and personal. Dr. Poorman and other wellness advocates provided their top 10 tips for staying well as the crisis continues.



Amid the instability created by trying to manage during a pandemic, being flexible is the most important skill in a physician's toolkit. Image by Jamie S. Newman, MD, MHA, MACP

1. Be flexible.

Uncertainty is a major feature of the COVID-19 crisis, said Kerri Palamara, MD, FACP, director of the Center for Physician Well-Being at Massachusetts General Hospital in Boston and physician coaching services lead for ACP. "This pandemic is a terrible perfect storm of uncertainty, anxiety, rapid-cycle change, seeing things for the first time, and a lack of data,"

she said. "And then you factor in a touch of social isolation... and you feel like you really have nothing to grasp on to."

This disease is also challenging because it is so novel, said Susan Thompson Hingle, MD, MACP, Chair of ACP's Physician Well-being and Professional Fulfillment Committee and professor of medicine at Southern Illinois University (SIU) School of Medicine in Springfield.

"For a lot of things in life, we learn from people who have experience. That's where we get our comfort. They reassure us, 'We've been through this before, and we'll get through this,'" she said. "This is so new and different, and the people who got through [the influenza pandemic] in 1918 are not here to share that wisdom with us."

Since the only stable aspect of a crisis is the instability, being flexible is perhaps the most important skill in a physician's toolkit, said Eileen D. Barrett, MD, MPH, FACP, an ACP Well-being Champion and former ACP Regent and Governor who spent six weeks in 2015 treating Ebola in Sierra Leone. "We know it's going to be unstable and changing for a while, so I will anchor myself onto knowing that this will be the case," she said.

2. Embrace what you can do with telemedicine.

Telemedicine is "totally different than face-to-face care," which makes for new intellectual challenges, said Dr. Hingle. "I didn't realize how much nonverbal information was provided by eye contact or body positions that you can't necessarily pick up on a phone call or on a video," she said. "And the accuracy—internists, we're known for liking our data, and you can't listen to a patient's heart or lungs."

Losing that therapeutic touch and connection from in-person visits can almost feel like losing a sense, said Tammy Lin, MD, MPH, FACP, an internist in private practice in Rancho Santa Fe, Calif., and Governor-elect for the ACP Southern California Region III Chapter. "But if you lose your sight or you lose your hearing, all the other senses become amplified, and you develop them further," she said. "So perhaps this is an opportunity to further develop some skills and senses."

One example is that telemedicine can sharpen your triage skills, said Dr. Lin, who is also an ACP Well-being Champion. "There are obviously things that you can't do via telemedicine, but I think what you can do over telemedicine has opened a lot of people's eyes in deciding who needs to be seen in person and what you may be able to take care of in other ways," she said.

To maximize your telemedicine visits, remember what's called the "golden minute," Dr. Poorman said during an ACP webinar on lessons learned from the front lines. "Traditionally, you may be familiar with that as the minute that you're walking to the exam room with the patient before you open the

computer and launch into your questions, but on telemedicine, I think you can also incorporate that as well," she said.

Precharting before a visit is an efficient way to help you customize your approach; in addition to the clinical agenda, consider making a note of the patient's job or some detail about the person that jogs your memory, said Dr. Poorman. "That moment of connection has been really important for them, but also really important for me. And many patients will actually ask me how I'm doing, which is unusual and has been really heartening," she said.

Then, after a patient has told you the reason for the appointment, it can be helpful to ask what he or she is most afraid of or concerned about, she added. "I think that's probably always a useful question, but right now, the fear and anxiety is so high that that question really helps me better understand what the patient is looking for, make them feel heard, and oftentimes will reveal some very helpful clinical information, such as the fact that they may be living with immunocompromised family members," Dr. Poorman said.

3. Keep financial concerns in perspective.

From pay cuts to layoffs to keeping the lights on, financial concerns are top of mind for everyone right now.

At SIU, the majority of patient care income comes from the outpatient setting, so the decline in patient visits immediately after the pandemic negatively impacted the financial bottom line, said Dr. Hingle. Effective in May, faculty were receiving 75% of their salary, with the rest of the money going toward payroll to avoid layoffs, she said.

Dr. Hingle advised keeping measures like this in perspective. "Physicians remain a very well-compensated profession. ... It is definitely a big pay cut. But still, what I'm able to bring home at 75% is way more than what my staff get paid and way more than the vast majority of my patients get paid, and I don't have to worry about living paycheck to paycheck. I can feel comfortable that I can pay my bills without needing to make hard decisions," she said.

No internist wants to hear about pay cuts, layoffs, and office closures, but reacting with worry and fear of the unknown can be paralyzing, said Dr. Lin. "Slowing down so you can get into a state where your mind can be clear and calm is helpful as you evaluate the situation, determine which resources you can tap into, and tackle one step at a time," she said.

While you will likely have an emotional reaction, taking a moment to do some breathing and mindfulness techniques before going into problem-solving mode can help reduce stress levels, Dr. Lin said. "Those techniques will increase your capacity to be there for others and to find effective solutions—to respond instead of react," she said.

For physician leaders, transparency with staff is key when salaries are on the line, said Dr. Poorman. While it's important to let them know you may be cutting hours or pay, be sure to work with them, listen to their concerns, and set expectations for the future, such as potential opportunities for overtime, she said. "In a few months, I think there's going to be a huge demand for our services. So how are you going to take care of your loyal and important staff?" she said.

4. Remember that you're not alone.

As the crisis began, organizations and clinicians were focused in solidarity on protecting and supporting the American public, which provided meaning and purpose, said ACP Member Read G. Pierce, MD, who is an associate professor of medicine at the University of Colorado Anschutz Medical Campus in Denver. But now that the country's trying to get back to normal, the realities of physician burnout are creeping back into the picture, he said.

"Now we have this environment where budgets are in bad shape for many health care systems, and support from the county, from the community, from the state, from the federal government is going to drop because of the economic impact," said Dr. Pierce. "I think we're going to enter this period where there is an even more acute challenge of needing to do the same amount of work with many fewer resources, and that's going to put a ton of pressure back on the previous drivers of burnout."

In these next phases of the pandemic, the onus is on health systems and other employers of clinicians, as well as the government, to make clinician well-being a priority, according to a perspective published May 13 by the *New England Journal of Medicine*. "Before the virus struck, the U.S. clinical workforce was already experiencing a crisis of burnout. We are now facing a surge of physical and emotional harm that amounts to a parallel pandemic," the authors wrote.

While caring for patients, providing for your family, and taking care of colleagues and employees is a lot to handle at this time, remember that you don't need to do it all alone, noted Dr. Lin.

"I think to seek help, tap into resources and support, and not be afraid to do so is a really important point," she said. "And also to not do it alone on a professional front. That is the role, in part, of our leaders and professional organizations and societies: to advocate for you in these times. That's why you're a member and you participate. We're all in this together."

5. Stay connected.

The world can feel strange, foreign, and suddenly dangerous right now, Dr. Palamara said. But physical distancing does not have to equal social isolation, and video platforms offer a great opportunity for connection, she said.

Mass General hosts "water cooler breaks" through Zoom to allow staff to share good stories with each other, Dr. Palamara said. As an added bonus, taking a few minutes to check in with a peer can even increase productivity compared to burying yourself further in your work, she said.

"It doesn't feel like it would work this way, but this actually increases your efficiency and productivity, and there are companies that have designed their entire strategy of the workday around that," said Dr. Palamara.

It's also important to continue mentoring relationships during this time, said Dr. Lin, who helps run Med Mindset, a pipeline mentorship program affiliated with the University of California, San Diego (UCSD), where medical students mentor high school students from groups that are underrepresented in medicine. "Mentoring is not just the transfer of information, but it also serves an important social function too," she said. "And you can help students, or whoever your mentee is, develop and grow in other ways as they encounter challenges."

Although COVID-19 caused a significant disruption to the mentor-mentee relationships, the mentors have adapted by helping their mentees focus on tangible, attainable goals to help them feel productive and keep their minds occupied, said ACP Medical Student Member Alexandra Maloof, a third-year medical student at UCSD School of Medicine who leads the Med Mindset mentors. "Another point is helping mentees understand their new normal, which varies from mentee to mentee based on their personal experiences that they're having and how they're coping with COVID," she said.

Another way to stay connected and share ideas is through online discussion boards, such as the ACP Member Forums. (The Member Forum for COVID-19 discussion is online.) As the pandemic escalated, the Association of Program Directors in Internal Medicine discussion board was invaluable to inform decision making around resident education, said Sandhya Wahi-Gururaj, MD, MPH, FACP, a former program director for 12 years and now associate program director of the internal medicine residency program at the University of Nevada, Las Vegas (UNLV), School of Medicine.

"Part of their well-being was just being well informed about what's happening, so it was so crucial to make sure everybody knew what was going on nationally to inform their decision making," she said.

In addition, connecting around difficult events can help clinic staff process the harsh realities of COVID-19, said Dr. Poorman. "We know that a lot of our patients are probably going to die in the next few months, and I think one thing that we have struggled with as physicians is thinking about ways to grieve," she said.

Patients have relationships with the entire staff, from the front desk to social workers to nurses, Dr. Poorman noted. "So it's important, when we lose a patient, to think about how our whole team is affected by that and to think about ways to grieve together," such as by calling families, writing notes together, and debriefing about difficult situations or concerns that something was missed, she said. "It's important when you debrief to think about psychological safety, which is where you say no one will be punished for speaking up," she added.

6. Find gratitude.

Practicing gratitude is one of the most important ways to get through a crisis, said Dr. Hingle. "There's lots of terrible, terrible things happening, but there are also lots of positive things that are happening in the midst of all of this," she said.

For example, many clinicians are learning to teach remotely and realizing in which situations video conferencing can be more efficient than face-to-face meetings, Dr. Hingle said. "We're also learning that our relationships are important and something that we need to pay attention to. ... So look for those learning lessons and positive things that are coming out of this, because there is definitely a lot to be learned throughout the challenge," she said.

Another area to practice gratitude is with your colleagues in the clinic, such as by writing thank you notes or giving kudos for a job well done, suggested Dr. Poorman. "And be kind. This is not the time to write an angry email," she said. "Keep in mind that a lot of our bad coping mechanisms are going to be coming out in the next few months, so just give people some space."

7. Be informed, but don't overdo it.

With information on COVID-19 constantly updating, "It's like a fire hose, 24/7," said Dr. Lin. While it's important to stay informed, it's also important to put limits on what you take in, "just like you would, hopefully, watch what you eat and what you consume," she said.

Dr. Wahi-Gururaj, also an ACP Well-being Champion and professor of medicine at UNLV, said when the crisis started, she was "nonstop" reading media coverage, reading scientific literature, and listening to podcasts about it. "But at some point, I was drowning in it. And I realized I needed to give myself breaks from reading about COVID all the time to do other things," she said. "I've never made pasta in my life, and I made pasta with my kids."

Twitter is another tool for staying connected, and the internal medicine community actively shares well-being advice (and challenges) at the hashtag #dontworryalone. However, Dr. Hingle found that limiting her Twitter use improved her well-being. "There was so much negativity, and it was getting to the point that it was creating so much anxiety that I really try to minimize it," she said. "I try to insert some positivity when I can, but for a lot of people, it's just not a positive time right now."

8. Recognize what's in your control.

We all know we can't control everything, but it can be helpful to be more specific. ACP Member Narath Carlile, MD, MPH, a clinical informaticist, found a way for physicians to do that.

While assessing the utility of apps for measuring stress with his 12-year-old daughter, he came across a simple yet powerful diagram: an inner circle depicting what one can control and an outer circle depicting what one cannot control. But as he reflected on that paradigm, he realized that for physicians, there is a gray area in between the circles. "In addition to the things that I can and cannot control, there are areas where my actions can matter, where I can influence but not control the outcome," Dr. Carlile wrote in an April blog post.

So he made his own diagram, customized to his clinical experience, which can be found in "COVID-19: An ACP Physician's Guide and Resources." Without a cure or vaccine for COVID-19, physicians cannot stop people from becoming sick or dying; the best they can do right now is "try and influence the best possible outcome, and give the best care possible," wrote Dr. Carlile, an associate physician at the Phyllis Jen Center for Primary Care and director of innovation for the internal medicine residency at Brigham and Women's Hospital in Boston.

But of course, every physician's circumstances are different. "I've been trying to find a way for people to easily make their own, or perhaps more easily for a small group of docs to create a shared understanding," he said. To do that, Dr. Carlile recreated his diagram on the Google Jamboard app, where users can make a copy of the diagram and create their own by adding customized sticky notes.

9. Nurture positivity.

Tapping into positive emotions, even for a few seconds, can both provide energy and balance the stress hormones and signaling in the brain, said Dr. Pierce.

"So part of what I think we can be working on, even at times like these, is [recognizing] little things we can do to tap

into healthy amusement, pride, hope, gratitude, or interest in daily work, and when we can do that," he said. "There are lots of opportunities to do that, if we look for them."

As part of his own version of this practice, Dr. Pierce said he inserts frequent small doses of positive emotion by recognizing three good things that happen every day, and he's shared this with colleagues as well. Writing down three specific good things at the end of each day is one of the most evidence-based positive psychology techniques, in company with the expression of gratitude and random acts of kindness, added Dr. Palamara, who presented an ACP webinar on using positive psychology in times of crisis.

"There's really cool data to show that if you even do this for three weeks, your overall depression scores over the course of three months, six months, and nine months go down, your efficiency in the workplace goes up, your subjective quality of life goes up ... and it's free," she said.

Dr. Palamara knows firsthand what the power of positivity can do. After her nearly 3-year-old son was killed in 2018 when he was struck by a car, she ran the 2019 Boston Marathon with a team of 11 runners and raised more than \$100,000 to give back to other children and families in Boston. As it did then, "Positive psychology has helped tremendously during this time," Dr. Palamara said. "This is not going to change this pandemic, but it can change how we feel in a moment. And no matter how awful things are in life, these still can play a role."

10. Remember to take care of yourself.

In addition to staying positive, mindful breathing and self-care are key tools to approaching a crisis with calm, experts agreed.

One technique called box breathing consists of a four-part cycle of four seconds each: breathing in, holding in, breathing out, and holding out, which can reduce anxiety and stress, said Carter Sigmon, MD, MHA, MS, a physical medicine and rehabilitation physician who is in private practice in Rancho Santa Fe, Calif., and served in the military for eight years as the medical director of the Navy's Wounded Warrior Battalion. "We've had a lot of success with these types of techniques in many areas of the armed forces. ... At first you have to initiate it, but after practice, it becomes reflexive," he said.

Meditation is also a useful practice, but it's not for everyone, said Dr. Palamara. "I'm more of an exercise-as-meditation person," she said. Finding ways to exercise at home has been crucial for ACP Resident/Fellow Member Caleb Murphy, MD, MBA, a third-year resident at UNLV. "Most of our decompressing activities—hiking, going out to eat, going to the gym—are not options right now, which makes wellness tough," he said.

With so many competing priorities, making time for exercise is difficult but necessary, noted Dr. Wahi-Gururaj. "I think you have to remember yourself and that your self-care is still important during this challenging time, because I think we often don't give ourselves permission to care for ourselves," she said. "As a woman and a mom, I tend to put myself last. So giving myself permission to go on those runs in the morning and walks to get the exercise, even though I'm busy, has been really important for me."

Dr. Poorman, also an addiction medicine fellow at the University of Washington, noted that a lot of people are using alcohol to unwind. "I certainly understand that. This is an incredibly stressful time and it's an easy thing to do," she said. "But one thing I'd like you to keep in mind is that we are at particularly high risk for substance use disorders in normal times, and I think during this pandemic maybe even higher."

At baseline, one of 10 physicians qualifies for a substance use disorder and one in five qualifies for hazardous drinking, Dr. Poorman reported. "Just be careful about that. Don't think you need more to the extent to which you will be wanting that alcohol to calm your nerves after work," she said.

Remember that maintaining well-being is both a marathon and a sprint, said Dr. Lin. "Just like any muscle, these skills will get stronger and you will be able to call on them and depend on them the more that you activate them," she said.

Finally, it's important to have hope, said Dr. Hingle. While physicians everywhere have worked tirelessly through many challenges during this pandemic, it won't last forever, she said. "I always liken it to when you're treading water and your nose is under the water," Dr. Hingle said. "It's terrible, but once you get that head above water, even though you're still treading water, you can keep going." ■

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A well-being boost, with a side of CME

ACP now offers well-being webinars for CME credit. The following presentations can be found under the Physician Well-being and Professional Satisfaction tab.

- COVID-19: Practical Advice and Support from Internists on the Front Lines
- Addressing and Supporting Physician Mental Health during Challenging Times
- Optimizing Well-being, Practice Culture, and Professional Thriving in an Era of Turbulence
- Building Your Resilient Self®
- Mindfulness in Medicine: What Physicians Need to Know
- Physician Well-being for Residents and Fellows

In addition, "COVID-19: An ACP Physician's Guide and Resources" features many additional resources under the Clinician Wellbeing tab. ACP members can claim free CME credits and MOC points when they use the guide, which is being updated throughout the pandemic.

How to get help

ACP's Physician Well-being and Professional Fulfillment page offers multiple resources for those in need of assistance, including information on crisis and counseling support, ways to connect with colleagues, and recommended tools to improve personal well-being and professional fulfillment. ■

Training meets pandemic

Academic medicine adapted rapidly to COVID-19

By Mollie Frost

It was early April in New Orleans when the Tulane University Health Sciences Center reached its peak of COVID-19 patients. After treating their index case on March 9, hospital staff had quickly created COVID-only units to conserve personal protective equipment (PPE), but a month later, the entire hospital was essentially COVID-only.



Image by Getty Images

To bolster the front lines, Jeffrey G. Wiese, MD, MACP, senior associate dean for graduate medical education, recruited residents from anesthesia, radiology, neurology, dermatology, and ophthalmology who had done their preliminary year with Tulane internal medicine. These volunteers began serving on the wards to support the medicine residents, allowing them to move up to the ICU, which had doubled in capacity. They also provided some intermittent rest time for the medicine residents, enabling sustainability of the effort. Psychiatry residents, unable to practice in their usual clinics, also moved to the ICU, serving as liaisons to patients' families to allow the ICU teams to focus on treatment.

The crisis did interfere with residents' didactics, but it also gave them an opportunity to prove themselves—one reminiscent of 2005, when Hurricane Katrina hit, said Dr. Wiese, who directed Tulane's internal medicine residency program for 20 years before stepping down in July 2019.

"I think about those residents that went through the Katrina years and just how much better of physicians in total they were at the time that they completed training," he said. "I feel

that that's going to be the same for the Tulane residents. I think the same will be said for all the residents nationally that have stepped up and shown that willingness to defer personal needs for the benefit of the patient ... which, at its core, is the definition of professionalism."

Dr. Wiese and clinician-educators across the country spoke about the various ways trainees have developed throughout the COVID-19 crisis, as well as how medical education has adapted to sudden changes necessitated by the pandemic.

Rethinking trainee competencies

Like everyone, residents and medical students have responded to the pandemic in various ways.

One survey asked 316 third- and fourth-year students, interns and residents in internal medicine and emergency medicine, and fellows in pulmonary and critical care at the University of Washington in Seattle to reflect on the unique ethical or practical challenges they'd experienced as a result of the pandemic. A sampling of the responses was published online in April by the *New England Journal of Medicine*.

Some worried about transmitting infection to others outside the hospital. Thanks to factors including shortages and rapidly changing recommendations regarding PPE, many felt vulnerable. As one internal medicine resident wrote, "It's a constant dialogue of 'Am I safe? Is my patient safe? Is this care adequate? Am I doing all I can?' All of this takes a serious toll on the psyche of trainees, and it's an impact that will likely be felt for a long time."

Everyone in medical education, including faculty, is living in a world full of volatility, uncertainty, complexity, and ambiguity, said Mukta Panda, MD, MACP, professor of medicine and medical education at the University of Tennessee College of Medicine Chattanooga. Therefore, while the knowledge of students and trainees is still defined by competencies, educators must assess them on an individual basis, she said.

"Some of the learners have not been involved because of either lack of PPE or the place where they work, and some of the learners have been passed over into the front lines, so we are looking at learners with different stages," said Dr. Panda. "It cannot be a one-size-fits-all."

Educators can also think about competencies that might be newly or more intensely needed, she said. "We need to definitely give them the science. That is important to be a physician or to be a health care professional," Dr. Panda said. "But we also need to give them skills," from fundamentals like telemedicine to other new focuses like advocacy. (See sidebar for resources on teaching telemedicine and other skills.)

The most important competency right now, she said, is self-care and colleague care. "This pandemic situation that we are going through now has shown us very explicitly that

being in this vocation has asked us to adapt, to improvise, and to overcome,” said Dr. Panda, who is also assistant dean for well-being and medical student education. “That becomes our resilience and allows us to recover, recharge, and rise above our challenges. This has to be incorporated right from the beginning.”

It’s important to remember that not every resident has had the same level of exposure to coping skills, said Charlene M. Dewey, MD, MEd, MACP, professor of medicine and medical education and administration and chair of the faculty well-being committee at Vanderbilt University School of Medicine in Nashville. Although new physicians usually start to develop these skills during residency, it may take a while, she said.

“As an older physician, my first thing is, you rush to the problem. But there were some younger physicians that were fearful and thought, ‘I don’t want to die,’ and they’re going to run from that problem. So, is that bad? Is that wrong? Fear, as an emotion, is neither bad nor wrong,” Dr. Dewey said. “They’re young, and they haven’t had the time to fully develop their identity as a physician. It is up to us [faculty and older physicians] to help residents manage that fear and build resilience and shape identity.”

In the survey, some residents reported feeling excited or lucky to help, even though they were afraid. While faculty primarily cared for patients with COVID-19 at the University of California, San Francisco (UCSF), Parnassus campus, residents were involved in ICU care of patients with the novel coronavirus and were also allowed to admit overnight, said Bradley Monash, MD, associate chief of the division of hospital medicine and site director of the UCSF medicine residency.

“The residents really were an active voice and were requesting to be involved and did not want to be sidelined,” he said.

On this point, some students who responded to the survey said they felt underutilized due to being removed from their clinical rotations. With less opportunity for patient care during the pandemic and internship looming, it’s “not an ideal time to be rusty,” said one concerned fourth-year student.

While working on an article about educational policies early on in the pandemic, Mel L. Anderson, MD, MACP, and coauthors reached out to medical schools. In a perspective published by the *Journal of Hospital Medicine* in April, they reported that students’ face-to-face interactions with patients had temporarily been put on hold.

“That was not required by the [Association of American Medical Colleges], but they issued guidance saying they were supportive of schools making that decision,” said Dr. Anderson, who is the national program director for hospital medicine for the Veterans Health Administration.

In contrast, some schools in hard-hit areas, such as New York University, graduated some fourth-year medical students two months early to address potential workforce shortages. This is a practice common in some other countries, such as New Zealand, where final-year medical students work as “junior” interns, Dawn E. DeWitt, MD, MSc, MACP, wrote in a perspective advocating for the practice, which was published online in April by *Annals of Internal Medicine*.

“My reason for writing that was hearing how bereft our students were to be pulled out of clinical education. ... Students

were being sent home for safety when they should have been gearing up for residency, but they wanted to be doing something meaningful,” said Dr. DeWitt, who directs the inaugural fourth-year class of medical students at Elson S. Floyd College of Medicine at Washington State University in Spokane.

Much of the value of fourth year is in professional identity formation, and if medical schools have done due diligence assessing students, early graduation shouldn’t pose a problem, said Benjamin Kinnear, MD, MEd, FACP, associate program director for the internal medicine-pediatrics residency and associate program director for the internal medicine residency’s Medical Education Pathway at the University of Cincinnati in Ohio.

For the hospitalists who may find themselves working alongside these newly minted interns, he wrote a perspective on developing trust, which was published online in May by the *Journal of Hospital Medicine*.

He addressed the concept of “entrustment,” or how attendings balance supervision and autonomy for students and residents. This balance can be informed by assessment tools, he said. “The problem with that is ... there’s a lot of things beyond how well the resident or student is performing that affect how much we trust someone,” from the person’s apparent confidence to their training background.

Hospitalist attendings should reflect on the variables that can affect their trust, he said. “We don’t often think in our head, ‘This person is confident and I will therefore trust them more.’ It just kind of happens without us knowing,” Dr. Kinnear said, adding that especially during a pandemic, trust should be based on direct observation rather than more biased criteria.

The new didactics

As of June, many medical students had returned to the wards across the country. While safety was still a concern, Dr. Anderson said it was necessary for schools to re-engage their trainees.

“You can only do so much outside of direct patient contact. It’s real patients that are the source of so much of our trainees’ learning,” he said. “The task is, how do we do that in a way that maintains patient safety, maintains learner safety, and leverages the opportunities that are there [while] communicating transparently?”

As the crisis ramped up in New Orleans, Tulane established a comprehensive plan for residents, Dr. Wiese said. “It was very much like Katrina. Point No. 1 was assuring the base of Maslow’s hierarchy of human needs: We weren’t going to do furloughs, everybody was going to keep their job, all of the benefits were going to continue, etc.,” he said.

The plan also addressed the personal factors that could prevent someone who wanted to help from contributing, such as the need for child care. Because a large percentage of residents had kids in schools that were now closed, the university figured out how to give them supplemental pay for child care, Dr. Wiese said, adding that medical students also stepped up to care for kids of residents, faculty, and nurses.

When it came to didactics, the plan was to continue with video conferencing through the summer and likely into the fall before moving to in-person, physically distanced conferences of no more than 10 people. “Early on, we told the program

directors, 'Didactics have to continue; they're just going to have to continue in a different way,'" said Dr. Wiese. "For us, that meant Zoom. I think that's probably the case for all the programs nationally." (See related story for tips on teaching through video.)

The residents likely missed some knowledge and skills they would have gained during usual in-person didactics, he said. "There was some recognition that during this time, we were going to learn different things. I don't have any qualms with that."

But by putting aside their own personal needs in favor of patient care needs, the residents gained valuable skills in professionalism, Dr. Wiese said. "They were learning different attitudes. They were learning about themselves, discovering just what they were capable of doing," he said. "I think all the credit really goes to the residents on this front. They stepped up like we knew they would. Months of deferring personal needs for the benefit of the patient had prepared them. They had been well trained."

Even though Cincinnati wasn't hit nearly as hard as New Orleans, teaching at the bedside has changed dramatically, said Dr. Kinnear, a med-peds hospitalist at Cincinnati Children's Hospital Medical Center and University of Cincinnati Medical Center. Both hospitals typically had a patient-centered style of rounding where large teams of residents and students have a discussion with the patient in the room, during which the teaching often happens, he said.

Rounds changed during the pandemic "We've had to do more teaching outside of the room, more teaching away from the wards to try to limit exposure, so it's changed how education happens on the wards," said Dr. Kinnear. As for educational conferences, "We obviously can't have 50 residents and students packed into a conference room, so everything has gone virtual," he said.

Chief medical resident ACP Member Yevgeny Novikov, MD, built a distance-learning series of virtual modules that include both homegrown content and content curated from the Web, hosted on The Silver Fridge, the residency program's website.

Dr. Novikov, who is now a hospitalist at the University of Rochester in New York, started the website at the beginning of his third year of residency as a place for review articles, PowerPoint presentations, and other materials. "It was mostly just a reference site," he said. "I think when COVID hit, that's when we started using it more as an educational site."

It helped that over the prior two years, the residents had gotten used to the website, Dr. Novikov said. "I've noticed it takes about a generation of a residency to get a new idea started. So the first- and second-years were very involved in the education; the third-years, not so much," he said.

At the beginning, the site mostly curated resources so that the residents could find vetted information that was worth their time, Dr. Novikov said. "And then, over the course of a few weeks, we formalized a curriculum" of four different components each week.

The residency program simply didn't have the time to create all original content for distance learning, said Dr. Kinnear. "You become a curator rather than a creator," using extant resources—podcasts like the Curbsiders Internal Medicine Podcast and the Clinical Problem Solvers and videos like Louisville Lectures, he said.

For ACP Member Laura Bishop, MD, a med-peds hospitalist at the University of Louisville and executive director of Louisville Lectures, the pandemic has only sped up incorporation of recorded videos and online materials. "We're really growing a new breed of doctor that learns in a very different way than some of us did, in terms of actually going and sitting in lectures," she said.

At her institution and others, the pandemic caused residency curriculums to suffer from not only the shift to virtual education but also the faculty's need to focus on COVID-19 preparations. "I've heard directly from residency program directors both locally and nationally that have been able to go to the Louisville Lectures recordings ... to quickly fill the gaps in the didactic calendar and schedule," said Dr. Bishop, who is also associate program director of the med-peds residency.

While the site's views typically decrease in the second half of the academic year, this year has been different, she said. "From January to June 1, we had double the YouTube views that we did in 2019. We're approaching half a million for this year so far," said Dr. Bishop. "When I look at them, they're the lectures you would expect: lots of pulmonary and critical care, cardiac ICU, and then some of the Little Lectures that I did on COVID, and we had an infectious disease doctor give a grand rounds on COVID."

Because clinical demands on medical educators are only growing and there is more and more to teach every year, the increased popularity of such resources is likely here to stay, she said. In addition, online materials allow learners to review topics they may have missed using information from anywhere in the world, and they can be updated as needed, said Dr. Bishop.

"My hope is that people who may have in the past thought that it was a flash in the pan or maybe it wasn't the way that they did medicine will hopefully see the benefit of it," she said.

Ultimately, the proliferation of online resources over the past decade has helped prepare medical education for this sudden transition to virtual learning, said Dr. Kinnear. "I think a lot of programs are trying to take advantage of that," he said. "It'll be interesting to see what happens when things go back to normal, if they do." ■

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ACP resources for educators

- Both learners and faculty have found ACP's telemedicine education module useful for getting up to speed.
- COVID-19: An ACP Physician's Guide & Resources offers a wealth of resources and is being consistently updated throughout the pandemic.
- ACP offers a series of free webinars, which educators can assign their learners to listen to and then have a flipped classroom discussion.
- Annals for Educators offers clinical practice points and takeaways from *Annals of Internal Medicine* that may be useful in teaching activities. Sign up for twice-monthly email alerts. ■

How to handle biased patients

Hospitalists have developed strategies for these problematic encounters

By Mollie Frost

As a black woman, ACP Resident/Fellow Member Lachelle Dawn Weeks, MD, has plenty of experience encountering bias from patients.

"I've certainly entered a patient's room with my white coat on, with a stethoscope, did a complete physical exam, offered the plan for the day, and then had the patient ask me to replenish their towels or clean their commode," she said.

Dr. Weeks, a fellow in hematology and oncology at Dana Farber Cancer Institute in Boston, said she is not alone. "I don't know of any black physicians, or even female physicians, who will tell you that they've never been on the receiving end of at least biased remarks from patients," she said. "They're so commonplace that we will brush them off when they occur. You can't respond to it every day."

But some comments can hit a physician so hard they provoke a response, and not always an ideal one. In a 2013 *Annals of Internal Medicine* essay titled "The Racist Patient," Sachin H. Jain, MD, FACP, recalled a moment during residency when a patient, unhappy that the hospital pharmacy did not stock his brand of insulin, yelled, "Why don't you go back to India!"

"On pure instinct, I responded, 'Why don't you leave our [expletive] hospital?' To underscore my point, I repeated myself," Dr. Jain wrote. "I exited the room in a cold sweat."

These types of encounters are not rare. In a 2017 survey of 823 U.S. physicians (33% based in the hospital) conducted by WebMD and Medscape, 59% of respondents reported that a patient had made an offensive remark about their personal characteristics in the past five years. The most common characteristics were younger age (28%), ethnicity/national origin (22%), gender (20%), and race (19%), along with accent, political views, religion, and body weight. Less frequently, incidents went beyond comments, with 31% of respondents reporting they had received a request from a patient to see a different clinician due to their personal characteristics.

There are little data on whether patient-bias incidents have increased in recent years, said Alicia Fernández, professor of medicine at the University of California, San Francisco and a general internist at Zuckerberg San Francisco General Hospital. But what's important, she said, is that more physicians feel like they are being targeted.

"We do have an increasingly diverse workforce, and we are in a much more polarized society now, perhaps, than we were, say, 10 years ago," said Dr. Fernández, who has researched patient bias and during residency had a patient refuse care from her because she is Latina. "And when those two things meet, I think that what happens is that more of these sorts of problems surface."

Despite the emotional toll, some experts believe that doctors have an ethical obligation to treat patients exhibiting bias. More hospitals are trying to get in front of this issue by creating policies and procedures to protect their clinicians, as well as teaching them strategies to handle these incidents when they arise.

An ethical issue

The ACP Ethics Manual, seventh edition, says that "By history, tradition, and professional oath, physicians have a moral obligation to provide care for ill persons. ... A physician may not discriminate against a class or category of patients."

This includes difficult patients, even if their behavior is morally reprehensible or hurtful, said Daniel P. Sulmasy, MD, PhD, MACP, acting director of the Kennedy Institute of Ethics and Andre Hellegers Professor of Biomedical Ethics at Georgetown University in Washington, D.C.

"I have many times in my experience even been spit at by patients, cursed at. I remember once having had a patient who . . . as we were leaving the room, came out in the hallway and said, 'Thanks for the effing good news, a*****,'" he said. "So what am I supposed to do, not care for the patient?"

Matthew DeCamp, MD, PhD, FACP, agreed. "In fact, the guiding principle, even in response to difficult comments, should be to focus on the well-being of the patient," he said.

On the other hand, there are points when it becomes necessary to take reasonable steps to protect health care professionals from threatening or violent behavior, Dr. Sulmasy said. "But short of the point of a threat of physical harm, my view is it's

hard to say when we would restrict the patient's access to care on the basis of their reprehensible behavior," he said.

In some cases, an individual physician may believe that he or she cannot provide the best care due to a patient's comments or beliefs, said Dr. DeCamp, an associate professor of bioethics and humanities and general internal medicine at the University of Colorado Anschutz Medical Campus in Aurora. But physicians should be very critical of the notion that they cannot provide good care due to what a patient says or believes, he said. Plus, arranging for care from another physician in the hospital setting can be tricky, Dr. DeCamp added.

"In high-acuity settings, there may or may not be other options for care or other physicians who can provide the kind of care expertise that an individual physician has in the inpatient setting," said Dr. DeCamp. "In some cases, it could actually be unethical to engage in physician reassignment." For instance, if the patient declines care from the only



Image by Getty Images

cardiologist on the floor, assigning another physician could compromise care, he said.

Dr. Weeks added that there may come a point at which it becomes harmful or unsafe for the physician-patient relationship to continue. "I do not think that a physician who is repeatedly on the receiving end of racist or bigoted comments necessarily needs to martyr themselves and continue to be in that position," she said.

Physicians subject to behaviors from patient refusal of care to explicit racist, sexist, or homophobic remarks to belittling compliments or jokes reported an emotional toll that included exhaustion, self-doubt, and cynicism, according to a qualitative study of 50 hospitalist attendings, internal medicine residents, and medical students conducted by Dr. Fernández and colleagues. Those who had been bystanders to such behaviors reported moral distress and uncertainty about how to respond, according to results published in 2019 by *JAMA Internal Medicine*.

Even if patients don't engage in obviously biased behaviors, repeated microaggressions can build up over time, potentially leading to decreased physician well-being if they are not addressed, Dr. DeCamp said.

Bias, whether from a patient toward a clinician or vice versa, can drive a wedge between the two parties in a way that could affect patient safety, Dr. Weeks said. "You like to have open avenues of communication between a clinician and a patient, and if there's something that is not allowing that avenue to be clear, then you might misinterpret clinical signals or clues because the patient is behaving in a certain way," she said. "So it's something that you definitely need to talk about up front."

Skills training

In a situation where the patient requests another physician, the first step should be for the treating physician to try to manage the situation without reassignment, which should be a last resort, said Dr. DeCamp. "The first response to a comment should be to engage with the patient about what they meant by that comment, or to help understand where that potential comment was coming from," he said.

Also, Dr. Fernández noted, "There's a difference between an affirming request versus a discriminatory refusal." For example, it can be reasonable for a woman to request a woman clinician to complete a pelvic exam or for a Spanish-speaking patient to request a Spanish-speaking physician, she said.

To better prepare their clinicians for these situations, hospitals should train them in useful ways to respond that don't threaten the therapeutic alliance but nonetheless put a halt to the conversation, said Dr. Fernández. "And it is important not only to train residents and interns and students, but it's also important to train faculty," she said.

When facing or witnessing biased patient comments or behavior, "No one quite knows how to respond," Dr. Fernández said. In her research, useful methods include acknowledging the comment while still in the room, debriefing as a team after the interaction, and placing careful limits on the patient, she said.

"I think saying something like, 'Actually, we're your medical team. It's not appropriate to speak like that, and we want to take very good care of you. We respect you, and we want you to treat everyone on the team with respect,' can be incredibly useful," Dr. Fernández said. "Because while there are patients who say things out of extreme bias and hatred, many patients may underestimate how offensive they're being."

The response from the care team is especially important to protecting trainees, said Sharonne N. Hayes, MD, professor

of cardiovascular medicine and director of diversity and inclusion at Mayo Clinic in Rochester, Minn. "Patients who are biased, they know the pecking order on a health care team. They might be all sweetness and light when the attending physician comes in and does rounds, but they may have done something very egregious to other staff members," she said. "And we see that very frequently."

Without training, clinicians, including those with trainees, may respond in highly variable ways, Dr. Weeks said. For example, during her residency, she and a Muslim-American intern were taking care of a patient who would comment that people who practice Islam are terrorists.

"We mentioned it to our attending, who was just kind of like, 'You know, sometimes people say things that are off-color, and you can't take it all seriously,' but it bothered both of us," she said. She later learned that other attendings were more vocal and would support their residents through having a conversation with the patient.

Not every hospitalist attending will feel comfortable explicitly setting boundaries with a patient on behalf of a trainee, but guidance, training, and practice can help, said Dr. Hayes. "This is the perfect thing for a simulation, honestly, because it doesn't naturally come out of your mouth to do this," she said.

Mayo uses the SAFER acronym to help physicians remember how to set limits and take action: Step up, Address the inappropriate behavior, Focus on our values, Explain expectations and boundaries to the patient, and Report. Dr. Hayes also recommended that hospitalists who practice in a learning environment explicitly tell learners that they can come talk about such situations, even if they feel uncomfortable.

She said, "How I do it is, 'When you're on my team, you're going to be treated with respect, whether it's by nursing staff or by the patients. So you let me know if you need any help in that regard. I'd like to hear, because I stick up for my team.'"

Hospitalists can also benefit from talking with peers after experiencing bias. "Physicians who don't talk about it, even to each other, miss the opportunity to bring these comments and circumstances more to the surface to allow them to be managed," Dr. DeCamp said. "Managing the situation by internalizing it and not talking about it with colleagues may not be the best approach."

What the law says

When out with physician friends one day, Kimani Paul-Emile, JD, PhD, professor of law at Fordham University in New York City, said she heard something unusual.

"One of them said, 'Today I had a patient who rejected me because he said, 'No Asian doctors.' My friend was put off by it, but he said ... it was just part of the job, and it happens to physicians of color,' she recalled. "I said, 'This wouldn't be tolerated in any other profession. It would violate a whole host of workplace discrimination laws.'"

While physicians have an ethical duty to treat patients, they also have employment rights. Under Title VII of the Civil Rights Act of 1964, physicians have the right to a workplace free from certain types of discrimination, including on the basis of sex, race, religion, and ethnicity, Dr. Paul-Emile said.

"So if a patient or a number of patients continue to discriminate against a particular provider, the obligation is the institution's," she said. "How they respond is what's important because if they don't respond or respond poorly, then they could be liable for creating a hostile work environment."

Nurses in nursing homes and hospitals have sued for this kind of discrimination, Dr. Paul-Emile reported. In one case, a black nurse in 2013 sued a Michigan hospital after a supervisor agreed to a man's request that no African-American nurses care for his newborn (he allegedly showed the supervisor his swastika tattoo as well). The lawsuit was settled but was followed by similar allegations of discrimination by black nurses.

Dr. Paul-Emile hasn't uncovered any such cases by physicians in her research. "What I found was that physicians weren't being forced to accommodate these patients; they were deciding amongst themselves whether and under what circumstances to accommodate," she said.

Dr. Paul-Emile said all hospitals should have policies in place to address biased patient behavior. "And more and more are because they're seeing more and more of it," she said.

The ways hospitals manage biased patient comments and requests for physician reassignment vary. In the WebMD/Medscape survey, only 15% of physicians said their institution provides formal training on how to handle patients' biases toward them and their colleagues.

Mayo Clinic was an early adopter of a patient bias and misconduct policy, which went into effect in 2017. The policy outlines when patient or visitor behavior becomes harassment and gives the care team the ultimate decision-making power on requests for physician reassignment, said Dr. Hayes.

Mayo also developed a reporting structure for this type of behavior in 2017, although it's still grossly underreported for a variety of reasons, she said. "If it hasn't been acted upon, people feel like, 'OK, I guess this is maybe part of what I have to put up with to work here,'" Dr. Hayes said. "We [also] go into health care for compassion and to care for people, so most of us will put up with a lot from patients. We shouldn't have to."

Dr. Hayes recalled giving a talk in 2018 to about 50 chief medical officers and chief nursing officers about patient bias and misconduct. "I said, 'How many of you have seen an uptick in this over the past couple of years?' Every hand went up," she said. "Because of the national discourse that has got people just saying what they want and need ... I think people are feeling emboldened to ask for things that they knew were 'politically incorrect' previously."

At the same talk, Dr. Hayes asked how many hospitals had a policy to address patient bias and misconduct. Other than Mayo, only two did, and at that point, none of the hospitals had had the policy in place for more than a year. Now, though, more and more institutions are developing such policies, she said. "There are dozens of hospitals and hospital systems that have reached out to us or who are actively working on them ... so it's very top of mind," Dr. Hayes said. ■

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One hospital's experience

The process of dealing with patient bias at Penn State Health Milton S. Hershey Medical Center in Hershey, Pa., started one day in 2016, when hospitalist Hyma V. Polimera, MD, FACP, received a special request from the daughter of a patient with dementia.

On the first day of her seven-day service, she introduced herself to the patient and the patient's daughter at the bedside. "I introduced myself and I explained my role and what I do," she said. "And immediately the daughter—without any additional conversation—told me that she would like to have an American doctor."

Dr. Polimera, who completed medical school in India and postgraduate training in the U.K., came to the U.S. in 2008 and completed her residency in Bethlehem, Pa. When she walked out of the patient's room, she told the daughter she'd see what she could do to arrange for another physician.

"When I was looking at the schedule, what I noticed is all the providers on that week's schedule were of different skin color," Dr. Polimera said. "When I explained that to the patient's daughter, she did not want them either, so I was in a dilemma."

She then called Brian McGillen, MD, FACP, who was the hospital's director of hospital medicine at the time, and the charge nurse on the unit to explain the situation. "They asked me whether I am comfortable taking care of the patient, because when somebody is discriminating you based on race or ethnicity, it is difficult . . . but I said I am OK to take care of the patient," said Dr. Polimera, also an assistant professor of medicine at Penn State.

Dr. McGillen met with the family to explain that Dr. Polimera was fully capable of practicing medicine.

When the requests continued, he made special accommodations, such as having a nurse help explain everything clearly. "Eventually, I finally just put my foot down, said, 'I'm not going to do this,'" and informed the patient's daughter her request would not be honored, said Dr. McGillen, now a hospitalist and an associate professor of medicine at Penn State.

Dr. Polimera stayed on as the patient's hospitalist for the rest of the week. "I wasn't very happy about how everything happened. I tried to keep myself in the patient's daughter's shoes, but still did not agree with her discriminatory behavior," she said. "Towards the end of the week, the patient's daughter was happy. She had no concerns."

Dr. McGillen then informed the chief medical officer that from that point forward, as a matter of policy, the hospitalist group would not change physicians because a patient didn't like the color of somebody's skin, didn't want a woman, or other discriminatory reasons. "I said, 'We're not going to budge on this, because we need to protect our own staff,' and the chief medical officer was OK with that," said Dr. McGillen.

In response to the incident, as of 2017, Penn State Health's patient rights and responsibilities policy has been updated to include a section stating that patients cannot decline a clinician based on the clinician's race, religion, gender, age, or sexual orientation. The policy applies to the hospital as well as the entire health system.

The policy made a substantial difference, said Dr. Polimera, adding that the hospitalist group was getting frequent physician-change requests up to that point. "I'm very proud to say after this policy implementation, at least in our hospitalist group, I did not see any more change-of-physician requests," she said. ■

Doctors with disability reflect on challenges

Physicians with disabilities who applied to and eventually completed medical school reflect on the progress and accomplishments offered by the Americans with Disabilities Act during the past 30 years.

By Mollie Frost

Paralyzed in a diving accident at age 14, ACP Member James Post, MD, would not walk again. But he was still determined to become a doctor.

Nearly three decades after fighting to be accepted into medical school, Dr. Post is now a nephrologist and chief of internal medicine at the James J. Peters Veterans Affairs Medical Center in New York City. When he cares for patients, he said it's almost as if the wheelchair disappears: "They just don't even see it anymore. They see me as their doctor."

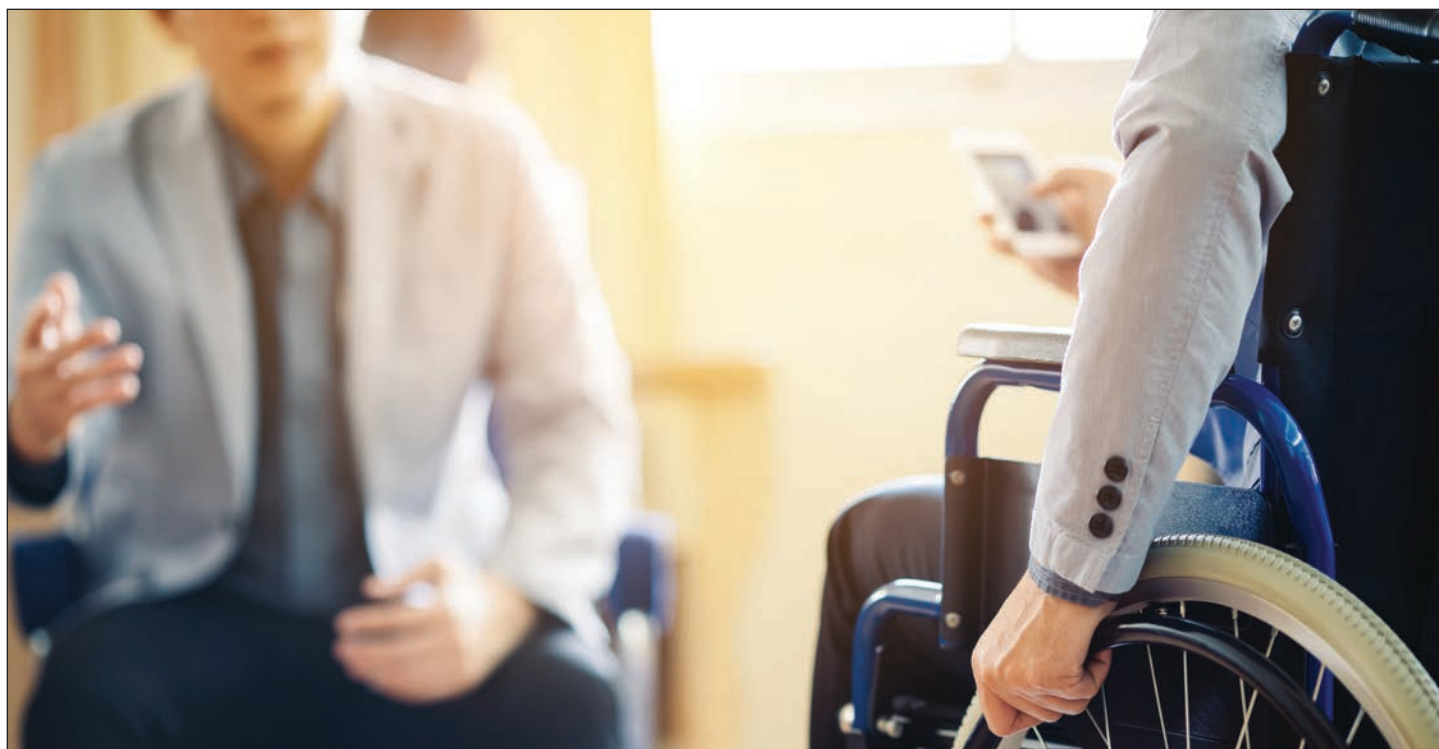
That's because patients can see he's been a patient himself, he said. "I've been in their place before," he said. "It's not like I'm walking in and brushing them off; they know that I know what it's like to be on the other side of the stethoscope."

revealing a constellation of progress marked in large part by the Americans with Disabilities Act (ADA), which went into effect 30 years ago this July.

A new era of accommodations

The idea of accommodating medical students with disability is relatively new, said Lisa Iezzoni, MD, MSc, a professor of medicine at Harvard Medical School in Boston. She attended medical school in the early '80s, well before the ADA was enacted.

Dr. Iezzoni called her experience in medical school at Harvard a "pre-ADA cautionary tale." She was diagnosed with multiple sclerosis at the end of her first semester in 1980.



Despite progress by the Americans with Disabilities Act (ADA), which went into effect 30 years ago this July, there's still room for improvement to accommodate people with disability who apply to medical school. Image by Natee127

The road to becoming a physician is challenging for anyone, let alone people with disability. While many medical school applicants face fear, doubt, and rejection, applicants with disability also have to be their own advocates, creating and requesting personal accommodations and educating those around them.

Today's students, trainees, and physicians with disability have more support than in the past, but there's still room for improvement. Physicians with disability who applied to medical school in the '80s, '90s, and '00s discussed their journeys,

During the first two years she had periodic relapses, and she began using a cane in her third year. She graduated in 1984, a time that she notes was "pre-Oprah."

"People didn't share information about their personal health," said Dr. Iezzoni. "It was a private matter back then. Plus, I was embarrassed. I would try to hide from patients that I was using a cane."

That time in medicine was different in other ways, with a more rigid sense of hierarchy and no 80-hour work week, she said. For instance, when Dr. Iezzoni's neurologist told her she

couldn't stay up all night during clerkship, her surgery attending chided her, saying she had no right to be in medicine.

Rather than feeling indignant, she felt invalidated. "I was dealing not only with symptoms that were sometimes pretty terrifying, like not being able to walk at all, as well as just outright invalidation by almost every attending physician who I had and almost every resident who encountered me," said Dr. Iezzoni.

When it came time for her to graduate, the medical school decided not to write a letter for her to apply for an internship or residency. Without that letter of support, she couldn't apply at all. "Basically, they engaged in a practice called constructive dismissal by the lawyers, which nowadays would be considered discrimination," said Dr. Iezzoni. Unable to train to practice medicine, she pursued health policy research and in 1998 became the first female professor in the department of medicine at Beth Israel Hospital in Boston. "It took a while to pick myself up and dust myself off and get going, but I was very fortunate that I was able to do that," she said.

In contrast to her experience, she said today's students and their needs are top of mind for medical educators. "When I see how their needs are very much in the forefront of discussion—personal needs as well as academically—it's totally different than back in 1980," Dr. Iezzoni said. "And all for the better."

But the ADA was no panacea for prospective doctors with disability. In the early '90s, when it came time for Dr. Post to apply to medical schools, he was rejected by all 10 Pennsylvania schools he applied to, even with his 3.92 GPA and above-average MCAT scores. Because he was living with quadriplegia and using a wheelchair, it was clear that the technical standards delineated for applicants by medical schools, which required physical tasks such as drawing blood, performing CPR, and delivering babies, were the main barrier.

After that first round of rejections, Dr. Post dedicated himself to volunteering and taking some courses in biochemistry. He also allowed his story to seep out into the media, in outlets ranging from his local newspaper to *The New York Times*. Initially, he was afraid to do this. "I thought that it would give the impression that I was just a troublemaker and I really wasn't genuine in my interest in becoming a doctor," said Dr. Post.

After he appeared on talk shows, his luck changed. Albert Einstein College of Medicine in New York City was willing to be flexible with the technical standards, allowing Dr. Post to use an assistant. During medical school and residency, he worked with either a nurse or a physician assistant to complete some physical components of his training.

"I was very thankful and very happy that they gave me the opportunity to actually study medicine and get my MD. ... They focused on my abilities instead of my disabilities," he said.

Fast forward to 2002, when Nathaniel Gleason, MD, FACP, was applying to medical schools. He has a genetic recessive condition called achromatopsia, which is the absence of functioning cone cells on the retina. This carries three implications: extreme sensitivity to light (he wears dark contact lenses and dark sunglasses), no color vision (he sees in black, white, and gray), and low visual acuity (his vision is 20/400, which qualifies him as legally blind). "The thing that matters most is the acuity," said Dr. Gleason.

Thus, as with Dr. Post, the technical standards were the main barrier. They explicitly required medical students to perform functions requiring normal vision, such as the use of a microscope. "The official message a prospective applicant with a disability encountered in 2002, 12 years after the ADA, was, in no uncertain terms ... 'You can't come,'" said Dr. Gleason, an associate professor of clinical medicine at the University of California, San Francisco (UCSF). "Many, though not all, medical schools now add to these lists of required functional abilities the brief but crucial phrase, 'with reasonable accommodation.' That is a monumental difference."

Accommodating a student with a disability takes overcoming the false ideal of pluripotency—that is, that every applicant should have the potential to become any kind of doctor, he said. "It's hard from that starting place for some physicians and medical school administrators to look at a candidate and say, 'She has the strengths to be a great doctor, even if her particular set of abilities and disabilities makes certain fields of medicine less likely to be a great fit,'" said Dr. Gleason.

UCSF was open to finding workarounds. While classroom coursework during the first two years went well, Dr. Gleason had to get creative with inventing his own accommodations. For example, he would take anatomy tests before the rest of the class, walking around with the instructor and sticking his face "preposterously close" to the cadaver to identify anatomical structures.

The most challenging bit was the clinical part of training, Dr. Gleason said. While he had taken tests and learned information throughout his life, the logistics involved in caring for patients made for a totally different experience. "Navigating different hospital and clinic rotations was incredibly challenging," he said, noting examples such as the ability to recognize a particular nurse, quickly scan a stack of records, or see displays in the ICU.

Of course, that also made residency a challenge, although training was made possible through continued basic problem solving at UCSF, Dr. Gleason said. These days, he uses modifications to read the computer and the EHR, such as a magnifier for written text and a large screen and low resolution so that the record is as large as possible.

Future outlooks

Overall, those interviewed for this story agreed that the most meaningful progress that could be made for doctors with disability is for them to be "no big deal" at some point.

"I would like for it to be the norm. ... That would mean that this wouldn't be a story anymore because it wouldn't be so novel that it would warrant a big story," said Lisa M. Meeks, PhD, coauthor of a March 2018 Association of American Medical Colleges report on accessibility, inclusion, and action for people with disability in medical education.

The report featured interviews with 49 medical students and physicians with disability. Initially, the aim was to interview five students, five residents, and five physicians. "I received over 200 emails from people willing to be interviewed," said Dr. Meeks, an assistant professor of family medicine and director of MDisability, an educational initiative at the University of Michigan in Ann Arbor.

To emphasize that physicians with disability aren't as rare as they may seem, Dr. Meeks co-developed a social media campaign, #DocsWithDisabilities, profiling physicians with varying specialties and types of disability. "The problem is people think it's a one-off. For the most part, people believe that there is this one great guy or girl that overcame all the odds to become a physician. ... People think there's one or two physicians with disabilities, and there are literally thousands," she said.

In fact, one in four—61 million—U.S. adults has a disability, according to a CDC analysis published in August 2018 by *Morbidity and Mortality Weekly Report*. Plus, there are signs that more people in medicine are disclosing their disability. In 2016 and 2019, researchers surveyed U.S. allopathic medical schools to assess the prevalence of students with disabilities. Among 64 schools that responded to both surveys, 2.7% and 4.6% of medical students disclosed a disability in 2016 and 2019, respectively, a 69% relative increase, according to results published in November 2019 by JAMA.

This is likely due to a confluence of factors, such as national improvement efforts, media attention, and a generation who are comfortable with, or even proud of, their identity as people with disability, said Dr. Meeks, lead author of the study. "At the same time, these learners know their rights and have a history of appropriate and reasonable accommodation. They are not afraid to ask for what they need to gain equal access," she said.

While the motivation for disclosing a disability remains unclear, the numbers may indicate that more students are receiving accommodations for standardized tests, which is a legitimate and welcome trend, Dr. Iezzoni said. "Students nowadays feel that there's more of a benefit to disclosing than a cost than previously, and I would like to know what they view that benefit as," she said. "My hypothesis is that it may have to do with accommodations around all the standardized testing."

Technical standards are set by individual medical schools, but residency programs have a more standardized approach to access for trainees with disability. The Accreditation Council for Graduate Medical Education (ACGME) has two specific common requirements: The institution or sponsoring institution for the residency program must follow federal law in terms of providing accommodations, and the residency program must provide accommodations for residents with disability consistent with their institutional policies.

The second requirement took effect in 2018. It may seem like a small change, but it's an important one, said Christopher Moreland, MD, MPH, FACP, a hospitalist and associate program director of the internal medicine residency program at UT Health San Antonio. "Now we have policies that apply to all GME programs across the board across the entire United States. ... I think that's one step towards providing a more standardized and supportive approach for current and future residents and physicians with disabilities."

Dr. Moreland, who was born Deaf, said that the choice to disclose a disability while training to be a doctor can be intimidating, and the fact that more students are disclosing disabilities is encouraging. "We need to start with identifying who those individuals are and identifying where the need is," he said. "From there, we have to engage in conversations with

each of those individuals who requested accommodations in terms of what those accommodations look like for them, because each person is going to be different."

Over the past several years, many medical institutions have addressed diversity, equity, and inclusion. "I think those efforts have been admirably focused on race, ethnicity, gender, amongst other things, and disability is an area that is unexplored," said Dr. Moreland, who is also president of the Association of Medical Professionals with Hearing Losses. "I anticipate that's going to change greatly."

Dr. Gleason agreed that disability is behind other civil rights struggles with regard to recognition and inclusion in those conversations about diversity. Still, "The overwhelming majority of people will have a disability at some point in their lives," he noted.

Plus, the literature on diversity has shown that patients often have a more positive experience and better health outcomes if they're able to work with physicians who look like them and share their communication style, and life experiences, said Dr. Moreland, speaking through an interpreter. "I think that same idea applies to physicians with disabilities."

Most clinics and hospitals are designed not with accessibility but with workflow and staff in mind, all of whom are seemingly presumed to be nondisabled, said Bruce (BJ) Miller, MD, a palliative care physician at UCSF. After an accident in college, he lost both legs below the knees and his left arm below the elbow due to electrical burns. "Living with illness or disability is harder—more isolating—than it needs to be, largely because, by way of our constructs and our infrastructure, we tend to exaggerate the gap between sick and well, disabled and able," said Dr. Miller.

For physicians who don't currently live with a disability but may become disabled in some way, he recommended paying attention to the details of the experience of patients with disabilities and avoiding rationalizing that this is the way it has to be. "Not only will you be doing your patients a great service with heightened understanding and empathy, but you'll also be preparing yourself for when your own time [as a patient] comes," Dr. Miller said.

On a practical level, Dr. Post said it's prudent to tailor your practice to your strengths and limitations. For tasks you can't do, incorporating nurse practitioners or physician assistants can help. "You can supervise them in that role, and you can still participate in the care," he said. These days, a medical staff assistant in the clinic helps Dr. Post get his stethoscope on and will place the stethoscope on the patient's chest, and he works alongside a nephrology fellow on inpatient rounds.

For Dr. Miller, living with a disability is not about "overcoming" something but learning to adapt to and live with it. He chose palliative care because he was interested in working with people who were confronting all they couldn't control, rather than in "fixing" them.

"One way or another, the truth is that everyone struggles with the vagaries of daily life, in general, and all of us need to depend on others," Dr. Miller said. "This is a point in common, not division, and the sooner we realize that fact ... the better for all." ■

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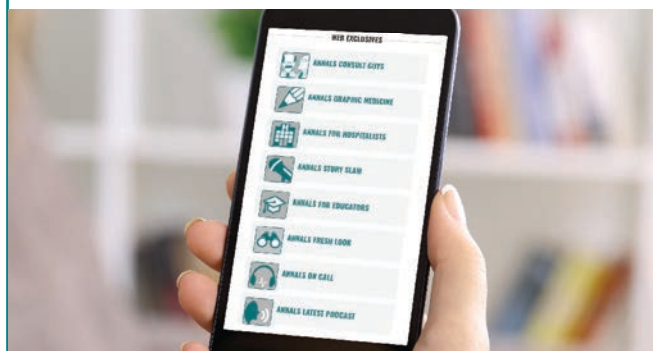
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That's why as an eligible ACP member under age 70, you are guaranteed acceptance for coverage in the ACP-Sponsored Group Accidental Death & Dismemberment (AD&D) Insurance Plan offered at competitive rates, negotiated by ACP on behalf of our members.

You can help your family be prepared for a sudden and unexpected loss by selecting the Principal Sum that best meets your financial needs: Benefit amounts up to \$500,000 (in multiples of \$100,000).

30-DAY FREE LOOK: If you're not completely satisfied with the terms of your Certificate of Insurance, your coverage will be invalidated (provided there have been no claims), and you will be sent a full refund, no questions asked!

The ACP-Sponsored AD&D Insurance Plan offers:

Guaranteed acceptance. As an eligible member, you cannot be turned down, regardless of health conditions.

Select the Principal Sum right for you: Benefit amounts up to \$500,000 (in multiples of \$100,000).

Additional benefits paid for covered loss that results from an accident while traveling as a passenger on a common carrier (such as a train, bus, etc.) and use of seatbelt and airbag.

Additional benefits paid to help cover expenses such as education and rehabilitation.

Competitive rates negotiated by ACP.

TO LEARN MORE ABOUT HOW THE ACP-SPONSORED AD&D INSURANCE PLAN CAN HELP YOU[†], CALL 1-888-643-0323 OR VISIT ACPGROUPINSURANCE.COM.



Underwritten by New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010 on Policy Form GMR



[†]Information includes costs, exclusions, eligibility, renewability, limitations and terms of coverage. Coverage is not available in some states.

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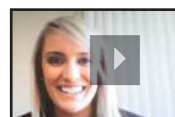
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Northwest Permanente
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Southern California Permanente Medical Group
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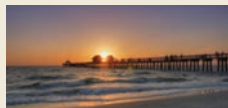
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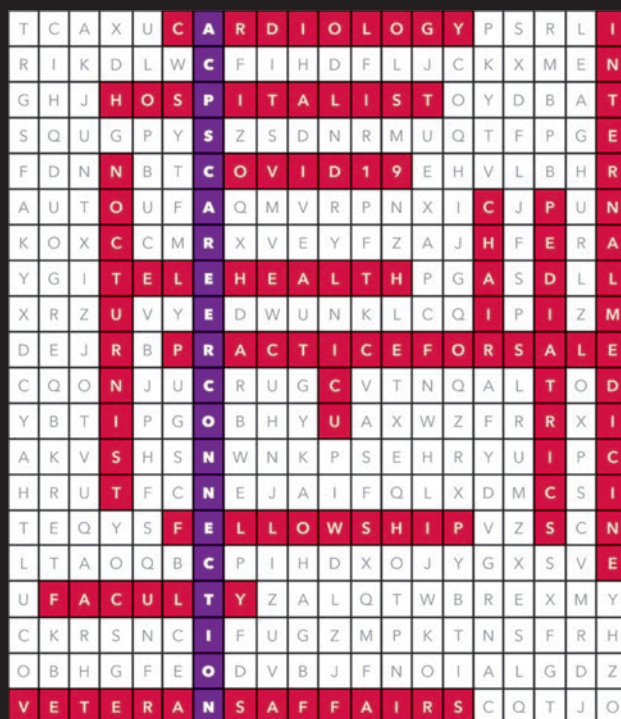
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