As individual providers, we often unknowingly contribute to health disparities due to the impact of implicit biases on clinical practice. Implicit bias influences provider communication patterns and medical decision-making. Our profession’s egalitarian and altruistic values have led to a greater prevalence of implicit bias instruction across the spectrum of medical training and practice. Such instruction is often offered as an “add-on,” or as one-time, mandated implicit bias training. Single-session trainings can lead to increased awareness of implicit bias, but the assumption that awareness will lead to behavior change pervades medical education despite no evidence to support this assertion. There is unfortunate evidence of unintended consequences of increased awareness of implicit bias as a sole strategy, including avoidance of the social groups against whom one is biased. Without specific attention to skill development, learners become aware of implicit bias and are left powerless to advocate for patients, colleagues, and even themselves.

My research over the past decade has focused on the design, implementation, and evaluation of curricular innovations to empower learners with the knowledge, attitudes, and skills to recognize and manage implicit bias as it relates to communication within clinical and nonclinical encounters. As part of this work, students have discussed perceiving bias in the hidden curriculum in both classroom and clinical settings. The hidden curriculum—the informal, unwritten processes of socialization within medical education—is replete with instances perceived as bias. Medical students describe cognitive dissonance when their actions do not match their values in the face of perceived bias. Students often accept their implicit bias and recognize its potential influence on clinical care; yet, they are unable to bridge their deep, emotional reactions to this awareness with meaningful strategies to mitigate it (unpublished data under review).

Education focused only on increasing awareness of implicit bias for our most junior, and therefore most vulnerable, learners is unfair and unjust. It is my view that we cannot keep disappointing our learners because we struggle with our discomfort with this emotionally charged topic and our assumptions about the difficulty of achieving skills in this area. Our learners need tools to address this crucial issue. Multiple frameworks exist to guide skills-based curriculum development; it is no longer an issue of not knowing how to teach about implicit bias, it is a matter of institutional will.

Given our national discourse focused on anti-racism, I will make a few points for clarification and understanding. My approach to teaching about implicit bias involves instruction on bias recognition and then the employment of skills to manage the encounter and mitigate the negative outcomes of implicit bias, a process called implicit bias recognition and management (IBRM). This approach is behaviorally based, moves beyond knowledge and awareness to address attitudes (which affect behavior), and provides opportunities for skills development, regardless of what type of bias is perceived (i.e., skills do not need to be developed separately for racial bias, gender bias, weight bias, etc). While much of my work is centered on racial implicit bias, we were pleased to discover that the skills...
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he year 2020 will be unforgettable in many ways. In this final Forum issue of 2020, we reflect on numerous national and global shifts and upheavals. At the time of this writing, various countries still address a prolonged first wave of COVID-19 cases while other regions, like Europe, are in their second wave, and the United States, in its third. If there are any silver linings to be learned from this chaotic year, it’s that we as individuals and societies are constantly changing. In medicine, we benefit from and engage in vast and far-reaching opportunities for collaboration and both individual and institutional learning. While not intended as a COVID-19 issue, this month’s articles reflect how significantly our experiences during the pandemic have molded our memories of 2020.


“The only thing that is constant is change,” said Greek philosopher, Heraclitus. Let’s remember 2020 as a time of growth, transition, or transformation. Global societies and climates are forever subject to change: the ebbs and flows are inevitable, but we also adapt and learn. As we grow, we will continue to serve each other and our patients as we begin 2021.

SGIM
SGIM ANNUAL MEETING 2021:  
A HIGH-VALUE OPPORTUNITY

Jean S. Kutner, MD, MSPH, President, SGIM; Hollis Day, MD, MS, Treasurer, SGIM

Despite the uncertainties we have been navigating since the beginning of COVID-19, one certainty has been that SGIM will hold its Annual Meeting in 2021. As we listened to members, a consistent theme is the value of the Annual Meeting—for learning, sharing, inspiring oneself and others, and, most of all, networking and connecting with the SGIM community. The Program Committee demonstrated significant flexibility and creativity—including how to best meet the needs of members as we have transitioned from planning for an in-person meeting to planning a fully virtual experience.

“People don’t value things that don’t have value.”  
—Jon Acuff

D espite the uncertainties we have been navigating since the beginning of the COVID-19 pandemic, one certainty has been that SGIM will hold its Annual Meeting in 2021. As we listened to members, a consistent theme is the value of the Annual Meeting—for learning, sharing, inspiring oneself and others, and, most of all, networking and connecting with the SGIM community. The Program Committee has demonstrated significant flexibility and creativity—considering how to best meet the needs of members as we have transitioned from planning for an in-person meeting to planning a fully virtual experience. Through conversation with other professional societies, we realized we are all learning together. For example, what platform best supports a virtual meeting? What format will best meet the needs of attendees? How do we provide the collaborative environment that is so important to SGIM members?

In my June 2020 President’s Column, I wrote about the world of “unknown unknowns.” Projecting for Annual Meeting 2021 definitely fits into this category. The known knowns:

• Annual Meeting 2021 will be fully virtual
• The annual meeting theme: Transforming Values into Action
• Based on submissions we have received so far, the content will be outstanding
• The keynote speakers will be exceptional—we have confirmed the following:
  o Vivian Lee, MD, PhD, MBA, President of health platforms at Verily Life Sciences and author of The Long Fix: Solving America’s Healthcare Crisis with Strategies that Work for Everyone.
  o Fawn Lopez, Publisher and Vice President of Modern Healthcare

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SGIM Forum

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</tr>
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</table>
| Tiffany L. Leung, MD, MPH, FACP, FAMIA  
Editor.SocietyGIMForum@gmail.com | Frank Darmstadt  
darmstadtfrank@gmail.com | Joseph Conigliaro, MD, MPH  
jconigliaro2010@gmail.com |

Editorial Board

- Yousaf Ali, MD, MS  
  Yousaf_Ali@URMC.Rochester.edu
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maria.frank@dha.org
- Kittu Jindal Garg, MD  
jindal.kittu@gmail.com
- Shauz Gupta, MD, FACP  
  Shauz.Gupta@rush.edu
- Tracey L. Henry, MD, MPH, MS  
  therry@emory.edu
- Francine Jetton, MA  
  jetton@sgim.org
- Megan McNamara, MD, MS  
  Megan.McNamara@va.gov
- Somnath Mookherjee, MD  
  smookh@u.washington.edu
- Susana Morales, MD  
  smr2001@gmed.cornell.edu
- Avital O’Glasser, MD, FACP, FHM  
avitaloglasser@gmail.com
- Tanu Pandey, MD, MPH  
tanumd@gmail.com
- Shobha Rao, MD  
  shobha_rao@rush.edu
- Jorge Rodriguez, MD  
jrodriquez@partners.org
- Gaetan Sgro, MD  
gaetan.sgro@va.gov
- Elisa Sottile, MD, FACP  
  Elisa.Sottile@jax.ufl.edu
- Megan McNamara, MD, MS  
  Megan.McNamara@va.gov
- Somnath Mookherjee, MD  
  smookh@u.washington.edu
- Susana Morales, MD  
  smr2001@gmed.cornell.edu

The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.
What did the Advancement Planning Task Force recommend to Council?

In April 2020, the Council acted upon the recommendations from our Financial Growth Workgroup by creating the Advancement Planning Task Force to guide plans for a new approach to fund-raising by the Society. At that time, the Council anticipated that the COVID-19 pandemic would have a substantial adverse effect on the Society’s financial position. I was delighted when Thomas Gallagher, Martha Gerrity, Thomas Inui, Carlos Oronce, Mark Schwartz, Valerie Stone, and William Tierney all agreed to serve on the Task Force with me. The initiative was funded by a grant from the Hess Foundation, and was supported by our Director of Finance, Leslie Dunne, and by two external consultants, John Wm. Thomas and Valerie L. Thomas.

Our consultants drafted a statement of the case for giving to SGIM, and I revised the statement after obtaining input from the Task Force. We based the case statement on the Society’s mission, vision, and organizational goals. The Task Force agreed that the mission and vision are as important as ever because of the COVID-19 pandemic and the national reckoning on racial injustice.

Our consultants also appraised SGIM’s capacity to implement a long-term fund-raising strategy by performing a survey of a randomly selected sample of our membership and by conducting in-depth interviews with selected long-time members. The survey indicated that most members felt SGIM has been very or extremely important to their professional growth and networking, while 76% of respondents said they would give to SGIM if there is a cause that resonates with them. The interviews helped confirm that senior members appreciated SGIM for being their professional home and were willing to help jump start a new philanthropy program. The consultants concluded that SGIM had enough assets to support a sustained philanthropy program based on an inspirational case statement, strong support from leadership, passionate commitment of members to our mission, and early success in securing sizeable new donations and pledges to the Society.

We then developed a comprehensive two-year plan for launching the new Forging Our Future fund-raising program that will nurture a culture of philanthropy at SGIM. The Task Force endorsed the plan in late August, and the Council approved the plan in early September. The plan makes philanthropy a priority for the organization, with Council members setting an example by establishing a target of having 100% Council participation by the end of 2020. The plan also sets a target of raising $200,000 by December 31, 2020, and another $300,000 in 2021, in addition to increasing the estimated value of commitments to our Legacy Program for Bequests and Advance Giving from $466,000 to $706,000 by the end of the year. To implement and sustain the new initiative, the Task Force recommended that we establish a standing Philanthropy Committee and hire a Development Officer.

What do we expect from the newly created Philanthropy Committee?

The Philanthropy Committee will assume a leadership role in creating and growing SGIM’s culture of philanthropy. Committee members will help to develop strategies and policies for running the Forging Our Future Program and will assist in cultivating relationships with prospective donors. I’m pleased to report that Martha Gerrity has agreed to serve as the inaugural Chair of the Philanthropy Committee, and she will be joined on the committee by Monica Lypson (SGIM’s President-elect), Gail Daumit (SGIM’s Secretary-elect), Janet Chu (Council Associate representative), Carlos Oronce (Council Associate representative), Anu Paranjape (ACLGIM President-elect), William Moran (SGIM Past President), Mark Schwartz (SGIM Past Treasurer), Shelly Ann Fluker (past Chair of SGIM’s Board of Regional Leaders), and Preston Reynolds (representative of the Ethics Committee).

What do we mean by developing a culture of philanthropy for our Society?

Simply put, this means that over the years ahead we will create within the Society a culture which cares deeply about philanthropy. In doing so, we will recognize that the Society’s growth and fiscal equilibrium are, to an increasing extent, dependent on expanding philanthropy by mem...
are relevant across biases. The IBRM instruction focuses on the individual learner with room to influence the culture and learning environment to enhance patient and organizational outcomes. Anti-racism work inherently includes an examination of systemic and structural racism, addresses multiple levels of racism, and has been eloquently addressed by our colleagues in previous Forum articles. Given the complexity of inequities in health, academic medicine, and society at large, a multi-faceted approach to addressing them is more likely to succeed. We must, however, resist the urge to fold these concepts into one another, as this will only serve to dilute efforts—these efforts merit dedicated time and institutional resources.

IBRM instruction is feasible. It requires minimal hours of dedicated time to deliver basic content and clarify concepts, an “Implicit Bias 101;” subsequent instruction can be integrated into existing instruction in reflection, perspective taking, empathy building, and communication skills. Many programs in medical education already utilize role-plays, standardized patient exercises, and observed structural clinical encounters. Opportunities for skill development in IBRM can be integrated into those active learning exercises. We can no longer say that we don’t know how to teach about implicit bias—we do know how. The biggest barrier is time in the curriculum; securing buy-in from leadership is essential. Faculty development programs that empower faculty and enhance their self-efficacy are imperative. Although time constraints may limit opportunities for IBRM instruction for practicing clinicians, changing the culture to allow for exploration of biases and empowering junior learners on the team to lead discussions (analogous to when they are giving clinical topic presentations during inpatient rounds) will solidify their own learning, and enhance discussions of this important topic by the team. We must de-stigmatize discussions of implicit bias and treat this topic like any other issue relevant to patient outcomes.

We want and deserve to develop skills to give excellent care to all our patients in line with our egalitarian values. Our patients deserve to feel respected and leave each encounter with their dignity intact. Other drivers for culture change include patient safety and quality improvement, payment structures, and grant dollars for continued research. We have an opportunity to collaborate to improve the culture of our healthcare system and academic institutions. While many approaches will be necessary to achieve social justice and equity in health care and academic medicine, skills-based training in implicit bias recognition and management is pivotal to these efforts.

References
LEADERSHIP AND HEALTHCARE ADMINISTRATION: PART I

CREATING AN INSTITUTIONAL WELLNESS PLATFORM IN UNDER 30 DAYS DURING COVID-19

Abigail Lenhart, MD; Megan Furnari, MD; MS, Kai Roller, MSW; Sydney Ey, PhD; Andrea Cedfeldt, MD

Dr. Lenhart (Lenhart@ohsu.edu) is an associate professor in the department of medicine in the School of Medicine at OHSU, wellness leader in the division of general internal medicine. Dr. Furnari (Furnari@ohsu.edu) is an assistant professor in the department of pediatrics in the School of Medicine at OHSU, director of medical student wellness. Mr. Roller (Rollerm@ohsu.edu) is a social work manager of population health at Kaiser NW. Dr. Ey (Eys@ohsu.edu) is a professor in the department of psychiatry in the School of Medicine at OHSU, associate director of the Resident and Faculty Wellness Program. Dr. Cedfeldt (Cedfeldt@ohsu.edu) is a professor in the department of medicine in the School of Medicine at OHSU, associate dean for faculty development in the School of Medicine. All authors are co-leaders of the OHSU COVID-19 Wellness Task Force.

Introduction

Each evening at 7:00 pm, Portlanders joined others in a symphony of shouts, applause, clanging pots, and pans. The cacophony of support was both recognition and encouragement for healthcare workers in the COVID-19 pandemic.

The first Oregon COVID-19 case appeared on February 28, 2020, followed in March by a shelter in place order and Oregon Health and Science University (OHSU) becoming the epicenter for the impending surge. Five institutional wellness leaders organized and formed the COVID-19 Wellness Task Force (CWT) in early March to develop, implement, and evaluate a plan to support the emotional and physical wellness of the OHSU community during the crisis. These leaders were incorporated in the Emergency Operations Center (EOC) to ensure that community wellness was part of the daily report.

CWT built programs quickly anticipating the surge. Each leader managed an interdisciplinary subcommittee: essential needs, wellness website, wellness resource phone line, psychological support, and feedback and evaluation. With regular meetings, thoughtful communication, and action-based plans, CWT was able to create a wellness platform to serve OHSU efficiently and effectively. They worked to amplify current programs, build new programs to address known gaps, create high-yield deliverables, and address community needs.

This article outlines the specific response and actions taken to support our healthcare workforce during the initial stages of the pandemic. Its intention is to guide other institutions as they enter a “new normal” and must build resilient communities in the face of immense health and economic challenges.

Adapting Roles: Creative Structure and Leadership

CWT used a collaborative leadership approach, alternating the team leader weekly to facilitate meetings and report to the EOC. Intentional check-ins started virtual meetings with a focus on relationship building and connection before diving into work. OHSU created a labor pool to re-assign those whose jobs temporarily waned during modified operations. The CWT acquired administrative support from the pool which allowed the CWT leaders to achieve maximum productivity by offloading the administrative burden. Subgroups were composed of experts from all over OHSU. Diverse points of view and rich dialogue in meetings capturing the temperature of the larger community, allowing the team to hear about wellness challenges early and work to address concerns quickly. Team success resulted from informed leadership, rapid mobilization, a budget support, and talented teams that brought innovations to life.

Where to Access Wellness Resources? Website, E-mail, and Grand Rounds

Resource accessibility and unified messaging is a challenge faced by academic institutions; however, during COVID order emerged from the usual communications overload. To provide clear messaging, a reporting structure was put into place with one daily email containing updated information and key resources from university leadership. Similarly, CWT designed a central wellness email address for the community to send ideas and concerns. In the first six months 145 emails were received. A wellness website was also launched with internal and external resources—it had 900 visits on launch day and 300 average visits per day in the following months. Resources were made visible and featured prominently in the daily email as the place to look for wellness support. CWT also gave 14 virtual Grand Rounds or department presentations over the course of three months, describing wellness programs and resources for the community.

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First Things First: Essential Needs

The essential needs subcommittee focused on the fundamental needs highlighted in Maslow’s hierarchy: nourishment, shelter, rest and physical safety. It partnered with “Frontline Foods PDX,” a national charitable organization that uses donations to pay local restaurants to prepare and deliver meals to healthcare staff. To shelter healthcare workers, OHSU offered rooms free of charge. Employee parking was made free limiting exposure to public transportation and shortening commutes. Additionally, hospital respite spaces were created and offered snacks, beverages, and relaxation kits. Badge access data indicated 900 staff per week accessed the spaces in May.

The Importance of Human Connection: Wellness Resource Concierge Phone Line

Fear can diminish people’s ability to process information making it challenging to access support. Medical students collaborated with CWT to create a phone line which connected OHSU members to a student resource navigator who could provide tailored wellness resources. The phone line launched April 6 with a team of 10 medical students led by a CWT faculty leader. They collated the best institutional, local, and national wellness resources in concert with the wellness website. Resources included topics such as psychological support, crisis and suicide assistance, physical wellbeing, financial assistance, children and family resources, interpersonal violence, and housing challenges. Any psychological support call was asked safety questions in order to assess for urgent crisis support. Calls were confidential, daytime hours only, and averaged 3-4 per day during March and April with a focus on essential needs. In May, the volume decreased to 1-2 calls per day and the focus shifted to mental and financial health needs. Overall, the phone line gave the students an opportunity to serve by supporting frontline workers. In two months, the line had 60 calls from 23 different groups.

Beyond the Basics: Psychological Support

The psychological support subcommittee’s initial challenge was to map out needs, structures, and tools to prepare for and manage the psychological impact of the surge on the OHSU community. The members’ wide skill set included: trauma intervention, suicide prevention, critical incident debriefing, public psychiatry, tele psychiatry, wellness program leadership, organizational and clinical psychology. The team coordinated psychological support services across the institution and addressed gaps by creating new services. Of particular importance was the development of a psychological first aid webinar and QPR suicide prevention training, as well as a Psychological Resilience Consult Service for leaders. The consult service arose from recognizing leader’s significant impact on employee wellbeing, and leaders seeking coaching on how to support their teams. The service provided one-on-one and small-group listening sessions for leaders, resources on psychological first aid principles, organizational psychology practices for employee communication and support, and individual and team resilience building strategies. In six months, the team has completed 28 consults with 20 unique groups of leaders.

Listening to Our Community: Feedback and Evaluation

A feedback process is essential for any rapidly implemented wellness intervention to guide effective resourcing and iterations. The feedback and evaluation subcommittee goals were to assess psychological health and the use and efficacy of wellness resources and to create a platform for anonymous feedback. Multiple methods of feedback were deployed and a structure for escalation to top leadership was developed. Feedback mechanisms included a one-item survey about immediate needs, a comprehensive pulse survey to measure wellness, and recruitment of wellness advocates providing in-person listening and feedback on high-needs units (ED, MICU, and environmental services).

The one-item survey included the questions: “What do you need right now?” or “What feedback do you have for the wellness team?” The initial survey gave valuable feedback, however required individual initiative, thus was not effective in gathering all opinions. In May and in September, comprehensive pulse survies were sent to the entire organization to measure wellbeing, psychological health, financial strain, and the effectiveness of wellbeing resources. The responses were used to inform the work of the task force.

Finally, CWT leaders regularly escalated relevant feedback to the EOC to identify gaps, find solutions, and allow leaders to get a sense of the day-to-day concerns. Feedback allowed leaders to focus resources where they were needed based on data rather than making assumptions.

Conclusion

The CWT elucidated issues facing OHSU, which allowed for rapid changes and new innovations. Prioritizing wellness initiatives, streamlining and centralizing resources, communicating with leadership, and institution-level wellness improved during the initial COVID-19 response. A clear leadership structure and mobilization of experts from across formal and informal community networks resulted in unprecedented inter-professional collaboration. The CWT increased wellness funding and brought new visibility to both previously existing and novel efforts. OHSU now provides centralized wellness resources for the entire community, bolstered psychological supports, a program to support resilient leaders, and a model

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Throughout the COVID-19 pandemic, healthcare professionals have faced unprecedented pressures in their professional and personal lives. The cumulative impact of higher volumes and acuity of patients, salary cuts, fears of personal exposure, unknowingly infecting our families, the long-term financial fall out, and other stressors is unknown, but could have a significant impact on mental health and resilience.

Since March 2020, the Hospital Medicine group at the University of Alabama at Birmingham (UAB) has faced these same stressors as the designated service for non-ICU COVID-19 care at University Hospital; yet, faculty morale and engagement remain high. In fact, news of a salary cut in the midst of an already stressful experience resulted in a collective shrug and gratitude for the transparency. How did we foster resilience during these uncertain times? We developed and used the following four tips for effective communication to FEEL our way from confusion to clarity.

**Frequent Communication**
Communication during times of uncertainty is akin to walking a tight rope—a leader must communicate frequently enough to drown out the “noise” but not so frequently that they add to it. During the early stages of the COVID-19 pandemic, healthcare professionals faced almost daily changes to operations and treatment guidelines. To combat confusion and frustration, we sent a summary e-mail every evening with updates and changes for the day, organized into sections for quick reference: a dashboard of overall volumes, updates in clinical operations, staffing, bed management, clinical guidelines, and faculty and staff resources. This consistent, standardized flow of information signaled transparency and instilled trust while minimizing disinformation.

**Explain the Why**
With every communication, it is essential to provide the cognitive bridge from problem to solution. Including the “why” behind decisions helps maintain trust, even if the decision proves to be faulty, and allows the group to analyze the underpinning logic and provide high-level, specific, and actionable feedback. The “why” is also an invitation to return to mission and vision—a compass amid chaos. In a rapidly shifting environment, reflecting on how changes bring us closer to providing excellent patient care (mission) and how every institutional ask is in fact an opportunity to embody leadership in inpatient care (vision) helps to keep everyone focused on the big picture.

**Express Gratitude and Grace**
Every day, 1,000 things are done well, but are often overshadowed by the few things that were not, especially in times of crisis. To avoid this pitfall, we intentionally used the beginning of each communication to acknowledge that these are challenging times and to thank our faculty for still continuing to provide excellent patient care. Expressing gratitude for everyday contributions is critical because those small, daily contributions are what make us successful. This also creates a climate in which team members are encouraged to celebrate great work and reinforces to our collaborators that we see them and appreciate their contributions.

**Leverage Multiple Channels of Communication**
Even carefully crafted messages are of little value if no one hears them, so it’s important to communicate via multiple modalities. Careful not to rely on e-mail alone, we also provided: (1) personal touch points (by phone or in-person)

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“Good communication is the bridge between confusion and clarity.”
—Nat Turner

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Dr. Kennedy (kierstin@uabmc.edu) is a clinical associate professor of medicine at the University of Alabama at Birmingham and chief of hospital medicine. Dr. Ring (ring4jeff@gmail.com) is a health psychologist, author, and leadership coach who specializes in health justice and health practitioner resilience and well-being. Dr. Willig (jwillig@uabmc.edu) is a professor of medicine at the University of Alabama at Birmingham leveraging Clinical Informatics to improve clinical outcomes.
In an unprecedented scenario, SGIM members from around the world are facing the same novel virus. At the time of this writing, COVID-19 has claimed the lives of more than 1.14 million people worldwide, with cases reaching 41.81 million. While all countries are facing the same pandemic, the responses and outcomes have varied dramatically from one country to the next. SGIM International members Enrique Casal, MD (Argentina); Moira Kapral, MD, MSc (Canada); Shinji Matsumura, MD, MSHS, PhD (Japan); Patrick Bodenmann, MD, MScPH (Switzerland) share their experiences during the last six months.

What were your countries’ initial policies to curb the spread of COVID-19?

**Dr. Casal:** At the end of February 2020, the Health Authorities hypothesized that the disease was not going to be a major issue for Argentina, not realizing how contagious the virus was. Despite swift action in March, there were few precautions taken at the beginning of the year. When the first cases presented from abroad and afterwards indigenous cases, the country installed an ad hoc Committee of Infectious Disease Experts. Argentina implemented strict quarantine measures and postponed an upsurge of cases, giving the health system’s public sector extra time to organize their response. This early quarantine was not followed consistently by other measures, however, and in October 2020, we are in the upslope of the curve, and in the world’s ten most affected countries by new cases.

**Dr. Kapral:** In March, Canada’s borders were closed, a 14-day quarantine was mandated for returning travelers, large gatherings of more than 250 people were prohibited, and schools and non-essential businesses were closed. The federal government released billions in economic aid, including an emergency benefit of $2000/month for any-one unable to work due to COVID-19 illness, caregiving duties, or unemployment.

**Dr. Matsumura:** On January 16, the first COVID-19 case was diagnosed in Japan. Soon after that, Japan had to deal with Wuhan’s returnees and an outbreak on the cruise ship, the Diamond Princess. Then, we began facing local outbreaks of COVID-19 in large cities, such as Tokyo, Osaka, and Sapporo. In the beginning, the PCR testing capacity was not enough, so the government focused on detecting clusters of infections and contact tracing. On April 8, Prime Minister Shinzo Abe declared a state of emergency, although the government did not impose a strict lockdown. As most residents in Japan followed the government’s request, the number of COVID-19 cases gradually decreased. On May 25, the governments lifted the nationwide state of emergency order. After societal activities resumed, the number of cases steadily increased. However, the infection has not led to a rapid spread as of October 2020.

**Dr. Bodenmann:** The virus was confirmed to have spread to Switzerland on February 25, 2020. On March 16, schools and most shops were closed nationwide, and, on March 20, all gatherings of more than five people in public spaces were banned. Additionally, the government gradually imposed restrictions on border crossings, and announced economic support measures. Those measures of partial lockdown were prolonged until April 26, 2020. Since then, Switzerland has eased restrictions gradually. The implementation of the SwissCovid app among more than two million people (a quarter of the general population) has permitted partial contact tracing of the population living in Switzerland. Since the beginning of the pandemic, the Federal Council has focused on the protection of the most vulnerable individuals (i.e., older persons and persons with pre-existing medical conditions). Taking
GATHERING INFORMATION ON COVID-19 SYMPTOMS FROM OPEN ONLINE SOURCES

Emily Leede, BA; Hannah Rosenthal, BS; Katherine Sebastian, RN, MPH; Lisa Jackson, JD, RN; Elizabeth A. Jacobs, MD, MPP

Ms. Leede (emilyleede@utexas.edu) and Ms. Rosenthal (rosenthalhr@utexas.edu) are fourth-year medical students at Dell Medical School at the University of Texas at Austin. Ms. Sebastian (kate.sebastian@austin.utexas.edu) is a research manager in the Department of Medicine at the University of Texas at Austin’s Dell Medical School. Ms. Jackson (lisa.jackson@austin.utexas.edu) is the executive clinical director of UT Health Austin at the University of Texas at Austin’s Dell Medical School. Dr. Jacobs (EAJacobs1@mmc.org; @DrLizJacobs) is vice president for research at Maine Medical Center Research Institute, the research arm of MaineHealth. At the time this work was conducted, she was chief of primary care and value–based health, professor of medicine and population health, and associate chair for research in the Department of Medicine at the University of Texas at Austin’s Dell Medical School.

Introduction

COVID-19 is a novel virus and the course of disease in non-hospitalized patients has not been well characterized. Most of the literature early in the pandemic and to date has focused on the hospital course; there is little information on outpatient disease progression1, 2, 3. This was especially true when the pandemic spread to the United States in January 2020. To guide care for patients at home and prevent unnecessary entry into an overwhelmed health care system, we sought to describe the outpatient course of COVID-19. At the time of this review, our outpatient primary care providers advised patients based on anecdotal evidence gleaned from patients actively ill with COVID-19. This experience-based advice included that patients with COVID-19 at home may experience a relapsing remitting disease course and that a relapse sometimes is severe enough to require hospitalization. To better inform our clinical practice, we used publicly available data to investigate if our guidance reflected what was being observed elsewhere. We systematically analyzed data in the form of first-person accounts from people who reported having COVID-19 while at home published online (e.g., on social media platforms). These data sources provided a rich description of COVID-19 symptomatology and progression and were easily searchable via Google, allowing us to quickly confirm our guidance.

Methods

We searched Google, Twitter, and YouTube to identify adults (≥18 years) who chronicled their COVID-19 symptoms at home on an online platform. We first searched these domains using broad search terms (SARS, SARS-CoV, SARS-CoV2, COVID-19, COVID, coronavirus, and corona), then used the find function within positive searches for more specific terms (positive, test, home, hospital, hospitalized, emergency, ambulance) and, finally, read accounts positive for one or more terms for inclusion criteria. When searching on Twitter, the above terms were preceded with a hashtag. Narrator’s accounts were included if they had self-reported lab test positive for SARS-CoV2, diagnosis of COVID-19 by a doctor based on clinical picture, or described close contact with a patient who had lab-confirmed COVID-19. Narrators were excluded if they did not describe their symptoms in a chronological order. Inclusion/exclusion criteria were screened using the online narration and were not confirmed in any additional way. The search began March 25 and was ended March 30, 2020, when continued web-searching with the above terms failed to reveal new accounts meeting criteria. Data collection included age, sex, self-reported diagnostic criteria, self-reported comorbidities, length of disease, symptom type and timing, timing of symptom remissions/relapses (defined as self-reported symptom improvement followed by worsening within 1 week), hospitalization timing, and discharge timing. Data were analyzed using descriptive data software on Microsoft Excel 2020.

Results

We reviewed 55 first-person accounts, of which 32 met criteria—of these, 23 were found via Google search, 7 YouTube, and 2 social media (Facebook or Twitter). Mean age of the narrators was 43 (95%CI 36-50) years old, 43% were male, and 9% described comorbid conditions. The majority (84%) self-reported that they had lab-confirmed COVID-19. Eighteen cases (56%) described a relapsing remitting course with a mean day of remission of 5 (95%CI: 4.3-5.7) and mean day of relapse of 6 (95%CI:5.2-6.8) Two people with a relapsing and remitting course had a second relapse; one recovered on day 11 with relapse day 12 and the other recovered day 16 with relapse day 17. Of those who relapsed, 7 (39%) noted worsening respiratory symptoms. Eight (25%) of patients were admitted to the hospital and 3 of them were admitted after a relapse. Mean admission day was 5.1 (95%CI: 2.6-7.6) and was earlier for those admitted...
BEING A PATIENT DURING THE COVID-19 PANDEMIC: A MASKED EXPERIENCE

Madeline H. Carney, BA

Ms. Carney (mcarney@usf.edu; @MadelineHCarney) is a fourth-year medical student at the University of South Florida Morsani College of Medicine.

Approximately two months after the World Health Organization declared COVID-19 was a pandemic, I was dropped off at the front of Tampa General Hospital for the resection of an L3 schwannoma. I would be staying in the hospital for at least two nights and because of social distancing measures, patients were not allowed to have visitors.

As a medical student nearing the end of my third year of school, I at least found solace in that I knew what to expect. I knew that I would be asked about the last time I ate. I expected that there would be IVs placed in pre-op. I also knew that I would be asked my full name and date of birth at least 10 times before surgery started. What I didn’t know was what it was like to be a patient during a global pandemic. I soon learned of the consequences of the measures taken to reduce the spread of COVID-19. In addition to limiting visitors at the hospital, staff and patients alike were expected to remain six feet apart and, of course, wear face masks.

A correctly fitted face mask must cover your nose and mouth and be tightly secured behind your ears or tied behind your head. The top of the mask should be positioned where there is the best seal around your nose and mouth. Simply put, a properly worn face mask covers the majority of the wearer’s face. I didn’t realize the emotional impact this face covering had on me until my experience in the hospital. When I was waiting in pre-op, the chief neurosurgery resident began the informed consent process, her eyes peeking above the sterile surgical blue of her mask. I already knew and understood the risks of the surgery: bleeding, infection, limb weakness, loss of sensation, CSF leak—the list goes on. Although I tried to focus on what she was saying, all I could think was that I just wanted to see her face. I wanted to see the face of the person who would be caring for me during the scariest and most vulnerable time of my life. As I signed my name, I made my last effort by glancing at the photo on her ID badge.

In medicine, we often talk about the physician-patient relationship and how sacred and privileged it is. In school, we learn tools for providing empathy and support for our patients in order to foster this bond. Could something as little as a surgical mask have compromised this relationship? As the rest of my surgical team trickled in one-by-one, I realized it could. It felt so bizarre not to see the faces of any of the people that would be providing my medical care. Especially during a time when I could not be with my family, I had hoped to rely on the reassurance and support of my medical care team. However, without the ability to see my providers’ facial expressions our encounters felt distant and impersonal. Throughout my hospital stay, I began to feel less like a person and more like an MRN number.

As a medical student, I thought I was prepared for the resection. I knew that the resident would be the one to close my incision at the end of the surgery, I knew what the role of the anesthesiologist was, and even that the CRNA would be monitoring me during the surgery. I knew the expert abilities of the medical professionals on my team and what the operating room was going to look like, because I had been in it before as a student; although I knew all of this, I still felt alone and scared. Even when there is not a pandemic, patients without a medical background are not afforded the comforts of such knowledge. Despite the best efforts of physicians to prepare their patients for what to expect, there is no way for patients to be aware of all of the nuances of surgery and a hospital stay in the same way that we as medical professionals are. The changes associated with the pandemic bring another set of challenges for patients. Without visitors, patients cannot as readily rely on their friends and family for support. Additionally, when every member of your healthcare team is wearing a face covering, it makes it more difficult to connect with them. As a result of this, patients may not feel as though they can look to their medical providers for emotional support. A hospital stay is often a stressful time for patients, and it is well established that social and emotional support are protective for health. This attests to the importance of a patient having a strong support team that can in part be made up of their healthcare providers. It is up to us as health workers to be aware of the effect of even the subtlest of changes caused by the pandemic, such as wearing face masks, and how to overcome these challenges to continue to care for our patients.

Based on my experience, the following are a few tips for providers caring for patients during the COVID-19 pandemic:

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o LaShyra “Lash” Nolen, Class of 2023 president, 2nd Year Student, Harvard School of Medicine

The known unknowns:

- How many people will register to attend the live virtual sessions?
- The market for recorded videos and on-demand content
- Member access to professional development funds to support registration costs
- The status of the COVID-19 pandemic in April 2021

The unknown unknowns—that’s the point, they are unknown.

If 2020 has taught us anything, it is that we can’t predict the future, that we can do the best that we can with the information that we have, knowing that the situation, and the available information, may change quickly. This morning while out doing errands, I heard an NPR interview with Shannon Lee about her new book, *Be Water, My Friend: The Teachings of Bruce Lee.* Ms. Lee explained that the teaching “be water” refers to being fluid, pliable, and flexible. I found this to be such an apt lesson as we plan for SGIM Annual Meeting 2021 in a rapidly changing and uncertain environment.

A key issue to resolve as we plan for the Annual Meeting is the registration fee. In the spirit of transparency, Hollis Day, SGIM Treasurer, and I wanted to share with you the process for making this determination. We are very conscious of the multiple competing demands on SGIM members, as well as institutional limitations on availability of funds. We also fully appreciate our fiduciary responsibility to assure SGIM’s financial stability and sustainability. All these factors were considered as the Finance Committee, and then the Executive Committee, considered the registration fees for the virtual Annual Meeting. If priced too high, people would not be able to afford attendance. If priced too low, SGIM would suffer financially, hampering our ability to provide other member-driven programs that have been prioritized by your Committees, Commissions, and Council.

The Finance Committee considered multiple factors, including estimating the number and types of attendees (e.g., associate or full members) and the costs of a virtual meeting that requires investment in additional technology to provide as close to the in-person experience as possible. We researched and compared meeting fees at multiple other similar organizations. We modeled different fee structures and talked with multiple SGIM members from different parts of the country and at different stages in their careers to best gauge what was a reasonable rate for the content that will be provided. The Finance Committee made recommendations to the Executive Committee, who, after further deliberation, ratified these recommendations. We were committed to publishing the registration fees prior to opening of the Round 2 submission window so that potential abstract and innovations presenters would know meeting registration costs at the time of submission.

While value may be in the eye of the beholder, here are the many ways that the virtual Annual Meeting is a tremendous value:

1. Ability to present your work nationally
2. Networking at all career levels
3. Cost per day is approximately $100 with the early-bird rate, including CME and MOC (versus other national meetings that charge extra for CME and MOC credits)
4. With the mix of live and recorded sessions, ability to access more content than is possible at an in-person meeting when we must decide between attending competing sessions
5. No travel expenses

In addition, with SGIM regional meeting registration being free to SGIM members this year, we are hopeful that SGIM members will see the combined value of attending both regional and the national meetings as a significant value of SGIM membership.

Our obligation is to make sure that you find value in attending SGIM Annual Meeting 2021. I am confident that our program committee, co-chaired by Drs. Rita Lee and Yael Schenker, is planning an innovative and inspiring event. Thank you to those of you who submitted to present. Register now (before early-bird deadline) and begin planning your Annual Meeting 2021 experience. I look forward to virtually seeing and learning from and with you in April!

**References**


of feedback for improving wellness programming.

The current and future impact of COVID-19 is unknown, the 7:00 pm cheer no longer occurs as COVID-19 becomes part of the “new normal,” but the newly established wellness platform continues to serve the community.

Acknowledgements:
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PERSPECTIVE: PART II (continued from page 11)

1. Using Masks:
   - Go out of your way to make patients feel comfortable: spend an extra minute in the room with them to ask how they are doing.
   - Speak clearly and enunciate. It is hard to hear through a mask.
   - Make your ID photo on your badge visible.
   - Make sure to clearly explain who you are and what your role will be in their care.

2. Be a Helping Hand:
   - Patients who are getting admitted to the hospital have to bring all of their belongings with them when they first arrive. Ask if there’s anything you can grab from their bags for them, such as: a computer charger, change of clothes, snacks they brought. This is especially important for patients who are post-op or have mobility issues for other reasons.
   - Call the patient’s family and give them an update on the patient. There is no such thing as too many updates for a family member that can’t be in the hospital with their loved one.

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References

LEADERSHIP AND HEALTHCARE ADMINISTRATION: PART II (continued from page 8)

with anyone immediately impacted by an upcoming change; (2) a readily accessible shared drive where electronic copies of all policies and prior emails are stored; (3) a leader on call to answer questions in real time, and (4) an asynchronous electronic Q&A box to submit non-urgent queries at our colleagues’ convenience, with responses provided individually via personal touch point (and high yield answers that would benefit the entire group included in the daily evening communication). Layering communication channels greatly broadened our audience and reduced the risk of employees being frustrated by seemingly unexpected changes.

Effective and thoughtful communication serves as a bridge over uncertainty and is critical to the health and productivity of teams, especially in times when confusion can dwarf clarity. Although we may not yet be able to see the other side of COVID-19, if we FEEL our way through we can remain resilient and emerge stronger.

References
care not only of the biomedical vulnerability but also of socioeconomic vulnerability is critical to decrease inequities.

What factors (social, political, cultural or otherwise) do you attribute to the success or failing of your country’s response to COVID-19?

Dr. Casal: While the capital, Buenos Aires, had a well-planned response, Argentina is a federal country, and the Ministry of Health has limited capabilities to lead action across the entire geography. Imported COVID-19 cases were attributed to commercial air transportation and concentrated on the metropolitan area of Buenos Aires. The severe lockdown initially succeeded and improved the infrastructure of the needed health services. The city of Buenos Aires constructed an appropriate health intervention, but as the pandemic spread, the poorer provinces received a growing number of cases. They have less developed health services and there is a special difficulty in providing tests and contact tracing in these more rural areas. From March to October 2020, the care of people without COVID-19 was severely affected, especially for people with chronic conditions, who often were forced to stop their treatment or follow-up visits. What I and many of my colleagues have observed is that people with acute illnesses suffered considerable delays in access to health care, increasing the number of complications.

Dr. Kapral: Canada’s response has been facilitated by its universal healthcare system, a coordinated public health response with the provinces taking direction from the Chief Public Health Officer, centralized distribution of PPE, early ramp-up of testing, broad public acceptance of masks and physical distancing, provision of basic income and other financial supports, and consistent messaging from politicians across all party lines. But there have been important failures. Most deaths in the first wave occurred in long-term care facilities, and subsequent investigations exposed major gaps in care and infection control measures at some of these sites. COVID-19 has also had a disproportionate effect on people of color, those from low-income areas, and those from underhoused populations.

Dr. Matsumura: Japan has a relatively low mortality of COVID-19 despite its high population density and aging population. One reason may be attributable to the social behaviors of the Japanese people. Japan has already had a habit of universal wearing of surgical masks in winter, and the early stage of the outbreak coincided with the spring pollen allergy season. Hence, the outdoor mask use was close to 100% from the beginning of the pandemic. Japan also has a culture where physical contact (shaking hands, hugging, and kissing) is uncommon.

Dr. Bodenmann: I practice in the canton of Vaud where the current figures of positive tests and quarantines required are increasing for a number of reasons: the density of our population compared to other cantons, the large number of young people, the presence of many educational institutions, and the borders with France. In addition, there has been a gradual abandoning of barrier gestures (measures people can take to reduce the risk of infection). On the other hand, the socio-political stability of the country and the constant interaction and coordination between politics, public health offices, academics and clinicians enabled us to respond effectively. However, there remains a need to focus on patients lacking financial resources or without legal status in Switzerland.

What do you imagine are the long-term changes to societal life in your country? Do you anticipate long-term changes to medical care?

Dr. Casal: Argentina is living a deep and progressive socio-economic decline in the last 30 years; it is highly impoverished with around a 40% of poverty rate, and a high level of unemployment. We have an opportunity to change these conditions and try to find a way towards effective production and wealth. COVID-19 may be helping to conceptualize this potential turning point. Medical care should be a leading part of this change, offering a better destiny of our almost 9% of GNP invested in health with a central role for primary and universal health care. Telemedicine has arrived to stay, but no one knows for certain in what proportion of usual care or how to charge and pay for these encounters. The cell phone may play a central role in telemedicine.

Dr. Kapral: The pandemic has demonstrated the importance of investment in public health, long-term care, healthy urban design, childcare, housing, social programs, and poverty reduction. If the initial measures that have been enacted to address these issues are continued and amplified, this could lead to long-term benefits for our communities and our health. And I expect that the increased availability of telehealth will be a huge benefit to our population, many of whom live in remote or rural areas with limited access to in-person health care.

Dr. Matsumura: People in Japan are changing the way they behave. There will be further expansion of online clinics, online meetings, and remote schooling or working. There is also the impression that people are becoming less directly connected and more socially isolated in the community. Telehealth will expand, and most health care will be more information driven. As physical examinations become more challenging to perform, our consultation process may differ. Primary care practices in Japan, which has had excellent access to medical care, are likely to change. Restrictions of visits in hospitals wards or long-term care will continue to be facilitated by telemedicine.
PERSPECTIVE: PART I
(continued from page 14)

care facilities may affect the nature of end-of-life care.

Dr. Bodenmann: The socio-economic stability of Switzerland may reduce the economic impact of the health crisis compared with other countries. However, the social crisis is inevitable and we will have to focus our attention on the most vulnerable people in medical terms but also in terms of mental health: this includes seniors, young people and all those left behind and too often invisible and neglected. COVID-19 gives us an opportunity to review our healthcare procedures, our quality processes, and even our missions regarding the most vulnerable and marginalized patients in our healthcare system.

As of October 24, Argentina had 1.05 million confirmed cases and 27,957 deaths. Canada had 209,148 confirmed cases and 9,862 deaths. Japan had 95,835 confirmed cases and 1,706 deaths. Switzerland had 96,731 cases and 1,866 deaths. The United States had 8.32 million confirmed cases and 221,564 deaths. As these numbers continue to grow, especially so as we face the winter months in the norther hemisphere, it is necessary that our healthcare professionals around the world share their experiences and insights in the fight against COVID-19. Lives are saved when we do.

References

SIGN OF THE TIMES: PART II (continued from page 10)

without a relapse than those admitted after a relapse.

Fatigue and cough were the most common initial symptoms. At the time of the review, we also identified many novel symptoms that had not been widely recognized and reported in the peer-reviewed literature. The most common novel symptoms identified were feeling like there was a “weight on [their] chest,” dizziness, and ocular complaints (eye pain/soresness, burning, and sensitivity to light). At the time of this project done in March 2020, the majority of narrators (75%) had reported symptoms not frequently described in the peer-reviewed hospital focused literature during their disease course.

Discussion
In this analysis of 32 first-person accounts of the COVID-19 symptom course, we found that the majority of narrators had a relapsing remitting course and the majority of them recovered at home without the need for hospitalization. Almost 40% of narrators who relapsed had worsening of their respiratory symptoms and almost half were hospitalized after their relapse. Our findings informed our guidance for patients and healthcare providers. As a result, we counseled patients about the possibility of relapse around day six, after a day of improvement, and that if patients have worsening respiratory symptoms, they should call their physician. While initial symptoms of the narrators were similar to those documented in hospitalized patients, a significant portion of them described novel symptoms that had not been widely described at the time of our review, including feeling like a “weight on [their] chest,” dizziness and eye symptoms. This was significant because patients with these symptoms may not suspect they are infected and could spread COVID-19. Our study was limited by the small number of self-reported COVID-19 infections and the inability to confirm self-reported information in a reliable way. It was also limited by the manual extraction of information as it relied on clinician ability to identify articles via search engines. Further research is needed to better understand the course of COVID-19 symptoms, especially in the home setting, and the long-term sequelae of COVID-19 in patients managed outside of the hospital.

This study exemplifies the role of open online platforms in delivering pertinent clinical information in the setting of a global pandemic, particularly when little is known about the infectious agent or disease course. Generalist physicians play a uniquely important role in pandemic management but are often left relying on early studies focused on diseases in the hospital setting. This creative approach to gathering outpatient-specific disease information is specifically suited to informing the generalist practice and should be considered in any future situations like that of COVID-19.

References
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