The COVID-19 pandemic has significantly altered activities, impacting global economies, governments, and communities. While unique cultural and societal factors have influenced the final shape of public health measures implemented in different countries, the responses share common themes and compromises towards common global aims of mitigating preventable death and human suffering and enabling communities’ recovery.

This article describes a country’s pandemic management, covering four global regions. We unfortunately cannot cover all countries but seek to open dialogue about the diversity and reach of our work and influence as general internists in global communities.

China

China, the epicenter of the global pandemic, invested astronomical resources to eliminate COVID-19, adopting a four-tier emergency response system (ERS) (Level-I: highest; Level-IV: low). Responses involved building temporary hospitals, implementing prolonged partial or full quarantines, and widely mobilizing health care workers. At peak, all 31 provincial-level regions were simultaneously at ERS Level-I. By May 2020, Tianjin and Hebei, neighboring Beijing, remained on Level-I, along with the hard-hit Hubei Province; and promisingly, less than 3% of patients are yet to recover from COVID-19. Overall, China’s broad-reaching containment strategies curbed otherwise exponential growth of COVID-19 cases by mid-March.1

Strategies to prevent a second wave of infection began as early as February. Domestic and international transit, accommodations, and assemblies were limited; borders closed to inbound foreign travellers on March 28. Gradual loosening of social distancing measures did not translate to loosening of preventive measures—they became even stricter. A crucial measure to prevent a second wave was screening asymptomatic individuals who are/were in close contact with or exposed to confirmed COVID-19 cases, involved in identified cluster outbreaks, and who are travellers from high-risk areas. These cases are mandatorily reported to the National Health Commission for daily surveillance.

In Shanghai, a city of more than 25 million inhabitants and China’s largest metropolis, and more than
FROM THE EDITOR

OH, THE PLACES YOU’LL GO!

Joseph Conigliaro, MD, MPH, Editor in Chief, SGIM Forum

“You’re off to Great Places!
Today is your day!
Your mountain is waiting.
So... get on your way!”
—Dr. Seuss, Oh, the Places You’ll Go!

Thirty-three years ago, this past June, I graduated medical school. I was the first and only child of eight siblings to attend college and one of only two physicians in my family. I started residency knowing that I wanted to do academic general internal medicine after spending an elective month as a fourth-year medical student with Drs. Alan Goroll and John Stoekle at Mass General. I really had no idea what I was getting into. I was introduced to SGIM as a second-year resident but didn’t attend a meeting until I was a third-year resident. I’ve already written about the effect the first meeting had on my career as well as what the meeting has meant to me over the last 30 years. As an SGIM member, I have served on the National Meeting Program committee, taskforce and committees, and most recently as Forum editor in chief and ex-officio council member.

My tenure as Forum editor in chief has come to an end and this is my last editorial. Serving as editor in chief for the SGIM Forum over the last three years has been a thoroughly rewarding and enjoyable experience—a highlight of my relationship with the Society and with you. Thank you for trusting me with your articles, thank you for trusting me in curating them and presenting them, and thank you for allowing me to express myself every month and share my thoughts and opinions. I want to specifically thank Forum’s managing editor and design editor, Frank Darmstadt and Howard Petlack respectively, both of whose professionalism and attention to detail taught me how to put out a first-rate publication every month. Also, Francine Jetton—SGIM’s communication director—SGIM staff, and Council served as both a wealth of knowledge and inspiration. Thank you to my associate editors, whose tireless edits to get me copy, sometime at the 11th hour, filled Forum with outstanding content. Finally, thank you to Rosemarie Conigliaro—fellow SGIM member, friend, colleague, and wife—for putting up with my late nights because “I gotta get the Forum out.”

In the last three years, Forum underwent a refresh with a new color scheme and logo to match that of SGIM. We refined the department of “Humanities” to “Breadth” to better capture the full spectrum of creative expression continued on page 13
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 an 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.

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**PRESIDENT’S COLUMN**

**SGIM 2021 ANNUAL MEETING THEME:**  
**TRANSFORMING VALUES INTO ACTION**  
Jean S. Kutner, MD, MSPH, President, SGIM

Why is “Transforming Values into Action” the theme of our 2021 Annual Meeting? Leadership is core to SGIM’s mission, vision, and values, and is a common thread across many of SGIM’s offerings and activities. This leadership is not leadership for the purpose of titles—it is leadership to effect positive change. As noted in the “who are we” section of the SGIM Web site: SGIM is a diverse community of talented people in academic general internal medicine who are passionately committed to improving health through research, education, and advocacy.

Compassion is bringing our deepest truth into our actions, no matter how much the world seems to resist, because that is ultimately what we have to give to this world and one another.1

We all have the opportunity to lead both as individuals and as members of communities and organizations. Furthermore, we all have the opportunity to continue to grow and learn in our roles as leaders. It was this realization, and the unique role that general internists play in leading from multiple levels, positions and perspectives, that lead to selection of the 2021 SGIM Annual Meeting theme—Transforming Values into Action. Leadership is not a new theme for SGIM Annual meetings. Recent leadership-related SGIM Annual Meeting themes have included—“Courage to Lead: Equity, Engagement, and Advocacy in Turbulent Times” (2019); “Health IT: Empowering General Internists to Lead Digital Innovation” (2018); and “Celebrating Generalism: Leading Innovation and Change” (2013).

Why is “Transforming Values into Action” the theme of the 2021 Annual Meeting? Leadership is core to SGIM’s mission, vision, and values, and is a common thread across many of SGIM’s offerings and activities. This leadership is not leadership for the purpose of titles—it is leadership to effect positive change. As noted in the “who are we” section of the SGIM Web site, SGIM is a diverse community of talented people in academic general internal medicine who are passionately committed to improving health through research, education, and advocacy.2

It is this focus on action that particularly resonates with me. As a clinician-investigator, I have long said that I did not want to conduct research for the sake of publishing papers. Research has to matter. The research question in the first place, and the findings from the research, has to continued on page 13
May 21, 2020

1. What are SGIM’s plans for regional meetings next year?

After determining that we could not hold SGIM’s in-person national meeting scheduled for May 6–9, 2020, we reassessed plans for SGIM’s seven regional meetings scheduled to be held September 2020–February 2021. Working with the Board of Regional Leaders (BRL), the SGIM meetings team identified important concerns emanating from the COVID-19 crisis: 1) uncertainty about a second wave of the pandemic; 2) state-to-state variation in policies about large group gatherings; 3) the impact of new hygiene standards on meeting facilities; 4) uncertainty about availability and cost of vendors; 5) institutional restrictions on travel and cutbacks in funding for professional expenses; and 6) potential effects of salary reductions, furloughs, and unemployment on members and their families. Fortunately, all seven regions have financial reserves exceeding 50% of their annual operating expenses, even though their by-laws only require reserves to exceed 25% of annual operating expenses.

With those considerations in mind, the BRL considered three options: 1) proceed with face-to-face regional meetings; 2) conduct regional meetings virtually; or 3) develop hybrid meetings involving a combination of virtual and face-to-face participation. The BRL chose the second option, with a focus on offering as much networking and attendee interaction as possible. In the coming months, regional leaders will thus be developing novel ways to support the SGIM community through virtual regional meetings. SGIM staff will be looking for the best platform and processes to support interactive virtual meetings. We look forward to seeing the innovative ideas that emerge from reimagining the content and format of the regional meetings, as well as from re-defining their role in providing an easily accessible forum for discussing topics in research, education, and clinical medicine.

2. What are SGIM’s plans for the 2021 Annual Meeting?

We have identified a theme and are assembling the planning committee for the 2021 Annual Meeting, currently scheduled for April 21–24 in Boston. Due to concerns that the pandemic may last more than a year, we concurrently are considering how to best meet the spirit and purpose of the Annual Meeting while acknowledging the significant impacts of the pandemic on the ability to hold in-person conferences. As you may have heard, the Association of American Medical Colleges recently decided to cancel all planned in-person meetings through June of 2021.

When the SGIM Council met on May 8, 2020, we reviewed three options for the Annual Meeting: 1) proceed with plans for an in-person meeting; 2) shift to planning for a fully virtual meeting; or 3) prepare for a hybrid meeting involving a combination of virtual and face-to-face participation. The options have widely varying implications for SGIM’s budget because the meeting is our largest source of revenue. The Council did not make a final decision because too many factors remain uncertain. However, the Council is firmly committed to having an inspiring Annual Meeting in 2021 because of its central role in the life of the organization.

In the meantime, the SGIM team is working hard to deliver to members through SGIM20 On-Demand much of the content that was scheduled for the 2020 Annual Meeting. As indicated on our Web site, SGIM20 On-Demand includes plenary speakers, special symposia, clinical updates, oral abstracts, clinical vignettes, and posters originally scheduled to be presented at the 2020 Annual Meeting. Recognizing that universities are cutting back on faculty funds for continuing education and travel, we decided to offer SGIM20 On-Demand to members for free. In addition, we will give members that use SGIM20 On-Demand up to 30 continuing medical education (CME) and maintenance of certification (MOC) credits for a very low price of $295 ($795 for non-members).

We expect to learn a lot from SGIM20 On-Demand that will help guide our approach to what we offer to members virtually when they cannot attend a meeting in person. We also expect that innovations with virtual meetings will generate new ideas for supporting the vital networking function that gives SGIM such a strong sense of community committed to an inspiring mission—to cultivate innovative educators, researchers, and clinicians in
REDUCING ENTROPY: REDEFINING RESPONSE TO CARDIOPULMONARY ARREST IN A LEVEL 1 TRAUMA CENTER THROUGH SIMULATION TRAINING

Revati Reddy, MD, MBA

Dr. Reddy (rbreddy1@outlook.com) is a hospitalist with the University of South Florida and the chief quality fellow at Tampa General Hospital.

On May 10, 2020, the Los Angeles Times reported the death of 62-year-old Celia Marcos, a charge nurse who rushed in to respond to a cardiac arrest in a patient suffering from COVID-19. She passed away from complications of the disease 14 days later. Her death, along with those of the hundreds of other healthcare workers around the world, highlights the need to balance and prioritize the health and safety of our team members without sacrificing the quality of care we provide for our patients in this new healthcare environment.

Survival to discharge of patients suffering in-hospital cardiopulmonary arrest (IHCA) at our institution has averaged between 20-25% over the past 2 years, which is average for medical centers globally. Staff members quoted problems with disorganized response, overcrowded rooms, and poor post-code transitions of care. Previous interventions, done independently over the course of the last two years, included introducing post-code debriefs, designating the code leader with a red hat, and advising the assignment of code roles to unit staff. Team members were incentivized with coffee shop gift cards or meals gifted to the unit. These interventions and incentives however, failed to sustain any changes in processes or outcomes.

The onset of the COVID-19 pandemic, however, brought a new sense of urgency in improving the processes surrounding cardiac arrest care. As an always-busy safety-net county hospital and quaternary care center, we could not afford to improvise when it comes to patient and staff member safety. A Critical Care/Code Blue committee comprised of providers from Emergency Medicine, Internal Medicine, Pulmonary/Critical Care Medicine, Anesthesia, Rapid Response Team, Nursing, and Pharmacy was formed soon after news of the first cases in the United States came to light to create protocols for critical care situations where there would be high risk for virus aerosolization. We named the new response to our IHCA in COVID-19 patients the “Code 100.”

**Code 100**
The Code 100 process emphasized limiting the number of responders to highly trained individuals who would have proper PPE while keeping as much of the equipment outside negative pressure rooms as possible. We developed use of a “Staff Assist” call button rather than the Code Blue call button on COVID-19 units to prevent the normal code team from responding. The crash cart would remain outside the room, and each member of the code team was responsible for bringing essential equipment (medication box with a set number of pre-dosed code medications, the defibrillator, the airway box, with a HEPA filter, the glidescope, and ventilator). A gate keeper and pharmacist outside the room would convey additional materials into the room as needed.

In mid-March, a patient being treated for COVID-19 suffered cardiac arrest while he was being lain prone in our ICU. Given education earlier the same day, team members were outfitted in proper Personal Protective Equipment (PPE). No team members ultimately contracted the virus because of this patient’s care. However, fears around safe and effective treatment of these patients still abound. While we had filmed simulated versions of the new processes, videos alone were not enough. Literature notes positive correlation between simulation training and better outcomes for IHCA. However, the uniqueness of the situation at hand was the urgency of training team members to properly care for known COVID-19 patients, without sacrificing the care of known negative or undifferentiated low risk patients due to fears of transmission.

The simulation training we designed originally encompassed the new Code 100 process, emphasizing the need for our team members to protect themselves with proper PPE, the donning and doffing of which takes valuable time, rather than responding immediately to a code in the hardwired way that all healthcare workers are taught to do. We eventually extended the use of high-level PPE for core code responders to IHCA in the undifferentiated, asymptomatic population in accordance with professional society guidelines. Partnering with the University of South Florida Center for Advanced Learning and Simulation and the Tampa...
One of the privileges of primary care is getting to know patients over time. Mr. B was a patient who brought a smile to my face whenever he called or came to see me. At 93, he lived independently, had a girlfriend, and always arrived wearing a dapper outfit with an apt remark about the news. He sent me postcards during his winters in Arizona and from family events. Last winter, while in Arizona, he had a stroke. He recovered quite well with physical and occupational therapy at home. This winter, he stayed in New York rather than travelling to Arizona to be closer to family and his medical team. We saw each other regularly, and I prided myself on contributing to the fact that he had remained spry and out of the hospital for a year following the stroke. I believe another key to his success over this time was his girlfriend, whom he visited weekly.

During mid-March, Mr. B came to see me for a “cold,” as he had several times before. Finding a benign exam, I explained social distancing and asked Mr. B to speak with his girlfriend on the phone rather than visiting due to the COVID-19 epidemic. He went anyway, and called me a few days later to report a cough.

Things started to worsen the following week, just as the COVID-19 pandemic began to spread in New York. Mr. B developed a fever. Considering the possibility his cold had developed into community acquired pneumonia, I treated him with antibiotics, which quelled the fever for a few days. We did telehealth visits, with the assistance of Mr. B’s tech-savvy daughter.

As the likelihood Mr. B had COVID-19 grew with each telehealth visit, I spoke with Mr. B and his family about potential hospitalization if his symptoms worsened. Discussing goals of care via telehealth was not something I was accustomed to as a primary care provider, but thankfully, Mr. B and his family were all on the same page. Mr. B wanted to be comfortable and to remain in his home. I brought up the idea of home hospice, as his probable COVID-19 might or might not be a life-limiting condition depending on the trajectory of the illness. Mr. B and his daughter were initially skeptical, but quickly warmed to the idea. Things progressed quickly. Papers were signed, and home nurses arrived the next day, just as Mr. B began to require oxygen and experience delirium. Again I raised the possibility of hospitalization, and again, the family resolutely declined. Two days later, his daughter, a former nurse, let me know his oxygen level was 72%. We focused on comfort and worked with the home hospice team. He died the following day, in his home.

As his primary care physician of four years, I will treasure our relationship. I miss Mr. B already. Reflecting on his end-of-life care, I take solace that Mr. B died as per his wishes in home hospice. In the midst of a global pandemic, with shortages of equipment and projected rationing of ventilators, the case seems revealing. Faced with the potential of hospitalization for a severe infection with a high pre-test probability of mechanical ventilation, a patient and his family chose home hospice...Tough conversations avoided an unwanted hospitalization, and likely, an ICU stay for mechanical ventilation.

As primary care physicians are redeployed to hospital care and in some cases ill themselves, who will have these conversations? How can we approach these conversations optimally and convey much needed empathy and support given the limitations of telehealth, when our training and experience has emphasized in-person conversations around goals of care? How can we encourage accessibility to telehealth for the isolated, elderly, and ill who may need these services the most? How can we preserve the patient-physician relationship as a scarce resource in this pandemic?
I recently discovered an app called TikTok. From what I can tell, it seems to be used primarily by younger people who record themselves performing short music videos, lip-syncing scenes, or absurdities with their unsuspecting family members and pets. Most of my friends and family scoff at the fact that I downloaded the app—after all, I am a 38-year old Internal Medicine physician at a prominent academic medical center and on the front lines of the COVID-19 pandemic. I assumed I would be in the very small minority of TikTok users in my professional demographic. But I was wrong.

Burnout in the field of health care has been a problem for a very long time. The major factors leading to burnout usually include the seeming impossibility of balancing work and home life, time pressures, emotional intensities of patient encounters, EMR demands, competing patient and institutional goals, and insurance constraints. All of these issues can contribute to moral injury over time. With healthcare burnout increasing in the United States and correlating with disturbing rates of provider depression and suicide, many hospital systems have devoted significant energy and resources into promoting the concept of “wellness.” Examples include opening wellness centers, procuring wellness apps, creating wellness newsletters, and making wellness rounds. While these efforts can be helpful, in my opinion, most of their effects are transient at best. Furthermore, few of them meaningfully address the fundamental contributors to burnout in the first place. Most providers realize that without broad, federal-level policy change to address these underlying issues, there is not a whole lot that hospitals, even with the best of intentions, can do to mitigate burnout beyond offering relatively superficial remedies. So, in the absence of timely legislation, what do healthcare providers really want? I believe most of us simply want to do the work we were trained to do, and to feel valued and respected for doing it. In my experience, when healthcare providers feel validated, appreciated, and respected, the pangs of burnout truly do dissipate.

Fast-forward to the year 2020 and the COVID-19 crisis. Suddenly healthcare providers were thrust onto an unfamiliar battlefield, fighting an unseen enemy with no known treatment and with no vetted weapons at our disposal. Coupled with perpetual PPE shortages, fear about personal and family safety, stress about staffing demands, anxiety about running out of ventilators, the onset of the coronavirus pandemic was a perfect recipe for a burnout explosion. Indeed, the physical and psychological toll of this pandemic on frontline providers is yet to be fully realized and likely will not be for years to come.

Remarkably, instead of increased feelings of acquiescence, what I am witnessing more than anything amongst my fellow colleagues is a striking and renewed sense of duty, purpose, and passion. And I found evidence of this in the most unexpected place: TikTok. After I joined, I started scrolling. I was surprised to see hundreds of examples of a distinctly similar scene: assorted groups of frontline healthcare workers—decked out in different-colored scrubs and a variety of PPE—performing dances, re-enacting hilarious healthcare scenes, promoting “Stay at Home” messages, or simply showing others what it’s like to don layer upon layer of PPE. Some healthcare TikTok users use the platform in more educational ways: to dispel myths or prevent the spread of medical misinformation. But why is it that so many healthcare workers are turning to TikTok these days? How did this become a “thing?”

I suspect that for a few minutes, and in the company of their coronavirus comrades, these healthcare TikTok users are connected once again to the feelings that burnout took away: Joy. Purpose. Camaraderie. A collective sense of accomplishment. Validation. Satisfaction. Whether these providers realize it or not, they are essentially using TikTok as a wellness tool. I have seen it at my own hospital: I recently persuaded a group of COVID unit doctors, residents, and APPs to do the “Blinding Lights challenge” on the roof of our hospital. None of us are particularly good at dancing or have any significant social media following, but that did not matter—the act of making the video brought us together as a team where everyone felt needed and valued. It required all of us to take risks (of looking dumb), but in a safe space. It built resilience by reminding us that practice makes perfect (or in our case, not really perfect). “Right foot left foot challenge” came the next day, followed by the “Oh...
MEET THE 2019 SGIM EDUCATION AWARDS WINNERS!
Daniella Zipkin, MD; Alia Chisty, MS, MD; Lawrence Kaplan, MD

Dr. Zipkin (Daniella.zipkin@duke.edu, Twitter @EvidenceBasedMD) is an associate professor of medicine at Duke University School of Medicine. Dr. Chisty (achisty@pennstatehealth.psu.edu, Twitter @aliachisty) is an associate professor at Penn State Milton S. Hershey Medical Center, Penn State College of Medicine. Dr. Kaplan (Kaplanli@tuhs.temple.edu, Twitter @LawrenceKaplan5) is a professor of medicine and associate dean for interprofessional education at the Lewis Katz School of Medicine at Temple University.

(Editor’s note: Due to a variety of reasons, this tribute to the 2019 SGIM Education Awards Winners never made it into an earlier issue of Forum. Regardless of the timing, we are happy to pay tribute to some of SGIM’s outstanding educators. Joseph Conigliaro)

The Awards Subcommittee of the Education Committee is pleased to highlight this past years’ SGIM Education Award Winners! Here we share Q&A with each winner where we explored the inspirations, triumphs, and challenges that contributed to their impressive achievements.

2019 Winner of the Career Achievement in Medical Education Award / Adina Kalet, MD, MPH
By Daniella Zipkin, MD

What inspired you to pursue a career in medical education?
I always wanted to be a dancer! My first educator role was teaching dance at Stuyvesant High School in New York City. As the daughter of refugees and Holocaust survivors, however, I grew up with an expectation that I would pursue a career in something more traditional, like medicine. I had a fantasy of doing something in medicine that would combine the arts and love of learning. When I first started at the Sophie-Davis School for Biomedical Education, a 6 year BS-MD program where I started studying medicine right off the bat in college, I was skeptical. But it turned out to be just the career defining experience that I needed: I was surrounded by non-traditional student peers and immersed in an environment of innovation in education. As part of the inaugural class of the Primary Care Internal Medicine Residency at NYU in 1984, led by Mack Lipkin Jr., my peers and I co-created the program as we went. I was sold! Inspired by my medical educator role models, I knew I could focus on teaching. With no clear path for educators after training, we blazed a trail with Mack’s help, through a year of funded international exchange and then a Robert Wood Johnson fellowship at UNC which I molded to my goals. I advocated and argued that health professions education research was just as important to the health of the public as basic science, clinical and health services research. Feeling that traditional medical education was sucking the humanity out of students, I was inspired to make change.

To date, what is a career accomplishment that you are most proud of?
Building the Program for Medical Education Innovation and Research at NYU (PrMEIR) was my most satisfying accomplishment. Through deeply collaborative relationships with Sandy Zabar and Colleen Gillespie, we were able to create our vision of a safe space for clinician educators to be taken seriously and grow as scholars, and we were continuously funded by HRSA, AHRQ, NIH and foundations for over 15 years.

Can you describe one of your biggest professional challenges and how you approached it?
After almost 30 years at the same institution things began to change. There were a few critical moments where my institutional leadership made clear they did not value the work I was doing. Undertones of differential treatment of female faculty made institutional pivots harder to weather. Realizing that these issues where not simply the normal ebbs and flows of any workplace but information about a change in institutional culture, I started to pay more attention to leadership opportunities elsewhere. In 2019 I was selected to lead the Kern Institute for the Transformation of Medical Education at the Medical College of Wisconsin. I am now a few months into starting the role and enjoying it immensely. (See the announcement here! https://www.mcw.edu/newsroom/news-articles/adina-luba-kalet-named-director-of-kern-institute)

2019 Winner of the Mid-Career Education Mentorship Award / Donna Windish, MD, MPH
By Alia Chisty, MS, MD

What inspired you to pursue a career in medical education?
When I entered medical school at the University of Connecticut, there was a change in the curriculum from lecture-based teaching to small group learning and problem-based medicine, and they partnered with med-continued on page 14
On the day that our dean made the difficult decision to recall the students from their clinical rotations in response to the growing SARS-CoV-2 pandemic, we submitted a proposal to restructure and expand our medical school’s offerings in the medical humanities—the study of history, literature, philosophy, ethics, social psychology, and other disciplines to better understand the complex relationships between individuals, health, illness, health care, and society.

We included with our submission a note of understanding that, since our proposal had little or no bearing on clinical operations in a time of crisis, we were prepared to wait patiently for a response.

Neither of us anticipated how the demand for opportunities to read, write, and reflect would surge among healthcare professionals in the coming weeks.

In the past month, we have been asked to develop humanities offerings that address the pandemic at two separate medical schools. We have facilitated virtual writing and reflection groups for medical students, residents, and faculty. Last week, as my division chief planned for a new normal of physically distant operations, she asked me to host an online poetry reading to restore a sense of community.

Our experience is not unique. Another faculty member at our university has redesigned her Literature and Medicine seminar for undergrads to address the ethical issues raised by the pandemic. The Nocturnists podcast, Stanford’s Medicine & the Muse Program, the Twitter-based #MedHumChat, and The Human Touch Magazine have all modified and expanded their formats to accommodate the growing need among healthcare providers, students, and trainees for opportunities to connect and create.

Perhaps we should have seen this coming, but a movement to de-emphasize the humanities in favor of science, technology, engineering, and math-oriented education has tempered our expectations. While this narrow focus on disciplines linked directly to the technology economy is misguided in the most ordinary times, it is morally perilous in a crisis.

It is also ahistorical. From the renaissance to the emergence of modernism in the wake of the First World War and the last pandemic, periods of investment in the humanities enabled and enhanced advances in science and technology. The arts have been no less important on a personal level. When asked to reflect on the value of poetry, the poet Michael Longley remarked:

> In the ashes outside the crematorium in Auschwitz, they discovered scraps of poems. And these are people who were going to their deaths, and they found time to write a poem. Well, I mean, that says it all, doesn’t it?

Poems will not produce antibodies against the virus that causes COVID-19, but an embrace of the humanities will be essential for addressing the deeper questions this moment has raised: how to ensure the sensible and just allocation of healthcare resources; how to address the shocking health disparities unmasked by the virus; how to support healthcare workers, patients, and families as they confront morality, survivor’s guilt, and grief?

If doctors want to be part of the solution to these problems, we need to prepare not only to interpret the results of randomized clinical trials but also to debate the merits of social-contract versus duty-based ethical theories; to see the world through the eyes of a character in an August Wilson play; and to confront grief through Joan Didion’s writing.

It is impossible to foresee the new world that will emerge in the post-pandemic era. History tells us that it will be different in both imagined and unimaginable ways. To ensure that the future of medicine is more just, more inclusive, and more faithful to its healing mission, medical schools and teaching hospitals must invest not only in ventilators and vaccines but also in poetry.

References

There are so many...so many. As healthcare providers and as a nation, we have been acutely aware of the impact of COVID-19 on communities of color and, more specifically, on the African-American community. In April, nearly three-fourths of patients who died from COVID-19 in Chicago were African American. But what I have been seeing more and more at my hospital is a shift toward a different (but also often marginalized) demographic: Hispanics. Sadly, these numbers are likely to be even higher since race and ethnicity are not always reported accurately. This is of personal importance to me because I am Hispanic, and I am one of a few Latina physicians at my hospital who is also fluent in Spanish. For my colleagues who do not speak the language, we typically have in-person translators available. But, because of the nature of COVID-19’s transmissibility, hospitals are limiting not only visitors but also non-essential in-person services such as translators. This means many of my colleagues are left to use an extremely impersonal method of communicating—an interpretalk phone.

Typically, I can manage to seek-out and admit the bulk of the Spanish-speaking patients but that for the past few weeks has not been the case, as the volume of Spanish-only speaking patients has become terrifyingly high. I want to be that familiar face that can communicate and connect with them, make them feel understood, and feel heard. A hospital is a scary place for patients to begin with, but especially now, and especially for patients who do not speak English, when there are multiple nameless, faceless strangers in their rooms, completely covered from head to toe in gowns, gloves, masks, and face shields. And when these patients start to decline, an additional wave of blue and yellow gowns enters the room, with alarm bells going off—and I want so badly to let them know that a familiar voice is there, one that they can understand, one that will explain what is happening, one that will communicate with their family. But there are simply too many of these situations, and I feel helpless.

When COVID-19 impacts a specific community of color so deeply, we talk about the socio-economic issues that factor in—broadly, we call these the social determinants of health that include things like the following:

- How many people live in the house with the patient?
- Does the patient have a job where they have the ability to work from home?
- Does the patient have access to health insurance, medications, and nutritious foods?
- Does the patient have pre-conceived or cultural misconceptions about certain disease processes or the healthcare system in general?

What I keep hearing from these patients is: “I’m undocumented, I thought ICE would know I was here.” “I don’t have insurance.” “I heard this is where you get the virus and you don’t come out.” “I don’t have internet so I don’t know where to go.” Generally, the Hispanic community faces many of the same access and healthcare challenges that the African-American community faces, but with additional unique obstacles, such as fears of deportation, living in a foreign country, and speaking a foreign language. I have heard many messages of caution in the Spanish-language media, for example, “things not to do” in order to stay safe. But I feel the message that needs to be emphasized is one of hope and reassurance. All of our patients, but especially our most vulnerable Spanish-speaking patients, need to hear concrete, meaningful, and practical instructions on how to care for each other when they live in large multi-generational families, and positive stories from people who have successfully managed infection with COVID-19. They need to hear that, as their physicians, we are here for them.

I want them to know that when they are sick, their immigration or insurance status is not my concern. My concern and my oath are to the patient in front of me and to the community I love.
500 miles from Wuhan province, COVID-19 peaked at 300 cases with seven related deaths. The Shanghai municipal government has begun downgrading the pandemic response level. Wuhan lifted its lockdown on April 8, however, remains on ERS Level I—this includes providing a negative nucleic acid report (within seven days pre-arrival) for all arrivals and a digital green health-code (instead of red or yellow, indicating higher risk) before entering hotels, markets, or other public spaces. Hotels verify guests’ health-code status and monitor guests’ temperature twice daily. Also, migrant workers from Hubei province, approximately 23 million overall, are offered free coronavirus testing when they travel to Guangdong province if they have not already been tested.2

As work life resumes in China, so does leisure: in the first three days of a five-day holiday period in May, residents took nearly 85 million domestic tourist trips, generating a total of 35.06 billion yuan (USD $4.97bn) in tourism revenue.3

Pakistan
A student who returned from Iran to Karachi, Pakistan on February 26, 2020, was the first case of COVID-19 in Pakistan. Within the following weeks, all four provinces and tribal territories of Pakistan saw rising cases of COVID-19. By May 5, the country reported 22,049 positive cases with 514 related deaths from this disease.4

The Pakistani government acted early, mandating that the national airline PIA suspend all flights between China and Pakistan beginning January 30. Students stranded in China were repatriated after screening measures were implemented at four international airports across Pakistan. The National Security Council of Pakistan assembled on March 13, deciding to close all non-essential businesses and institutions, including schools and mosques. All land borders with Afghanistan, Iran, and China were closed by the end of March. Around that time, all international flights to and from Pakistan were also suspended. Meanwhile, provinces started their own partial lockdown measures.

Ramadan, a month of fasting that started April 25, often draws many to mosques. Certain religious and political parties opposed closure measures, resulting in a compromise of reopening mosques with specific physical distancing conditions. The scientific community fears an upcoming spike of COVID-19 related to in-person religious observance of Ramadan.

In April, physicians were arrested for clashing with police during a protest for more personal protective equipment (PPE) in Quetta, Baluchistan. A doctor in Khyber Pakhtunkhwa province wore plastic bags on his head and hands due to lack of PPE. Limited testing capability involved PCR kits acquired from China and subsequent antibody point-of-care tests acquired from Finland. There are reports of shared ventilator use in some parts of Pakistan to compensate for resource scarcity.

Most people in Pakistan are daily wage earners. The Pakistani government worries that the lockdown will result in more deaths from lack of food than deaths from COVID-19. Therefore, on March 21, the prime minister announced incentives for construction jobs. The government is watching the situation closely and is extending the lockdown for two weeks at a time amidst increasing numbers of positive cases and deaths from COVID-19.

Argentina
After the first reported COVID-19 case in Argentina on March 3, Argentina’s federal government implemented a preventive and mandatory social isolation rule of law on March 20. All educational activities were suspended, as well as sporting and social events. This early measure greatly contributed to flattening the curve and preventing healthcare system collapse.

Parallel to containment, a tiered-healthcare network for caring for COVID-19 and non-COVID-19 patients was developed. Temporary surge hospitals were built to care for patients, and hotels and other social facilities were repurposed to host quarantined individuals. In this context, hospitals were devoted to care for those suffering a SARS-2-CoV severe infection as well as non-COVID related urgent and emergent pathologies, deferring the provision of elective and non-urgent medical care to a later time in pandemic recovery. Telemedicine played a crucial role in elective medical care and patient triage.

The following sequential stages of social isolation in Argentina were defined based on essentiality of services and were modified based on SARS-2-CoV prevalence:

- Stage 1, or strict social isolation (March 20 to March 31), only allowed essential workers to circulate and led to a city traffic of approximately 10%;
- Stage 2, or administrative isolation (April 1 to April 12), was characterized by intensified vehicular control, closed borders and city traffic of approximately 25%);
- Stage 3 or geographical segmentation stage (April 12 to May 10), during which some public services restrictions were lifted to progressively reactivate the economy. City traffic was calculated to be approximately 50%;
- Stage 4 (May 10 to May 24) allowed for greater activity level, particularly in areas with low community viral transmission; and
- Stage 5 (after May 24), a period of “new normal,” involves use of facial masks in public and new hygiene standards, expected to lead to an estimated city traffic of 75%.

Hospital de Clínicas Jose de San Martin, affiliated with the University of Buenos Aires, modified
the delivery of care and institutional geographic distribution of patients based on medical triage: (1) COVID; (2) non-COVID emergencies; and (3) ambulatory and elective care. This innovative model—where patients are cared for at the same institution, but without physical proximity—was feasible and safe.

The Netherlands

The first COVID-19 case was reported in late February, within days of Limburg province’s infamous Carnival celebrations, a weekend-long celebration marked by colorful costumes, street parties, and singing local folk songs in this southern region of the Netherlands. Then, North Brabant, about 75 miles from Amsterdam, became the Dutch epicenter for COVID-19.

Measures began with a public call for working from home, staying home except for essentials (e.g., buying groceries or medicine and seeing a doctor), and maintaining 1.5-meter physical distance in public spaces. However, without enforcement, life went on as usual—on March 14, shops and cafes remained open. Days later, financial penalties were issued for non-compliance. Businesses abided. Restaurants operated by takeaway or delivery and shops limited occupancy. As cases grew exponentially, the prime minister limited occupancy. As cases grew progressively, the prime minister imposed 14-day self-isolation for all travelers from abroad. Unemployment has risen but staged reopenings may offer surveillance despite persistently low testing capacity. Unemployment has risen but staged reopenings may offer a tangible pathway towards local economic recovery.

In closing, as we reflect on global responses to the pandemic, time will tell if these measures—balancing the tenuous social and economic consequences of protecting against an emerging infectious disease—are sufficient to prevent a second wave of COVID-19 cases and its other downstream health consequences.

References

FROM THE SOCIETY: PART I (continued from page 4)

academic general internal medicine, leading the way to better health for everyone!

(In the next issue of the Forum, we will address additional questions about SGIM’s plans.)

References
make a difference to those who are affected by the research findings. One of my favorite things about being a Division Head was being in the position of learning about the passions of faculty, trainees, and students and finding ways to help them thrive and succeed. I often describe my current role as Chief Medical Officer as that of “cultural navigator,” interpreting the worlds of the academic and hospital/health system and identifying and facilitating action to achieve common goals. I am a firm believer that, for the most part, people are well-intentioned and truly trying to do what is best. Even in the most contentious situations, if we can bring the discussion back to “what is best for the patient” (or family or community), we can reach agreement on a path forward.

As leaders, one of our most important roles is to articulate a clear, overarching purpose:

• making it clear how what we are doing contributes to the social good and addresses pressing issues;
• showing how the work at hand contributes to a larger mission; and
• empowering people to solve problems, make suggestions and implement their own ideas.

A leader’s most important job is “to connect the people to their purpose.” That said, transforming values into action is not limited to those in titled or formal leadership roles. The actions that we take on a day-to-day basis can be manifestations of our values and those of our communities and institutions. The decisions we make about how and where we spend our time and effort and emotional and intellectual capital should ideally be rooted on our core values. We can all find ways to transform our values into action. To quote Sheryl Sandberg, “Leadership is the expectation that you can use your voice for good. That you can make the world a better place.”

As the 2021 Annual Meeting Chair and Co-chairs (Drs. Rita Lee and Yael Schenker) and I were ideating potential 2021 meeting themes, we reflected on what we were seeing around us in spring 2020, particularly how people are making connections and creating community in a fragmented, uncertain world, and how everyone is leading in their own way and unifying for the common good. As one SGIM Council member stated, “Our priorities haven’t changed but our environment has.” Drs. Lee and Schenker have assembled the 2021 Annual Meeting Planning Committee and we, along with the SGIM staff, are committed to creating a meaningful learning and community-building experience, even as we face an uncertain future as to the format of the 2021 Annual Meeting. Together, we will stay rooted in our values to enhance our ability to act for good.

References

FROM THE EDITOR (continued from page 2)

of our members. And, most recently, we published the first-ever special issue of Forum on COVID-19, an extraordinary collection of articles about a single disease or syndrome and its staggering impact on all of us. All that and the regular contribution of extraordinary material from the Society’s membership.

I leave the Forum in the able hands of Dr. Tiffany Leung, who has been an associate editor for the Forum over the last four years and a regular contributor of wide-ranging and informative content. Dr. Leung’s vision for the Forum, including how best to use the online platform and make ample use of social media, will take Forum to the next level.

Your mountain is waiting—SGIM and the Forum are needed now more than ever in these uncertain times. What effect will the COVID-19 pandemic have on our country and health care in general? I want to end this editorial by encouraging you to support the Society, one that truly represents the interests of academic internists. Membership brings access to a diverse group of like-minded individuals with the expressed vision “to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.” Keep active through membership, attendance at national and regional meetings (even virtually), and participation in interest group and committee work. Submit articles about your work, opinions, and thoughts to Forum. Consider service to the society by applying for selection to the editorial board or as an editor in chief of Forum when those positions are available in the future. Serving the Society in those roles, for me, has been a blast. I look forward to all of us having new opportunities to serve SGIM in the future.

Thanks!

SGIM
nanana challenge” shortly thereafter. Each exercise brought smiles to faces and palpably improved moods, and each was a true manifestation of teamwork. And then naturally, as positivity seems just as infectious as the coronavirus itself, the videos permeated everyone’s e-mails and social media platforms, and that positivity ended up spreading to others. Sadly, none of us is going to become the next sleeper TikTok star, but the simple act of taking a few minutes away from the intensity of managing COVID patients for a frivolous but genuine morale-boost might be one of the most unanticipated, authentic exercises in wellness in which I have participated.

To be clear, I am not suggesting that an app like TikTok answers the extraordinarily complicated issue of healthcare provider burnout. Actually, this is not really about TikTok or social media at all, but rather about what we gain when we take a moment to come together for a common cause. To me, TikTok highlights an important aspect about what “wellness” in the healthcare setting genuinely means. Ultimately, the real essence of wellness is found in the enduring importance of feeling like a valued member of a team—an authentic sense of belonging—whether at a patient’s bedside or in a silly 10-second dance video. If an app meant for bored teenagers can help provide that, I’m all for it.

And if you start scrolling, you will see that I am not alone.

FROM THE SOCIETY: PART II (continued from page 8)

ical students to assure that the new curriculum was effective. I jumped at the opportunity to be a part of the new initiatives and served on different curricular committees in addition to developing new curricula of my own. I later pursued teaching roles in residency and then a clinician-educator fellowship at Johns Hopkins. Early teaching experiences and outstanding mentorship have cemented my passion for education.

To date, what is a career accomplishment that you are most proud of? First, I developed the Yale General Internal Medicine Medical Education Fellowship Program which is now in its 4th year. This program was built out of my accumulated experience of what knowledge, attitudes and skills a clinician-educator scholar needs to succeed in academic medicine. The fellowship has become a popular option for residents looking into academic careers. I now work side by side with two of my past fellows, and I am impressed at how successful they have become as clinician educators and leaders.

This year, I established the Yale University Department of Internal Medicine Advancement of Clinician-Educator Scholarship (ACES) Faculty Development Program. This program is designed to improve the educational scholarship of junior clinician educators in the Department. I have recruited talented faculty to teach in the program, including some of my own past fellows, and it is a joy to have created a space where their ideas come alive.

Can you describe one of your biggest professional challenges and how you approached it? My biggest professional challenge was becoming a program director of an internal medicine training program at a new hospital when our program was expanding. It was short notice and a new program needed to be established quickly. It needed to be built from the ground up, with new trainees, faculty, and staff. Though it seemed insurmountable at times, the support of mentors and peers helped to bring it together. It truly took a village!

What has been your favorite part of mentoring your learners? There really is no greater joy to me than to mentor. To see a person’s ideas come to life or to help guide the direction of a project or a person’s career really makes my day. I take my role as a mentor seriously and find myself mentoring others who have varied interests in medicine. I feel proud to watch those whom I mentored grow and succeed.

What advice would you give to a junior clinician educator who is looking to pursue a similar career?

1. Join organizations that support clinician educators. Do this locally, regionally and nationally early in your career.
2. Get mentors and collaborators in medical education both inside and outside your institution.
3. Find ways to get leadership roles, even if they seem small at first.
4. Develop scholarship early in your career and find your niche.
5. Learn to say yes to things that seem like they can further your career, but no to things that may be distractors.
6. Get additional education in areas that will advance your career through classes, courses, or mentors with special interests or training.

2019 Winner of the Scholarship in Medical Education Award / Subha Ramani, MBBS, MPH, MMEd, PhD
By Lawrence Kaplan, MD

What inspired you to pursue a career in medical education? I always knew I wanted to be a teacher. My first exposure to education was through the Stanford faculty development program. Later, at Dundee in 2002, Ronald Harden’s passion for education and his description of the Three Circle Dundee model spoke to me. The first circle is doing the right thing, becoming a better teacher through

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General Hospital education department, we started with Just-In-Time training for staff on our COVID-19 designated units in late March and then expanded to other areas of the hospital from April to May 2020 with once-weekly sessions, including nursing, physicians, respiratory therapists, and pharmacists. Each simulation was recorded for immediate debrief. A post-simulation survey obtained feedback regarding the training process. We then debriefed with unit managers on units where true Code Blue events were called for feedback regarding the impact of training on implementing the new processes. Over 500 team members, including nurses, providers, respiratory therapists, and pharmacists have been trained so far.

Lessons Learned
While outcomes data such as Survival of Event of IHCA or Survival to Discharge after IHCA will lag for several months, we have seen improvement in team member level of comfort with responding to codes, especially on units where most nurses are BLS trained. Commonly, unit managers reported that IHCA events, when they happened, were more organized, with only essential people in the room. Furthermore, the inclusion of providers and pharmacists in the training encouraged a culture of camaraderie and teamwork. The multidisciplinary approach to process development, training, and information dissemination also served to collect more perspectives on the successes and pitfalls of this new process. The role of the pharmacist, for example, has been to have closed loop communication with the code leader and mix medications right in the patient’s room. With the code leader now speaking through a closed door and walkie-talkie to the recorder, the pharmacist now had the additional task of anticipating medication needs based on what was already used from the limited medication box taken into the room. Communication, more than anything else, took precedence. The team members who played the first responder during the simulations noted loneliness and anxiety while waiting for the rest of the code team to arrive. When one is the lone provider performing compressions inside the room without any external feedback, the very quiet two to three minutes it usually took for others to enter seemed like eternity. These feelings were assuaged by communication from the recorder over the walkie-talkie system. We incorporated the impact of this kind of team member support into future sessions.

Additionally, as we continue to provide training and obtain feedback, more requests for unit-specific and patient-specific scenarios arise. As the pandemic lingers, the leadership implemented viral testing for all patients admitted to the hospital. For example, one unit would like help simulating the care of obese patients on bariatric beds that are too large to move out of their doors with the patient still in them. Our Labor and Delivery unit would like for the mannequin to be that of a pregnant female and to include the neonatal resuscitation in their scenario. In service of these requests, we expanded scope on training and improvement efforts towards all inpatient resuscitations.

Changing both the process and mindset around code response at our institution came with the rapidly changing environment—we needed to update both the process and the training multiple times a day based on new CDC recommendations as well as updated literature. The learning and response within each simulation session embodies rapid cycle improvement, and each training and debriefing session resulted in process changes, as did actively seeking feedback from units that had Code Blues called. As our number of new COVID-19 cases plateau and the organization opens to higher censuses, we now focus on keeping the momentum generated in the creating and disseminating of these new processes. In the past, small rewards like gift cards and meals temporarily incentivized compliance. However, the current impetus to change and to sustain these changes appears driven by stories—both of successful outcomes and continued challenges. There is a feeling that team member input directly impacts patient care in a value-added way. The changes made reflect how our organization continues to evolve from a reactionary to proactive approach in quality improvement in health care, and how other organizations can adapt new processes and disseminate their use throughout the organization in a relatively short period of time.

References
faculty development. The second is taking a scholarly approach to teaching, which led me to my MMEd. Realizing I loved education as a science, that led me to the third circle, becoming a scholar, and ultimately a PhD at Maastricht. I’ve had great mentors who inspired me including Ronald Harden, Cees van der Vleuten and Karen Mann. My Department Chair formerly at BU and now at the Brigham was Joseph Loscalzo, MD, PhD. I snuck into his office to ask for advice and he became a tremendous mentor to me. I like writing and like to think that I could be the JK Rowling of medical education!

To date, what is a career accomplishment that you are most proud of? First is mentoring. I set up the scholars in medical education pathway as part of the IM residency at BWH and subsequently won the residency research mentor award. It is exciting to stimulate a passion for education in young trainees. Secondly I was willing to step outside the box and look beyond the medical education literature to other realms like organizational psychology and linguistics to learn to expand my knowledge. I believe in lifelong learning.

Can you describe one of your biggest professional challenges and how you approached it? The biggest setback is getting buy in from others in leadership, as I’ve not taken a traditional path. There are still skeptics, but going through this unorthodox process forces you to sweep the cobwebs from your brain and makes you think outside the box.

What advice would you give to a junior clinician educator who is looking to pursue a similar career? You have to find your own passion. If you want to be a master teacher and stop there, that is fine. If you want to go further and become a scholar that is great but don’t force yourself to do what you don’t have a passion for you also need to have humility and the ability to take harsh constructive feedback.

Do you have any other wisdom to share? What you can’t do is just follow your own interests; you need to align with department and institutional mission. You have to give back. Recognize and write down how you are your own worst enemy and learn to be introspective to self-identify your stumbling blocks. Life is short, follow your passion but make a contribution to the field.

Haw pin—it literally means hold on. A local artist created posters and merchandise with this motivational slogan in the Maastricht dialect from the Netherlands, showing that we are “pin hawwe” together. We persevere, remain courageous, and think of each other. Sales support a local non-profit organization. Source: https://www.bezoekmaastricht.nl/maastricht-supports-local/haw-pin. (Tiffany I. Leung, MD)