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MORNING REPORT

CARING FOR ADOLESCENTS AND YOUNG ADULTS WITH CANCER

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Case

A patient in his 30s with a history of gastric cancer presented with fever, dyspnea, and hypoxia. We met his wife and young children on admission when the suspected diagnosis was a parapneumonic effusion. Repeat testing revealed evidence of lymphangitic spread of his tumor. Informing him of these results and assessing his goals of care was emotionally challenging for all involved.

Adolescents and young adults (AYA) with cancer are defined as those aged 15-39.[1] Advanced care planning discussions with AYA patients can be especially emotional for patients, families, and clinicians, all of whom want to maintain hope. The transition from family caregiver to the patient, loss of employment, and changes in self-identity are causes of suffering in AYA patients. We approach this case from a Palliative Medicine perspective to raise awareness of these AYA-specific issues and highlight the importance of early Palliative Medicine consultation to address the physical, psychosocial, and spiritual needs of AYA patients with cancer.

When engaging in advanced care planning discussions with AYA patients, the lurking pitfall is the hidden assumption that those wanting aggressive treatments are "not ready for Palliative Care." This has its roots in the synonymous use of Palliative Medicine with "end-of-life care," which can feel antithetical to supporting a culture of hope for both the patient and provider.[2] AYA patients with cancer are more likely to receive aggressive treatments in their last month of life, less likely to receive hospice and palliative care services, and carry a higher burden of undertreated physical symptoms.[3] In one study of AYA patients, Palliative Medicine was consulted an average of only 4 to 16 days before death.[3]

Many AYA patients exit pediatric care but have not established care in adult medical homes, and present to the Emergency Department or hospital with uncontrolled cancer symptoms. Unique points for distress include autonomy from parents, changes in self-identity, social isolation, loss of employment, welfare of children and significant others, fertility preservation, and wellness in survivorship.[1] Understanding the breadth of these issues is important to ensure that goals of care discussions with this patient encompass both "what treatments are wanted" and these multiple facets essential to the patient's quality of life. Recognizing family structure and dynamics allows for referrals to child life services to support his children. Knowing the fertility implications of specific chemotherapy treatment can prompt referrals to aid in family planning and reproductive health. Advocacy and peer support programs that exist through AYA foundations (e.g., LIVESTRONG) can help provide age-appropriate peer support systems.

Advanced Care Planning

As we discussed his preferences for ongoing treatment, he simply nodded affirmatively as each potential treatment

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LEADERSHIP—BIG AND SMALL

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"The interconnected leader sees [theirself] as the generator of impulses into an interconnected system to realize the purpose of the organization."

—Dalai Lama & Laurens van den Muyzenberg, *The Leader's Way*

Reflecting on global events and the continuing work of SGIM members to address our ongoing health disparities and challenges, I see the creativity and impact of our long-established and emerging leaders shine through. Leaders can serve as a powerful guiding force, yet do not act in isolation from the people and systems that they serve—a lesson that comes sharply into focus as this issue of *Forum* publishes against the backdrop of an upcoming U.S. presidential election.

This issue examines how SGIM members are leading on evergreen issues in general internal medicine. Leadership skills are arguably core competencies of our professional training as physicians. They begin from the core values of our profession, despite differences in the timing and availability of formal curricula on leadership development. Jean Kutner, our president, shares how leadership lessons can come from non-work experiences. Julie Oyler, BRL chair, describes how SGIM region presidents are adapting local events to continue serving members, including offering vital networking and mentoring opportunities.

Leading can be advocating for a single patient and leading their care management and decision-making—at any career stage. Cunningham, et al, share the underrecognized importance of advanced care planning among young adults with cancer in their morning report.

Leading can be starting or engaging in large-scale advocacy, of which there are many powerful and innovative movements with grassroots origins—to dismantle racism in medicine and science, promote humanism in clinical medicine, create environments free of gender-based discrimination and harassment, naming only a few mutually inclusive movements. Van Doren, a third-year resident, calls our medical communities to action towards building anti-racist medical institutions, while Hasnain, et al, outline their consortium's 10-step pathway for dismantling racism in academic medicine.

Leading in medicine can be crafting educational innovations at a local, regional, or national scale. Kane, et

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LEADERSHIP LESSONS FROM THE BACKCOUNTRY

Jean S. Kutner, MD, MSPH, President, SGIM

We have never been truly lost, only temporarily misplaced. The positives far outweigh the challenges. This can happen in the backcountry and in our professional lives. Consistently question your assumptions, be willing to reconsider decisions and define your goals and then seek a path that gets you there, even if it is less well-worn. And, take time away and off the grid, however you define it. It is good for the soul.

Every August, Rob, my partner, and I go backpacking. It is the one time we truly disconnect—no cell phones, no internet, no e-mail. Just us and the woods. Ten to twelve days on the trail completely disconnected. We have been doing this for so long that even my patients ask, starting around June, when I will be gone. My colleagues, both close and afar, my CEO, and my chair start asking in about May—where are you and Rob going this year on your "walk in the woods?" We are so disconnected on these trips that in September 2001 we didn't find out about the events of 9/11 until the Friday of that week.

Backpacking is simple—all you have to do is walk, eat, sleep, and stay dry and warm. There is ample time to think, reflect, talk, and reconnect. Rob and I often joke that there is no better test of teamwork, or of a couple, than being out in the wilderness together. We each have days when we are feeling stronger or less strong. We know each other's strengths and weaknesses. We have roles—when we get into camp, Rob starts the stove, gets water, and hangs the bear rope while I set up and organize the tent. That said, we can be flexible based on the situation—hailstorm coming in = all hands on deck to set things up and get sheltered. In many a reflective moment on the trail, it has struck me how these experiences and lessons learned in the backcountry apply directly to our professional lives, as both informal and formal leaders.

Leadership lessons from the backcountry:

- • Sometimes you need four pairs of eyes (and you only have two);
- • Just because you have a clear path, it doesn't mean you are headed in the right direction.
- • If you know the direction you are headed, you can get there even if there isn't a clear path.
- • No decision is a decision.

Sometimes You Need Four Pairs of Eyes (and You Only Have Two)

Several years ago, we were dropped off to start our hike by someone who assured us that he knew exactly the trailhead that we had intended. It was only after

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Q & A WITH SGIM'S CEO AND THE CHAIR OF THE BOARD OF REGIONAL LEADERS (BRL): RE-IMAGINING SGIM'S REGIONAL MEETINGS

Julie Oyler, MD; Eric B. Bass, MD, MPH

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Dr. Bass (basse@sgim.org) is the CEO of SGIM.

How does SGIM plan to adapt essential educational programs to our new learning, mentoring, and networking environments for our regional meetings?

SGIM is working with the Board of Regional Leaders (BRL) to reimagine how to implement virtual learning with an interactive component. We recognize that SGIM members value the opportunity to present their scholarly work while also maintaining live interactions with colleagues and trainees. The spontaneous interactions that happen while talking beside a poster or sitting at a table during a workshop are challenging to replicate, but SGIM's regional presidents are working hard to provide virtual spaces for similar interactions to happen at the upcoming fall and winter regional meetings. Each regional meeting will generally take place virtually over two days, usually in one 4-5 hour segment per day. Attendees can expect plenary sessions and oral presentations for scientific abstracts, clinical vignettes, and innovations with interactive moderation and audience participation in question and answer sessions. Poster sessions will be held with time to listen to short prerecorded summaries followed by live interaction with poster presenters. The goal of these sessions is to bring attendees together to facilitate live interaction and thus networking and mentoring opportunities.

What opportunities for innovation do these new environments offer for SGIM member engagement?
Virtual regional meetings will allow for more participants to engage with attendees around the region without paying for travel. Submission and attendance costs will be kept low to allow for greater participation of medical students, residents, fellows, and junior faculty, recognizing the financial strain of the current environment. Some regions have chosen to partner to share costs and plenary speakers while still maintaining oral, poster and networking sessions unique to their region. Over half the regions plan to implement virtual workshops using breakout rooms for live small group learning. Other regions are also experimenting with live teaching competitions and mentoring happy hour sessions. Regions look forward to the participation of SGIM members and trainees at the following meetings (*see* https://www.sgim.org/meetings/regional-meetings):

- **October 22-23, 2020—Midwest Virtual meeting**
- **November 6-7, 2020—Mountain West and New England Virtual Meeting**
- **November 13, 2020—Mid-Atlantic Virtual Meeting**
- **January 22-23, 2021—Northwest and California/ Hawaii Virtual Meeting**
- **February 25-27, 2021—Southern Virtual Meeting** SGIM

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al, offer local learning on a residency continuity clinic for obesity medicine and LeFrancois, et al, from the MOC Subcommittee of SGIM's Education Committee offer updates on ABIM maintenance of certification options.

Importantly, leading means having a set of skills and traits that embody a high standard of ethics and morality, role modeling and engendering compassion, and a sense of service and responsibility for those who follow, and paving a clearly visioned pathway towards our shared future. In these ways, physicians are trained to lead, in ways big and small, in the infinite interconnected facets of society and medicine. In these ways, we clearly offer our own powerful guiding forces towards a better shared future for all.

SGIM

TEN TIPS FOR DISMANTLING RACISM: A ROADMAP FOR ENSURING DIVERSITY, EQUITY, AND INCLUSION ACROSS THE ACADEMIC CONTINUUM

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The COVID-19 pandemic and the murders of George Floyd, Ahmaud Arbery, Breonna Taylor, and others have laid bare the harsh reality that U.S. health and social systems are disproportionately harming and killing Black and Brown people. While health professionals readily acknowledge the disparities in morbidity and mortality among communities of color, the full spectrum of social determinants of health remains unaddressed. Policies shaping social determinants of health, including neighborhood segregation and mass incarceration, are imbued with racism and contribute to people of color dying at higher rates.[1]

Historically, health professionals have used polite, guarded language to talk about societal ills or avoided them altogether. It is time for academic healthcare institutions to raise their voices and take concrete, comprehensive action to dismantle racism and truly embrace diversity, equity, and inclusion at all levels. We, a diverse group of health professions educators and practitioners, offer practical recommendations for galvanizing the much-needed work to address racism within academic institutions. Our recommendations are organized in the following three stages and 10 steps:

Stage A. Preparing the Ground—Identifying Root Causes of Racism

1. Conduct Needs Assessment

Academic institutions committed to anti-racism, diversity, equity, and inclusion should start with a rigorous needs assessment to uncover and understand their current situation. The Multicultural Organization Development Stage Model[2] suggests that racism and multiculturalism should be viewed as a spectrum rather than a binary model. Explicit institutional values—such as mission statements and policies—and implicit messages expressed through everyday practice, cultural norms, and products or services (e.g., curricula and healthcare services) must be analyzed. This should be a data-driven process that engages the perspectives of all stakeholders, particularly Underrepresented Minority (URM) students, faculty and staff, through questionnaires and focus groups, in addition to auditing the entire organization by reviewing personnel files (e.g., for hiring and firing patterns), admission and graduation rates, filed grievances, and budget allocations. Data should be viewed through the lens of demographics with an eye for identifying inequities. While a committee of change is helpful for collecting, organizing and reporting such data, ultimately the review and analysis should be done within each department, so that all groups can participate in identifying gaps and next steps.[2] A thoughtful needs assessment will be the cornerstone of all subsequent steps.

2. Refine Mission Statement

A carefully crafted mission statement allows institutions to reflect on the degree to which actions and policies align with values of anti-racism, diversity, equity, and inclusion. Institutions should consider engaging a community advisory committee to ensure that the mission statement reflects the needs of the communities it serves.

3. Redistribute Power

Leadership in medicine tends to be more homogeneous than the workforce as a whole, concentrating decision making among predominantly white voices. Examine whether the people impacted by institutional policies and processes have a voice. By deliberately sharing power with faculty of color, students, and the community, institutions will be better able to identify biases that perpetuate institutionalized racism and implement changes towards a more inclusive organization. This step is integral to admissions and recruitment, curriculum development, learning environment, promotions

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DRAINING THE POOL: OUR COLLECTIVE RESPONSIBILITY TO END RACISM IN MEDICINE

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I grew up in a die-hard liberal part of the country. As I have learned the myriad ways in which racism rears its head, I have discovered that my northeast "culture" perpetuates its own forms of racism and classism. This manifests as a dearth of Black people in leadership positions, huge racial disparities in income and life expectancy, subtle messaging about who is welcome, and condescension about "the South" and "flyover states," often aimed at places with large Black populations. I love Boston—it is my home. I am proud of our high standard of education, social services, and low rates of uninsurance. But loving something doesn't mean there is no room to improve.

I want to examine our collective discomfort with criticizing what we consider important parts of our identity, and few professions are more entwined with identity and ideas of self-worth than that of the physician. The long, expensive training, and the way our hours in the hospital pull time away from relationships and outside interests, make many of us feel like we are doctors before anything else. Challenging the traditions upon which our profession is built may mean challenging the framework for our whole personhood. It can call into question the value of the sacrifice we made to pursue this calling. Unsurprisingly, this often results in outrage and defensiveness. At the same time, to justify that sacrifice, it is immensely important that we do the uncomfortable work of evaluating whether our institutions are living up to their moral promise. If we can establish a culture where this introspection both is normalized and necessitates collective action, I believe that we can build that equitable system together.

Physician as Hero

Emory was my last interview because I canceled all subsequent ones after coming here. I knew this is where I wanted to be. Two things stood out to me that day. First, while every program had something to say about "diversity and inclusion," Emory's diverse program leadership exemplified this ideal. Second, the intense pride in resident and faculty voices when they talked about advocating for their patients at Grady—one of the country's largest public hospitals—contrasted with awkward silences at many other programs when I inquired about care for uninsured patients.

I am now in my third year at Emory. I consistently am struck by the lengths to which my colleagues will go to care for their individual patients, but unfortunately, even our best is not enough. Inequality routinely plays out in horrific ways here: hospitalizations, evictions, deaths. The majority of patients I have watched die due to COVID-19 were Black and Brown. Even when I help someone get better in the hospital, I often discharge them back to the street or to unsafe housing or without needed supplies.

I am equally struck by how powerless we as healthcare workers feel in addressing, or even learning about, upstream causes of this inequality. In a state rife with voter suppression, where Medicaid is virtually impossible to access, and where long-standing racist policing leads to immeasurable harm, the challenges often feel insurmountable. Despite the expertise we develop through our work with marginalized patients, health policy and political advocacy make us nervous.

Much like our criminal justice system, the entire institution of medicine is steeped in the tradition of racism.[1] Experimentation, without analgesia or consent, on Black bodies laid the groundwork for many modern surgeries and medications. For hundreds of years, Black people were excluded from care or only seen in poorer-quality segregated hospitals, and to a great extent de-facto segregated medical care continues today. Black patients are less likely to receive adequate pain control[2] compared to white patients with the same injury. Even after controlling for income, Black patients receive consistently worse care and

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suffer worse outcomes.[3] Somehow, these facts still are not routinely taught in medical schools.

Physician as Human

After the murders of Ahmaud Arbery and Rayshard Brooks in Georgia, Emory's Internal Medicine leadership immediately condemned racist police violence, and many joined local demonstrations. They held a conference for the internal medicine faculty and residents to discuss both the impact of racism on our community and the importance of examining our own practices. One of our program directors talked about the day her eight-year-old son was seen as a threat because of the color of his skin. Another faculty member openly introspected about his own lack of barriers as a straight, wealthy, cis-gendered, able-bodied white man. Residents talked about microaggressions: both as victim and perpetrator.

By holding this conference, our leadership set an important standard—that we *all* internalize racism, and that the only way to reduce how much we perpetuate it is to unflinchingly examine and own up to our own biases. This is the first step in the continuous work of being anti-racist. Within a week, the program rolled out a Racism and Social Justice lecture series, highlighting racism and bias in medicine, the impact of microaggressions, and ways to advocate for structural change. With full program support, Emory residents have begun educating ourselves, lobbying our representatives about police reform and hate crimes legislation, promoting voter registration, joining street medic trainings, and soliciting donations to local grassroots organizations.

We are now considering long-term residency program reforms to address key questions: How can we increase diverse recruitment? What changes must we make to our core curriculum? How can we ensure that we apply the same standard of care to all our patients regardless of race or whether we see them at our private or public hospitals?

Draining the Pool Together

Our patients are neck-deep in water, and rather than burning ourselves out as we individually prop each person's mouth above drowning-level, we need to work together to drain the pool.

Education about our country and profession's history of racism must become a required competency interwoven throughout the medical curriculum. Only then can we begin to understand, respect, and bridge our Black patients' distrust of the medical system as part of a comprehensive effort to provide equitable care. We must also examine how our own institutional policies and practices contribute to structural racism. If and when we identify such policies, we must change them. There can be no excuses.

Education about our complex healthcare system also must become a required competency if we are to be informed policy advocates. We need to retire the "physician as hero" narrative that lets us substitute feel-good stories about helping one patient for long-term advocacy and systemic change.

We must recruit a physician workforce that reflects our patient population, both for equitable patient care and to equalize access to positions of power. On a national level, the physician workforce remains overwhelmingly white and wealthy. While programs that implement diverse leadership and recruitment are mounting, we still have a long way to go.

We need to think about the connections between the educational debt, inhumane hours, and extreme hierarchies that define medical training and how this shapes physicians' willingness to push for change. We all know that pushing leadership to make change could put a promotion or recommendation in jeopardy; this is a big reason that more physicians (particularly those still in training) do not speak up. Physician culture teaches us that the wisest course of action is to keep your head down, get through, and get yours. It is no surprise that as a group we are politically apathetic and unimaginative about envisioning better institutions. We must examine how often the phrase "this is the best we can do" shields those in power from discomfort or loss of their own privilege. And if our own concern for career advancement leads us to stop pushing when we feel similarly threatened, we must acknowledge that we may be doing the same thing.

Finally, allies must also start shouldering their share of the work and risk inherent in advocating for better systems. If we do not share this burden, it will continue to predominantly rest on women of color,[4] adding to the barriers they already face in this field and disproportionately taking time away from career development and self-care. This is a very concrete way that allies can "give back some of their privilege."

If we can move beyond our lone hero complexes to join together, and if we can be imaginative and brave enough to envision and advocate for something better, I believe we can build the system we all hoped to work within when we decided to become doctors.

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SGIM

BEYOND DIDACTIC TEACHING: IMPLEMENTING AN OBESITY MEDICINE CLINIC FOR INTERNAL MEDICINE RESIDENCY EDUCATION

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Introduction

The prevalence of obesity in the United States from 2018 was estimated at greater than 35% for men and >40% for women. The obese state is associated with cardiovascular disease, type 2 diabetes, obstructive sleep apnea, nonalcoholic fatty liver disease, cancer, polycystic ovarian syndrome, gallstones, and disability.[1] A recent meta-analysis by Kim and Basu in Value Health, estimated medical costs attributable to obesity at approximately $1,900 annually per person, amounting to $149.4 billion nationally in preventable or modifiable healthcare spending. Primary care physicians are the first in line for prevention and treatment of obesity, necessitating adequate training to handle this complex and prevalent condition. Prior studies have assessed primary care physicians' comfort, ability and desire to care for patients with obesity, often suggesting suboptimal treatment.[2] The U.S. Preventive Services Task Force (USPSTF) and several medical organizations have released practice guidelines covering the evaluation and management of obesity in the primary care setting, recommending screening adults for obesity and referral to intensive, multicomponent behavioral interventions.[1]

Despite the magnitude of the health condition and several clinical practice guidelines, training of primary care residents to manage obesity remains inadequate. A survey of 25 residency programs completed in 2016 found that minimal time was dedicated to obesity and nutrition training.[3] Out of an average of 255 hours of didactic teaching annually, fewer than three hours were spent on obesity-related topics. Furthermore, only four of the 25 programs provided instruction on the use of obesity specific guidelines.[3] A recent survey of 219 senior residents from primary care residency programs revealed only 14% of respondents participated in a rotation that incorporated instruction on obesity counseling.[4]

Given the disparity between need and treatment for obesity, it is incumbent upon primary care residency training programs to equip trainees with the knowledge and skills required to care for this patient population. Incorporation of obesity medicine specific competencies and milestones into the curriculum will ensure a minimum standard of education and training for residents. In order to ensure residents enrolled in the internal medicine residency program at the Zucker School of Medicine at Hofstra/Northwell (ZSOM) receive obesity management training, a resident Obesity Medicine Continuity Clinic was created.

Providing dedicated training in obesity medicine increases resident physician self-efficacy and adherence to guidelines and fosters a more positive attitude towards obesity counseling. Providing lectures has been demonstrated to improve residents' attitudes and clinical practice behaviors towards obesity care, although lectures did not lead to improved knowledge of obesity medicine or improved outcomes of obese patients treated in residency clinics.[5] Therefore, our approach to obesity medicine training of primary care residents included both didactic sessions and clinical experience. This paper outlines the program, the goals, and the metrics used to gauge success.

Setting and Participants

The internal medicine residency program at Hofstra Northwell School of Medicine follows a traditional "X+Y" model for scheduling inpatient and ambulatory care blocks. The schedule incorporates a rolling four-week inpatient block followed by a one-week ambulatory continuity clinic over three years. The Division

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MAINTENANCE OF CERTIFICATION (MOC) MATTERS: WHAT YOU NEED TO KNOW

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The American Board of Internal Medicine (ABIM) encourages diplomate participation in continuing certification (also known as MOC) as a demonstration of their commitment to lifelong learning. Certification engenders public trust, is meaningful, and is valued by diplomates.

Since the MOC process can be confusing and seems to be ever changing, this column addresses frequently asked questions about navigating MOC, especially relevant for new graduates and those considering alternatives to the traditional 10-year MOC exam.

What Is the Evidence that MOC Matters?

While there is ongoing debate about the utility of participation in MOC, studies reveal convincing correlations between MOC and quality of care provided by general internal medicine (GIM) physicians. McDonald, et al,[1] found that passing the Internal Medicine (IM) MOC within 10 years of initial certification was associated with decreased state medical board disciplinary actions, an important quality outcome for patients and the profession. In this historical cohort study of more than 45,000 GIM physicians, the risk for disciplinary action—such as loss of licensure among physicians who did not pass the IM MOC examination within the 10 year requirement window—was more than double that of those who did pass the examination. In a separate study of 1,260 GIM physicians by Gray, et al,[2] quality of care as measured by annual comparisons of HEDIS performance measures differed according to physician MOC status. Specifically, physician maintenance of certification 20 years after initial certification was positively associated with meeting HEDIS measures for patients with diabetes, coronary artery disease, and some preventive care services.

What Are the Basic MOC Requirements?

Diplomates of the ABIM are publicly reported on the website abim.org/verify as to whether or not they are participating and/or certified in MOC. "Participating" in MOC is defined as follows:

- Completing one (1) MOC activity every two (2) years, such as: a Medical Knowledge Module or Knowledge Check-In, QI/PI activity, utilizing decision support with tools such as UpToDate, or attending a live group learning session (e.g., SGIM meeting).
  Points earned will count toward the five-year requirement of 100 MOC points.

Certified is defined as:

- Earning 100 MOC points every five (5) years.
  Twenty (20) of these points must be in the Medical Knowledge category.
- Passing either the traditional MOC Exam within ten (10) years of when you last passed OR remaining on a successful path of Knowledge Check-Ins (KCI) every two (2) years.
  Your specific assessment deadline is noted in your ABIM physician portal.

What Changes Have Recently Been Made Regarding MOC Exams and What Does the Future Hold?

In 2018, the shorter, lower stakes KCI exam was launched. This biennial exam, available every even-numbered year, is three hours long and is taken either remotely or at a testing center by virtual proctor. Five KCIs or one traditional MOC exam is the same cost over 10 years—$650.00. Test results are immediately available upon completion of the KCI, with a complete score report available 3-4 weeks later. In comparison, the traditional MOC exam is required every 10 years at a center with a live proctor; complete score reports are available 6-8 later. Both exams provide free access to UpToDate during testing sessions.

In April 2020, due to COVID-19, the ABIM announced that all currently certified physicians with a MOC 2020 requirement will now have until the end of 2021 to complete it. Spring MOC examination dates were

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cancelled, but fall 2020 MOC assessments remain available. Updates due to COVID-19 are available at https://www.abim.org/media-center/Coronavirus-Updates.aspx.

The ABIM met in August 2019 to discuss further changes to MOC and unveiled the plan to provide a longitudinal assessment option starting in 2022.[3] With this option, physicians will be able to answer a question utilizing resources they use in practice and at their own pace, receive immediate feedback as to whether it was correct or not, along with the rationale, and links to educational material. The longitudinal option will replace the current KCI that will end at the close of 2021. Longitudinal assessment, a five-year cycle that includes a longitudinal participation and performance standard requirement, was developed in response to physician feedback to ABIM asking for more flexibility, relevancy, and higher educational value in the process of MOC. Over the course of five years, physicians will be offered 600 questions and can skip 100 of them to meet the participation requirement. While feedback is provided along the way, a determination is made at the end of the fifth year if you've met the performance standard. To maintain certification if you don't meet either of these requirements you must pass the traditional MOC exam in the following year.[4]

What Strategies Does the ABIM Employ to Improve the MOC Process?

The ABIM continually strives to improve the process and quality of exams. Part of this improvement process includes surveying diplomates about their perception of assessment fairness. In November 2019, ABIM diplomate survey results showed that perception of the fairness of assessment continues to improve and is the best it has been since this metric started being collected.[5] This may be related to new methods that have been instituted to develop exam content in response to feedback from the internal medicine community.

ABIM staff and its exam committees are currently collaborating with a group of physician volunteers assembled as the Item-Writing Task Force which aims to improve the relevance and validity of assessment questions to clinical practice while meeting the increased demand for content associated with the longitudinal assessment option. This Task Force is represented broadly with physicians from across the country who work in diverse practice settings and are engaged in all aspects of clinical practice. In addition, new model-based question development techniques involve establishing a set of specifications for creating exam questions in a certain area. These specifications are then used to produce high-quality questions in that content area. Finally, as ABIM works towards implementing this longitudinal assessment option, they are engaging with Family Medicine and

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approximately two hours of hiking that we realized that we didn't actually know where we were. We had to question our assumptions. We had a map, but the location we assumed we were on the map was not actually where we were. We stopped, drew on our map and terrain reading skills, and quickly realized that we had been working off faulty data. Once we realized where we really were, we started out again and quickly found the originally intended trail.

When we realized our mistaken assumptions, I said, "sometimes you need four pairs of eyes." Multiple perspectives are important: sometimes, you don't have all of the relevant viewpoints, and there are dangers of not questioning the assumptions that have informed your decision making. How often have you been in a situation where you or your team are having difficulty solving a complex problem and feel stuck? You, or you and your team, keep trying to get to a solution and end up effectively going in circles.

Applying this lesson from the backcountry, a potential approach is either to bring in fresh eyes to consider the situation or, as we did, pretend like you were starting fresh and question all of your assumptions, effectively bringing to the situation the missing "pairs of eyes."

Last year, we were backpacking in an area that gets very few visitors. We were trail finding for much of the trip. The following two lessons arise from that trip.

Just Because You Have a Clear Path, it Doesn't Mean You Are Headed in the Right Direction

At one point on the trip, after bushwhacking through downed trees and questionable trails, we came across a clearly delineated trail. Relieved that we had finally found a passable trail, we turned left and kept hiking. After about half an hour, we paused and asked, "Is there supposed to be a stream to our left"? We took out our map and compass and realized that we were headed exactly opposite from our intended direction. We had been fooled into taking the clear path, when the correct direction was the unmarked, little-used path.

If You Know the Direction You Are Headed, You Can Get There Even If There Isn't a Clear Path

From there, we kept a close eye on the map and the compass, relying on these tools rather than relying on a clearly marked trail. In fact, the more clearly obvious trail in this section would have taken us about three miles out of the way.

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PRESIDENT'S COLUMN *(continued from page 10)*

The professional life application from these two lessons is that we first need to set a direction and be confident in that goal and then figure out the path to get there. If we start down a path because it is the well-worn and "easier" route, we need to make sure that it is taking us where we want to go. We need to clarify the problem we are trying to solve and confirm that the proposed approach solves that problem before we proceed. I see this often in my professional life, when we start working on a solution before we agree on the problem or destination. I also see this when we continue with one approach because that is how we started, without stopping now and then to check our map and compass to make sure that we are still going in the right direction. When we are hiking, we start each day with reviewing the goal destination and the plan, and then checking in regularly. We have a rule that anyone can question whether we are headed in the right direction. Imagine if our professional teams functioned similarly.

No Decision Is a Decision

We borrowed this lesson from *Touching the Void*,[1] a book that tells the story of Joe Simpson and Simon Yates, his climbing partner, who face tremendous challenges after disaster occurs on their descent from scaling a 21,000-foot peak in the Andes. Joe Simpson writes, "You've got to make decisions, you've got to keep making decisions, even if they are wrong decisions. If you don't make decisions, you're stuffed."[1] Our shorthand version: "No decision is a decision."

On one trip many years ago, it had rained nonstop for most of the trip. On what was supposed to be our last night in the wilderness, we arrived at our campsite and began our usual ritual of setting up camp. After five days of nonstop rain, everything was at least damp if not downright wet. As we got into our sleeping bags, Rob asked me, "Is there any way that you will be warm tonight"? I could have answered, "I'll be OK" (the "no decision" equivalent). Instead, I answered, "Nope". We had a decision to make—do we pack up everything and trek eight miles out to the car in the dark and rain or do we stay the night, knowing that we would be cold, and hike out in the morning? Neither option was particularly appealing. Weighing our options, we packed up and hiked out. As I apply the "no decision is a decision" lesson to my professional life, I think about the times when we accept things the way they are, even if they are the equivalent of spending the night in a cold wet sleeping bag, and not taking the initiative to make change, to question the status quo and to take action to effect change. Not taking action is the equivalent of making a decision—it is the decision to keep things the way they are. Or, as is attributed to Walt Disney, "The way to get started is to quit talking and begin doing."

You may be under the impression that we get lost in the backcountry often or often have unpleasant experiences. We have never been truly lost, only temporarily misplaced. The positives far outweigh these challenges. This can happen in the backcountry and in our professional lives. Consistently question your assumptions, be willing to reconsider decisions and define your goals and then seek a path that gets you there, even if it is less well-worn. And, take time away and off the grid, however you define it. It is good for the soul. As Simon Yates wrote in *Against the Wall*, "Ultimately we have to look after ourselves, whether on the mountains or in day to day life…that is not a license to be selfish, for only by taking good care of ourselves are we able to help others."[2]

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MEDICAL EDUCATION

(continued from page 8)

of General Internal Medicine and the Section of Obesity Medicine at ZSOM designed and implemented a subspecialty training program utilizing the repeated ambulatory block. The program incorporated the six Accreditation Council for Graduate Medical Education core competencies as they pertain to obesity medicine. The intention was to achieve trainee improvement in obesity medicine knowledge, attitude towards treatment of the obese patient, comfort level in discussing the topic with patients, and a clinical skill set including interview techniques, clinical decision making and ease of facility with relaying key behavioral changes.

The obesity clinic pilot involved second year residents (PGY-2) working in the Improving Patient Access, Care, and Cost through Training (IMPACcT) clinic, funded by the Health Resources and Services Administration. The IMPACcT clinic was designed to train internal medicine residents, pharmacy students, medical students and physician assistant students to deliver team-based care that included attending physicians, pharmacists and social workers. Patients with BMI ≥30 and an interest in actively managing obesity could be referred from general internal medicine residency continuity clinics.

Program Description

A total of five PGY-2 residents applied for and were accepted to replace their traditional ambulatory continuity clinic with the IMPACcT clinic. During each IMPACcT week, each resident staffed the obesity clinic for one 3.5-hour session on Tuesday afternoon every fifth week for the entire academic year. A board certified obesity medicine physician and obesity medicine fellows precepted each clinic. Allotment times were 60 minutes for new consultations and 30 minutes for follow-up visits. Each visit started with the resident

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modality was explained. His goals of care were clear—he wanted to receive all treatments necessary to prolong life. However, it was not clear that he was ready to discuss the possibility that these treatments may not work. We consulted Palliative Medicine to facilitate discussion of his prognosis and the patient's priorities to ensure his quality of life. After a therapeutic thoracentesis, his breathing improved and wished to return home prior to the Palliative Medicine consultation.

How can we ensure that our patients want to engage in advanced care planning discussions? Evidence shows that AYA patients are ready for these conversations. Asking these brief "yes" or "no" screening questions can help assess a patient's readiness for these discussions:[4]

- **It might be helpful for me to talk about what would happen if treatments were no longer effective.**
- **Talking about medical care plans ahead of time to make sure my wishes are followed in the case that treatment options are limited or there are no more treatment options available would upset me very much.**
- **I feel comfortable writing down or discussing what I would want to happen to me if treatments were no longer effective.**

The advanced care planning tool "5 Wishes®" was evaluated in patients 16-28 years old, and 95% of participants felt that such a document would be "helpful or very helpful".[4] While clinicians may have a significant interest in "the kind of medical treatment I would want," AYA patients perceived this question as being the most stressful. They often requested more discussion on how they would want to be remembered and what they want their loved ones to know to leave their legacy. If patients are ready, writing letters to their children or loved ones can provide a sense of control of the legacy that they will leave. Best practice is to start these conversations at diagnosis and build over time, monitoring for changes in functional status, disease progression, or other life changes that impact patient goals or prognosis.

At this point, symptom management, allowing time to communicate wishes with family, elucidating end-of-life wishes, and helping children understand their parent's disease and symptoms would be key Palliative Medicine objectives. If not addressed early, there may be a time when it is "too late" for Palliative Care, and the patient is unable to convey their wishes.

End-of-life Care

Unfortunately, our patient did not make it to his Palliative Care appointment. He returned shortly after his discharge with respiratory failure due to worsening pulmonary tumor burden. We expressed our concerns to the patient and family that he was nearing the end of life. We discussed the possibility of transitioning to comfort care; however, he wished to continue to pursue treatments, including chest tube placement, intubation, and a time trial of immunotherapy.

First, let us focus on the meaning of "transition," as its significance may differ between patients and clinicians. Understanding a patient's wishes about end of life care, prioritizing symptom management, and beliefs about "a good death" can occur in parallel with ongoing treatment rather than 'in-sequence' as they transition to end-of-life care. Waiting to discuss these concepts until an AYA patient has "transitioned" to no longer believing treatment could be effective, unfortunately, leads to the observed delays in Palliative Medicine referral.

Second, patients such as ours challenge a conceptual framework that aggressive treatments towards the end of life and death in the hospital represent failures of advanced care planning. The quality of advanced care planning is not measured simply on the absence of these outcomes. Late aggressive treatments and 'in-hospital death' on their own do not indicate poor quality of care or that a "good death" did not occur. Characteristics constituting a "good death" are shaped by multiple cultural, social, and personal circumstances. For many patients, dying at home is not wanted as it may increase their sense of being a burden to loved ones. Studies suggest that the place of death is no longer a benchmark of providing quality end of life care.[5]

Case Conclusion

Our patient ultimately transitioned to comfort care and died in the hospital, surrounded by loved ones. While the end seemed peaceful, we witnessed the emotional toll of rapidly transitioning from novel immunologic therapies to end of life care on his wife and family. Did he have enough time and guidance to communicate with his family, and did they, in turn, have the support in place to minimize the trauma of watching their loved one go through this process?

While the features of this case stand out due to their emotional impact, they also sadly confirm the common clinical course for AYA cancer patients. To address gaps in care for this population, many hospitals have designed specialized AYA units where there is collaborative care between pediatric and adult oncology. Providing early interdisciplinary support across all psychosocial and physical realms to patients and their families can result in a higher quality of life and lower symptom burden. However, early integration of Palliative Medicine remains suboptimal and exceptionally challenging in young adults. General internists play a critical role in bridging this gap. Internists can provide holistic care to AYA patients thru awareness of their unique needs and ensuring communication with the multiple subspecialists involved. We hope clinicians will

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criteria, research priorities, as well as community outreach and pipeline programs.

Stage B. Sowing the Seeds—Dismantling Institutional Racism

4. Build the Pipeline

It is critical to support the development of future healthcare professionals from the communities served by institutions. Since diversity in medical schools is lacking, support and mentorship programs should begin early. This should include partnering with public schools and after-school programs to foster a pipeline of diverse students choosing to pursue medical careers.

5. Revamp Hiring and Admissions

Develop hiring and admission goals and policies to better reflect the patient population served by the institution. This requires an anti-bias lens in all process steps: review of applications, selection of interview candidates, interactions during interviews, and candidate ranking. Truglio, et al,[3] outline a strategy that includes community input for the hiring mission, academic metrics designed to eliminate structural racism, steps to reduce implicit bias in the interview process, and a ranking committee broadened to modify current power structures.

6. Realign Academic Environment

Academic institutions must support the recruitment, retention, and mentorship of more URM voices into the power structure of academic medicine. This includes dedicating time, resources, and funding to support mentorship of URM faculty, and recognizing a broader range of promotions criteria, recognizing diversity work, mentorship of learners and junior colleagues, and committee work. Compensate and protect faculty time for diversity initiatives.[4]

7. Refine Curriculum

Health educators should ensure that curricula teach race as a social construct, not a biological difference, and highlight the structural nature of heath inequities. In addition, medical and health professions curricula contain numerous examples of lectures, problem-based learning cases, and clinical vignettes that reinforce stereotypes, implicit bias, and prejudices. Educators should review their curricula for bias according to available anti-bias checklists, then make necessary corrections.[5] Curriculum committees can incorporate such checklists into course reviews and invite community members to participate in curriculum development.

8. Appoint and Empower Chief Diversity Officer

A Chief Diversity Officer (CDO) is a critical resource for institutional guidance, creating systems of accountability, coordinating leadership efforts between departments and schools, and implementing plans to create a culture of anti-racism, diversity, equity, and inclusion throughout the institution. The CDOs must be sufficiently empowered by a President, Provost, and Deans who inherently believe in the value of diversity.

Stage C. Tending and Sustaining the Crop—Dismantling Personal Racism

9. Provide Implicit Bias and Allyship Training

Institutional cultural change requires operationalizing a framework that dismantles individual presumptions, prejudices, discrimination, and racism, and builds an authentic culture of allyship. All individuals working within healthcare environments need training to recognize and address explicit racial discrimination and micro-aggressions that may emanate from or towards patients, trainees, faculty, staff, and other personnel. Furthermore,

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consider earlier referral to Palliative Medicine to assist their patients with advanced care planning. As the disease progresses, regular visits help elucidate personal values and provide strategies to mitigate social, spiritual, psychological, and physical distress.

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interviewing and examining the patients, followed by precepting with the attending.

Curricular objectives included the following: 1) physical exam skills, 2) appreciation of the treatment modalities and specialty referral, and 3) developing and sharpening counseling skills including interviewing and dissemination of behavior change techniques, problem solving and joint decision making with patients. Each session began with 30 minutes of didactic and case-based learning. The didactic sessions covered essential elements such as the approach, assessment, evaluation, and treatment of the obese patient.

Program Evaluation

The program will be assessed using resident feedback via the end of year program survey. A survey prior to academic year 2020-21 on attitudes and knowledge towards obesity medicine was conducted and will be repeated at the end of the year. This included a self-reported assessment of knowledge of obesity medicine topics, comfort in discussing relevant issues with patients, improvement in clinical decision making, and perceived ability to transfer these skills back to their general medicine clinic. The Division of General Internal Medicine leadership will evaluate the program on its ability to maintain patient continuity, appropriate referrals and clinical outcomes.

Discussion

Our obesity clinic expanded upon the traditional "X+Y" block model of internal medicine residency training programs, specifically incorporating the subspecialty clinic into the outpatient weeks of the second post graduate year. This ensured both didactic and experiential learning. Participating residents reported that they were able to apply what they learned in obesity clinic seamlessly into their general medicine clinics, including primary care management of patients with obesity and behavioral change techniques for all patients.

Other approaches to curriculum development may be more appropriate for different settings. For example, a dedicated four-week block rotation in obesity medicine may be feasible for centers without ambulatory blocks. This approach would follow similar subspecialty elective models for primary care residencies. Such an elective block would allow ample time for evaluation and initial treatment of obesity but not for longitudinal follow-up and relationship building which are part of intensive treatment models better mimicking the primary care setting.

Challenges exist when embedding and implementing a teaching program in obesity medicine. There are financial hindrances to managing a subspecialty resident clinic. In some states, managed Medicaid insurers do not consider obesity medicine to be a subspecialty and consequently do not cover services. Many residency clinic patients are insured by Medicaid or are uninsured. In these settings, the funding for a clinic would have to come from an external source such as an academic department, hospital administration, or philanthropy. Many standard-of-care obesity treatments are not, moreover, covered by insurance. These include newer medications and referrals to registered dietitians, with the exception of patients with additional underlying conditions such as diabetes mellitus or renal failure.

Finally, maintenance of continuity is challenging in the obesity clinic. Patients often had many challenging social determinants of health and suffered from high no show rates. This has a potentially negative effect on patient outcomes and can deny the resident the experience of longitudinal treatment of a chronic illness. We tried to alleviate this issue through frequent follow-ups, reminder calls, access to a patient portal for communication, and adding additional patient visit opportunities with a registered dietitian for patients requiring more frequent supervision.

In our experience, an obesity medicine continuity clinic can provide the needed training for residents. With support and collaboration from residency directors and obesity medicine physicians, evaluation metrics and a robust curriculum can be developed. This will ensure competence when trainees are caring for this patient population.

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it is vital to recognize that individuals within academic institutions may be anywhere on the spectrum from denying racism, to learning and actively engaging in anti-racist practices. Creating a culture of trust and humility starts with acknowledging that all of us possess some degree of implicit bias. This needs to be coupled with the willingness to open our hearts and minds to allow for challenging conversations and mutual learning through sharing of missteps and struggles.

10. Develop Policies and Procedures to Report and Respond to Bias and Racism

Complementary to building safe spaces and training to recognize and speak up against micro-aggressions and racism, establish an anonymous reporting system. This system can provide ongoing accountability, rapid corrective action, and continuous quality improvement through regular program evaluation. This effort should include teaching sessions that may promote bias, stereotype or shame, or micro aggressions in the classroom or in the clinical setting. Transparency and psychological safety are paramount for any reporting system: knowing that raised concerns are deliberated through a fair process and how these are ultimately addressed (safeguarding privacy and ensuring whistle blower protections) are essential. By dismantling personal racism, we can build a culture that promotes courage for recognizing, speaking, and standing up to counter racism.

Conclusions

Academic healthcare institutions must act to dismantle personal and institutional racism that stem from centuries of lack of knowledge, implicit bias, and intolerance. We propose a step-wise process to systematically address the institutional culture, equitable redistribution of power through hiring and promotions, community-engaged approach to build a workforce reflective of its diversity, refinement of the curriculum and learning climate, education and training to build the next generation of anti-racist health workforce, and establish a system of accountability. The path forward may be fraught with challenges, including educating and engaging those who may be unwilling to participate in this type of transformative change. Despite the hurdles that may lie ahead, the stakes are too high to maintain the status quo.

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Masking up starts at home—repurposing the key rack at the front door with a variety of sizes, styles, and fabric designs. (*Avital O'Glasser, MD, FACP, FHM*)

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COMMITTEE UPDATE *(continued from page 10)*

Pediatrics, to learn from their specialties' already piloted, as of 2018 and 2017 respectively, longitudinal assessment experiences.[5]

What MOC Qualifying Activities Does the Society of General Internal Medicine Offer?

Regional and national SGIM conferences are wonderful ways to learn and network with colleagues. Since 2019, they have also become an excellent way to earn MOC points. MOC points usually arrive within six weeks of providing your ABIM number and requesting MOC when filling out after-meeting evaluations. SGIM2020 On-Demand offers a cost-effective option for purchasing approximately 30 MOC points after answering viewed session questions. Additional opportunities to earn MOC points through SGIM-related experiences are likely coming.

How Can Physicians Earn MOC Points for Their Institutional CME-Eligible Programs?

ABIM's collaboration with the Accreditation Council for Continuing Medical Education (ACCME) provides the opportunity for ABIM Board Certified physicians to earn MOC points for thousands of accredited CME activities. These collaborations increase the number and diversity of accredited CME activities that meet the requirements for MOC and streamline the process for accredited CME providers and physicians. Many doctors are currently getting most of their CME/MOC points searching decision support tools like UpToDate.

For institutional CME-eligible programs not currently granting MOC points, physicians can contact their institutional CME provider and advocate for their participation in the educational activity to be reported to the ABIM. Physicians should also leverage the support and resources provided by the ACCME by reaching out to info@accme.org. The ACCME will then follow up with the institutional CME provider to explain how the process works and encourage their participation in MOC.

Conclusion

ABIM MOC is valuable and currently offers physicians options for satisfying the requirements of both MOC participation and certification. A longitudinal assessment option is scheduled to begin in 2022 and will replace the KCI assessment option. ABIM's new processes for question development hopes to achieve less reliance on rote memory and a more valid and relevant assessment of the physician knowledge and clinical judgment. SGIM and local institutions are excellent sources for GIM physician MOC participation.

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