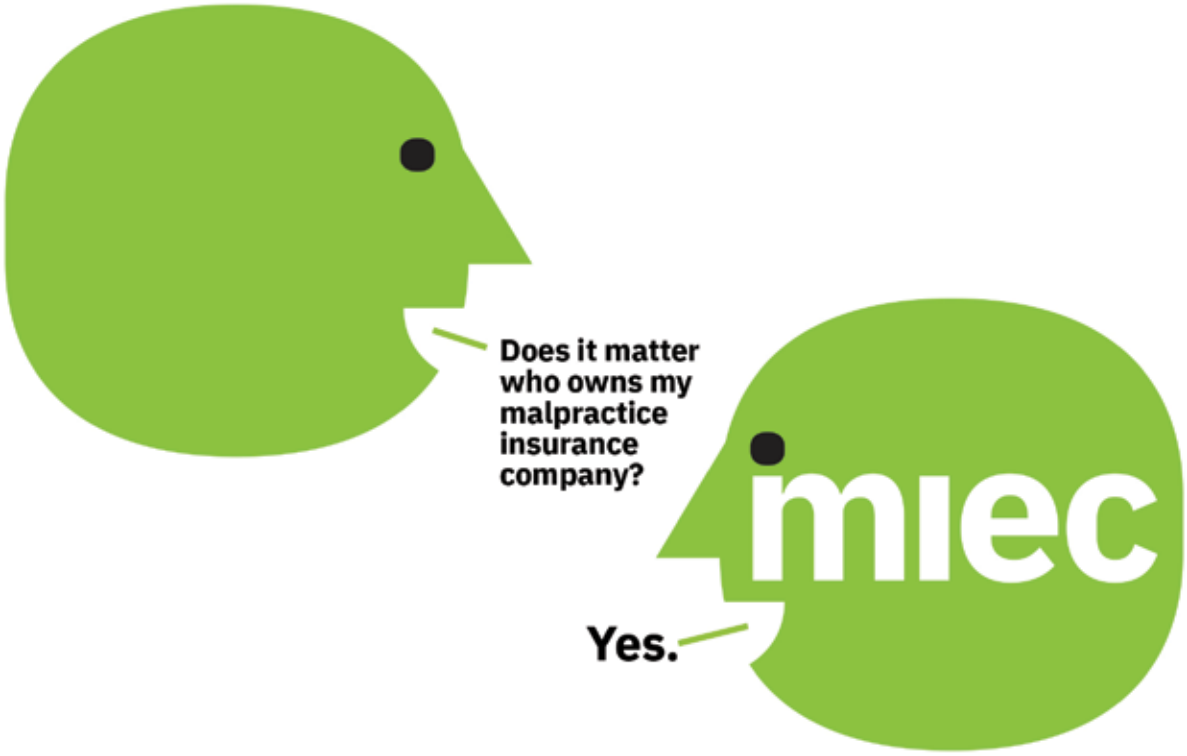
SAN FRANCISCO MARIN MEDICINE

JOURNAL OF THE SAN FRANCISCO MARIN MEDICAL SOCIETY

Reopening Schools
Medical Education in the Covid Era
Environmental Health and Medicine

PLUS: The SFMMS Medical Trainee Writing Contest!

Volume 94, Number 1 | JANUARY/FEBRUARY/MARCH 2021



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SPECIAL SECTION

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MEMBERSHIP MATTERS

Did You Miss the Passing-of-the-Gavel?

Throughout its 152-year history, the San Francisco Marin Medical Society has celebrated our past and future Presidents with an Annual Gala. We celebrated our outgoing President, Brian Grady, MD, on a successful term, and welcomed our new President, Monique Schaulis, MD. We were joined by special guests, Congresswoman Jackie Speier and Dr. Peter Bretan, CMA President and SFMMS Member. One of our medical trainee contest winners read a moving poem as well. Watch here:
http://bit.ly/3dc9VQ6

Vaccine Provider Toolkit Available from CMA

The California Medical Association (CMA) has published the COVID-19 Vaccine Toolkit for Physician Practices to provide answers to frequently asked physician questions about the COVID-19 vaccine rollout. The toolkit covers areas such as liability concerns for vaccine administrators, employer issues for physician practices and how to bill for the administration of the vaccine. This toolkit will be updated frequently with the latest information.
https://bit.ly/3jDlX6w

Newsom Order Protects Physicians from Liability When Administering Vaccines

The Governor's order from earlier this week, which was sought by the California Medical Association (CMA), confirms that all COVID-19 vaccination efforts, whether administered through a private practice or public effort, are pursuant to the state's vaccine program and therefore safeguarded under existing law that protects physicians and other vaccine administrators from lawsuits when they render services at the request of state or local officials during a state of emergency.
https://www.cmadocs.org/newsroom/news/view/ArticleId/49212/Newsom-signs-order-protecting-physicians-from-liability-when-administering-COVID-19-vaccines

SFMMS' Women in Medicine Starts April!

SFMMS is bringing back its quarterly Women in Medicine group for members, starting April 29, 6:30 pm-7:30 pm via Zoom. Please email Molly Baldridge, SFMMS Director of Engagement at mbaldridge@sfmms.org if you have questions and to receive the invite.

Your Voice, Your AMA: Health Care Advocacy and the New Administration

The American Medical Association hosted a webinar where panelists discussed the impact a new administration could have on health care advocacy at the national and state levels. Panelists shared how organized medicine advocates for physicians, residents, and students and why medical students' voices matter. If students are interested in learning more about how to be a successful health care advocate, AMA encourages them to register for the AMA Medical Student Advocacy Conference March 4-5, 2021.

Watch the recording here: *https://www.youtube.com/watch?v=QZQEQLD09sc&feature=youtu.be*

SFMMS Physician Members Volunteer at City College Vaccine Site!

SFMMS leaders, past-President Dr. Man-Kit Leung and President-elect, Dr. Michael Schrader volunteered this past weekend at City College vaccination site, a Saint Francis and St. Mary's partnership with UCSF Health, One Medical, and Dignity Health. Thank you, Dr. Leung & Dr. Schrader!
Dignity Health is still recruiting volunteers - SIGN UP HERE.
http://bit.ly/3pb0Jhy

"Mike and I noted an under-representation of minority groups at the mass vaccination event. In fact, I recall our lane vaccinating only one African-American couple. I would like to bring attention to SFMMS readers that outreach and accessible vaccines are needed for minority communities in San Francisco."

– Man-Kit Leung, MD

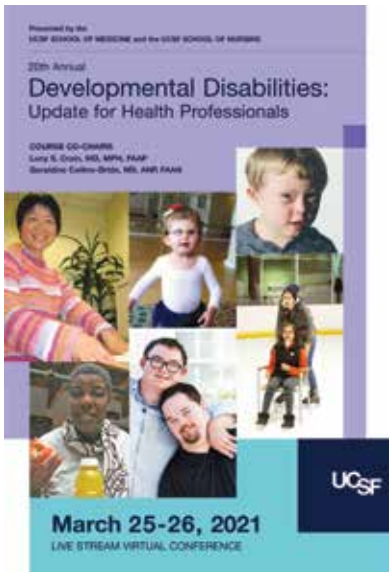
FREE PPE Available to SFMMS Members

SFMMS has an inventory of KN95 masks available for FREE to SFMMS members. Please contact Steve Heilig at heilig@sfmms.org to coordinate.

SFMMS Foundation Funds Local Programs and Manages Research Grants

The SFMMS Community Service Foundation (CSF) was established to both allow physicians to channel grants for worthy projects with low overhead, and to disperse funds to health organizations in our area. Researchers have used the CSF to manage grants for their own efforts, and most recently the CSF has made grants to Operation Access, the San Francisco Free Clinic, and the Marin Canal Alliance. For information on the CSF contact Steve Heilig at Heilig@sfmms.org.

2021 UCSF DEVELOPMENTAL DISABILITIES
Update for Health Professionals CME Conference



This year's focus on the pandemic and racial inequities in accessing health care for people with disabilities. A broad range of topics covers developmental disabilities across the age span. Also of interest is a presentation by *Elderhood* author and SFFMS

Member Dr. Louise Aronson, as well as other topics by outstanding faculty.

The conference will be on a virtual Zoom conference platform on March 25 and 26.

Details and registration:
https://www.ucsfcme.com/2021/MOC21001/info.html

***Distanced*, by Cynthia Fletcher**
12x16 oil on panel
Coronavirus series

What is it like to be young and have no playmates, no time at a park or school? Though social distancing is hard for everyone, children especially suffer and are affected both psychologically and developmentally by the isolation. *http://www.cynthiafletcherart.com/*

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Editor Gordon L. Fung, MD, PhD, FACC, FACP
Managing Editor Steve Heilig, MPH
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"We can ask our First Republic banker about anything, from refinancing student loans to starting a new business, and get objective advice."

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JENNIFER BUCZYNER, M.D., *Neurologist, Comprehensive Neurology of the Palm Beaches*

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PRESIDENT'S MESSAGE

Monique Schaulis, MD, MPH, FAAHPM

MOVING ON FROM ANNUS HORRIBILUS

"To support quality health care and the practice of medicine, we must move forward with the same focus that we've had for the last 152 years: a combination of society, education, and action."

I never took Latin, but know enough Spanish, French, and medicalese to understand this phrase. What's unusual is that it wasn't my bad year, or yours, but the collective experience of billions.

I know that given the current pace of change, this column is likely to be obsolete by the time you read it. But things are looking up. Our new president is just days into his term. Medical workers have been vaccinated. Despite significant obstacles, our family's elders have gotten a dose and I feel such relief that they are safer. I remain wary after the repeated punishments of 2020 but fervently hope that 2021 will be light at the end of the tunnel.

I have been proud of our city through this pandemic. Through our collective confidence in science, we have been able to repeatedly push back on the virus. Our scientists and researchers are at the forefront of treatments and vaccines as our clinicians work hard to save lives. Public health officers acknowledge glaring disparities and work to right them at the same time as they frenetically organize testing and mass vaccinations. I feel our collective responsibility in action as I run in Golden Gate park and along the Great Highway. While taking care of our precious physical and mental health by exercising outdoors, we respectfully distance and mask.

SFMMS is strong. Despite 2020, we have accomplished much, and have even grown stronger on zoom. Seeing our families, pets, and homes has allowed me a glimpse of our members not only as physicians, but as people, reminding me that community is the most important ingredient in the medical society's secret sauce.

It is especially easy now for physicians to become isolated in their disciplines or institutions, and even in their own suffering. SFMMS, by bringing us together, can help be part of our healing. This social aspect of the medical society is a necessity, not a luxury. As we work together on public health and advocacy, we must remember that personal ties are the glue that unites physicians in SF and Marin. To support quality health care and the practice of medicine, we must move forward with the same focus that we've had for the last 152 years: a combination of society, education, and action.

Together forward!
Monique

Dr. Monique Schaulis, MD, MPH, FAAHPM, is a graduate of the University of Chicago Pritzker School of Medicine. She practices Emergency and Palliative Medicine with The Permanente Medical Group in San Francisco. She is President of SFMMS and serves as faculty for Vital Talk, a non-profit that teaches communication skills for serious illness. Dr. Schaulis chairs the Medical Aid in Dying special interest group for the American Academy of Hospice and Palliative Medicine.

EXECUTIVE MEMO

Conrad Amenta, SFMMS Executive Director

PRIORITIZATION FOR COVID-19 VACCINATION RAISES THORNY QUESTIONS OF POLICY

The rollout of COVID-19 vaccines across the country has highlighted preexisting disparities between counties and states when it comes to resources and relationships. While vaccines are purchased at the federal level and allocated to states for distribution, the logistics of vaccine administration have largely been handled by County Departments of Public Health in collaboration with large, intercounty health entities.

We should have no illusions about what this means: the least resourced level of government has been responsible for carrying out many of the most complex tasks. The Departments of Public Health also happen to be how the bulk of the public interact with, and express their frustration about, the vaccination process.

Some counties, such as Marin, have stood up their own vaccination clinics for health care workers. In other counties, Departments of Public Health have relied upon the intercounty health entities in which the majority of physicians practice in an increasingly consolidated market. Yet in other counties, Departments of Public Health looked to regional medical societies to staff drive-through vaccination events. And yet in others, they asked that every single physician practice become an approved Vaccination Facility in and of itself, and thus have the capacity to vaccinate its own staff.

Each of these approaches possesses its trade-offs, risks, and shortcomings. But the simultaneity of these approaches across counties, and the varying degrees of rigor with which the prioritization order has been applied, has created uncertainty at a time when physicians and their staff are anxious about their safety – and have been told that they are prioritized for vaccination.

At the root of the challenged prioritization equation is the missing factor of supply. The degree of scarcity determines the degree of specificity in and application of the prioritization order. We understand, for example, that primary care physician practices are prioritized over subspecialty physician practices. But what medical specialties, services, and settings constitute primary care? Should the size and makeup of a physician's patient panel be considered? Does the prioritization order stand if someone does not show up for their appointment and the dose may go to waste? How much, if any of this, is verifiable? The relevancy of these questions ebbs and flows relative to the projected supply of vaccine.

Federal communication about the supply of vaccine has been lacking, forcing states and counties to develop guidance in the dark. County Departments of Public Health, tasked with executing on that guidance at the locus of unimaginable public and political pressure, have surfaced predictable challenges to consistency and fairness. We should acknowledge that though we have been operating in a vacuum of information, and this is frustrating, so too have County Departments of Public Health.

As this issue of San Francisco Marin Medicine goes to print, we can be sure that the immensely complex prioritization questions when it comes to vaccination of health care workers will be relatively simple compared to the prioritization order for the general public. I know that physicians, and their Society, will do all we can to help navigate the thorny policy questions that are sure to ensue.

Conrad Amenta

FROM THE CMA PRESIDENT

Peter N. Bretan, Jr., M.D.

THE VACCINE ROLLOUT: EFFICIENCY AND EQUITY

Dear Colleagues,

The approval of two COVID vaccines in December 2020 has brought some much-needed positive news in the fight against COVID-19. But we know that many physicians are still struggling to find useful and reliable information to share with their patients about how and when vaccines are coming to their community.

While supply continues to be an issue, CMA is engaged with the Newsom Administration to ensure the needs and voices of California physicians, and their patients, are heard. We have successfully pushed the Newsom Administration to relax the strict tier system for vaccine prioritization that was causing confusion and slowing down the vaccine distribution process and are now working to ensure our vast network of community physicians are deployed as a key part of the vaccination solution. We also argued that we needed a statewide, rather than a decentralized local strategy, to simplify navigating the system for both physicians and the general public.

CMA has demonstrated its ability to reach community physicians and shown the state how it is possible to equip those who most directly serve the communities across the state. When California struggled to get personal protective equipment (PPE) in the hands of community practices, they turned to CMA. So far CMA, with help from our component medical societies, has distributed more than 100 million pieces of PPE to physician practices across California.

CMA can help connect state administrators with community physicians to build a robust vaccination network and help the state meet its goal of getting California vaccinated.

Equity and speed are both vital components of any successful vaccination strategy. We must make sure we do not compromise one in the name of the other, and that we have a fast, effective and fair distribution of vaccines statewide.

That means getting the vaccine into the communities that need it most. We do not have to reinvent the wheel. We can simply stick with what has worked for other types of vaccinations. That means fully engaging community-based physicians so that people can be vaccinated in a place they are familiar with, under the care of a provider they trust. Millions of Californians receive care from an independent physician practice. This is the place where they get their routine vaccinations and annual flu shots. We must ensure, when supply allows, they can get their COVID vaccination the same way.

Community physician practices have the capability to administer 4.5 million doses of COVID vaccines requiring refrigeration per month statewide, according to projections based on recent CMA survey results. These practices can reach patients who may not have the technological savvy to schedule an appointment through a new smartphone app or the ability to wait in line all day at a mass vaccination clinic.

While smartphone apps and mass vaccination sites are an important part of the solution, they cannot be the entire solution. CMA is fighting to get the vaccine in the hands of community-based physicians who can most easily and effectively reach Californians where they live – particularly those that are in low-income communities and/or communities of color.

CMA leaders have made this case in hours of discussions with senior Newsom administration officials, and collected some of these ideas in a recent letter to the governor's office. Simplifying the eligibility framework and standardizing vaccine information and data on a statewide basis are necessary to connect our communities to vaccination in a timely way. These changes will accelerate the rate of vaccinations across California and improve the experience of both vaccine administrators and vaccine recipients.

Meanwhile, we are also working to make it easier for the thousands of physicians who have reached out looking to help staff vaccine clinics in their communities and around the state. Last month, the governor signed an Executive Order that extends liability protections to physicians and other vaccine administrators – something that CMA had requested for months.

We know that your patients want to know when they will be able to get the vaccine. The short answer is – we don't know yet. But we are fighting to make sure the concerns of all of you, and your patients, are heard. Despite the frustrations, we are making progress, and will continue to advocate on your behalf, and keep you informed of our efforts. I encourage you to regularly visit CMA's COVID-19 vaccine page for the latest information.

Sincerely,

Peter N. Bretan, Jr., M.D.
CMA President

CALIFORNIA MEDICAL ASSOCIATION

EDITORIAL:

PHYSICIAN LEADERS CALL FOR SCHOOL REOPENING

Jeanne Noble, MD and many more

Long term school closures have a detrimental, measurable impact on children and adolescents. While school closure is challenging for all families, households which include essential workers and those with limited financial means are disproportionately impacted. Children with special needs, in particular, are uniquely negatively impacted because they depend on in-person learning for educational, rehabilitative, social, and behavioral resources that cannot be adequately supported in distance learning, resulting in additional stress on these families. School closures have widened the achievement gap. Educational inequities have the potential to translate into a lifelong barrier and a staggering number of life years lost. In California, many private schools reopened during the Fall, while the majority of public schools have been closed since March. The essential societal role of public education is reflected in Article IX of California's constitution, which mandates unfettered access to education for all children to ensure that a child's ability to participate in public education is not dependent on the financial means of their family.

Because literacy and health literacy influence health status, prolonged school closure is contributing to social isolation among children and adolescents. It is taking a heavy toll on their mental health and well-being. The Emergency Department at Benioff Children's Hospital-Oakland reported a temporal increase in the proportion of all children and youth (10 to 17 years) who reported suicidal ideation, from 6% in March 2020 to 16% in September 2020. Similarly, the CDC reported that compared to 2019, the proportion of pediatric emergency visits due to mental health issues in 2020 increased by 24% among children ages 5 to 11 and by 31% for children ages 12 to 17. Apart from social isolation, an increase in high-risk behaviors among youth could be related to a lack of parental or adult supervision. The cumulative long-term impact of trauma related to social isolation, educational distress, family stress, and other stressors may culminate in post-traumatic stress disorder, depression, anxiety, and other behavioral disorders. It is reasonable to expect that children who live in poverty are even more likely to experience these adverse outcomes.

There is also a real concern for significant but unknown drops in student attendance, especially in disadvantaged communities with less access to computers and the internet for online learning. School districts around the country are reporting higher rates of students failing classes, a phenomenon which has been disproportionately seen among low-income Latinx and African American children.

Since March 2020, we have learned that young children are not the primary drivers of COVID-19 transmission. We have also learned that children are generally not at risk of severe health consequences from COVID-19. Indeed, in the entire state of California there have been only 5 COVID-related deaths among persons younger than age 18. For comparison, there were 15 deaths due to influenza in this same age group during the 2018-19 flu season. Fortunately, there is accumulating evidence from the Bay Area and other states that schools can safely reopen. In Marin county, for example, more than 450,000 "student days" (i.e., tens of thousands of students on school campuses for over 3 months) have been associated with just six cases of school-based transmission. That is, there have been only 6 additional COVID cases resulting from 40,000 students and 5,000 teachers interacting on campus since September. There is similarly reassuring data from the state of New York where COVID prevalence is no higher among high school students and teachers who returned to campus compared with community matched prevalence rates.

Teachers and other school staff are key players in this process and should be viewed as essential workers. Their health and safety are paramount. Fortunately, we now have robust data demonstrating that schools may be safely re-opened and school-based transmission remains very infrequent when universal masking and social distancing rules are carefully followed. We support the availability and use of universally accepted PPE including surgical masks and face shields for all school staff. We also support their prioritization for vaccine administration along with appropriate testing and COVID-related time-off alongside other essential workers, though school opening can and should proceed prior to vaccination availability or completion.

Following the lead of many European and Asian countries, we believe that California schools should be the first sector of our economy to reopen and the very last to close. Given the significant negative health and educational consequences of school closures for children and their families, coupled with robust data supporting reopening with appropriate mitigation strategies, we strongly support efforts to reopen California schools as soon as possible. Prioritizing reopening must include adequate resources to support the most important mitigation strategies: universal masking and social distancing. As pediatricians, internists, infectious disease specialists, epidemiologists, emergency physicians, and other healthcare professionals, we believe these strategies need immediate support and implementation, so that all schools can reopen for in-person learning as soon as permitted by the state.

Jeanne Noble, MD, MA is Associate Professor of Emergency Medicine and Director of COVID Response, UCSF Emergency Department. Dozens of other physician leaders, primarily but not only in pediatrics, co-signed this editorial, including Kimberly Newell Green, MD, Assistant Clinical Professor, UCSF and Past President San Francisco Marin Medical Society, and Shannon Udovic-Constant, MD, UCSF Associate Clinical Professor and Chair, California Medical Association Board of Trustees. The full list is available at https://www.sfexaminer.com/opinion/ucsf-health-professionals-call-for-february-1st-school-reopening/

The original version appeared in the San Francisco Examiner in January.

From the San Francisco Department of Public Health

BREAKING DOWN SILOS—THE "INNOVATION" NECESSARY TO BEAT THE COVID PANDEMIC

John Brown, MD and Mary Mercer, MD, MPH

The traditions of excellence and innovation in medical care have a long and well-deserved history in improving personal health and well-being in American society. Their positive effects have included high standards in teaching, medical care and research; resources from government grants and private philanthropy; and a long lineage of mentorship and protégées that have provided leadership in all aspects of direct care, public health and medical science.

It is difficult to recognize when a new paradigm for the organization of medical care is necessary, especially in mature medical cultures and traditions like San Francisco's. Yet new and demanding situations should give us pause to question our assumptions about how this care has always been given and whether or not our current structures are up to today's challenges.

The COVID pandemic has challenged our efficient, "just in time" approach to staffing and maintenance of supplies as well as training of medical personnel. Still finding ourselves in the middle of the fight against this disease, we are dealing with hospital in-patient bed shortages brought on by previous innovative ideas of more in-home or in-community and less in-facility care for many chronic illnesses and behavioral health crises. These approaches never took into account the unpredictable acuity of illness that such a pandemic can produce. In an economy where jobs in the technology sector are compensated far more than jobs in the essential worker or health care sector, we now face an exodus of the former and increasing needs for the latter with limited ability to change incentives to induce young workers to make decisions based on societal needs.

On the micro level, we are faced with the need to vaccinate thousands of patients per day in a system that was designed for at best a few hundred in the same time period. One innovation that has broken down silos is to reassign EMS providers from emergency to preventive medical care. Due to many factors, including both decreased mobility and patient concern over potential exposure to infection to obtain needed medical care, our EMS system has experienced lower than normal volume of patient calls. We have partnered with the California EMS Agency and our local EMS providers to train EMS personnel at the EMT and Paramedic level to participate in vaccination teams, along with nurses, information technology specialists, logisticians, pharmacists, physicians and midlevel providers. This has enabled establishing vaccination capabilities in health care facilities, our Moscone Convention Center, congregate living facilities and other "non-traditional" sites to increase the delivery of vaccines to individuals according to the state Department of Health's tiered system of risk and or age group.

On the macro-level, in the face of national and regional complexities of the vaccine supply chain and distribution guidelines, our public and private health systems have found benefit in the practices of collaboration and transparency. In San Francisco, the multi-county health systems, community hospitals and clinics and the Department of Public Health have formed a Health System Vaccine Collaborative (HSVC) to share best practices for efficient vaccine delivery and to plan and operate high-volume vaccination sites (mass vaccination) throughout the community. Together, in assessing the challenges ahead, the group set an ambitious goal to achieve or exceed 10,000 vaccines per day throughout the city and county and to "level-load" scarce resources (whether vaccine, vaccinators, or space) across the community, to serve the greatest need. Such a level of coordination requires transparent communications and processes, coupled with a good measure of optimism in what is possible to achieve together.

We have been there as a community before—whether it was the arrival of bubonic plague to San Francisco in the 1890's or the burden imposed by HIV in the 1980's. As this community we have sometimes been at the forefront and sometimes lagging behind others in our response but we have developed a common

vision and goal and implemented it to good effect. We have to guard against the more traditional/parochial role of health care systems overwhelming these innovations until we have achieved our common goal of pandemic control. Individual providers can remain vigilant by routinely visiting the DPH COVID website for information on protecting themselves and their staff, but also to provide up to date information to their patients. Many opportunities exist to assist with the rapid deployment of vaccine through DPH as well as community partner efforts. We need to get "all hands on deck" as the new tools for pandemic control (e.g. vaccines and improved testing/contact tracing) coincide with our bad weather/influenza seasons.

It's a new day and time for a new effort in our longstanding efforts as medical leaders in the community to end the pandemic. Let's "be the light," as Poet Laureate Amanda Gorman said recently, for our patients and our institutions to break down our traditional silos and get the work ahead of us done as quickly and safely as we can.

John Brown, MD is Medical Health Operations Area Coordinator, San Francisco Department of Public Health, an emergency physician practicing at San Francisco General Hospital and a Medical Officer on the Disaster Medical Assistance Team CA-6.

Mary P. Mercer MD, MPH is an associate professor of emergency medicine and EMS/disaster medicine fellowship director at University of California San Francisco and Zuckerberg San Francisco General Hospital. She is currently serving as Vaccine Branch Director for San Francisco's Covid-19 Command Center.

Upcoming Events for SFMMS Members

SFMMS Book Discussions

THE BOOK SELECTION will be one of the following to be chosen at the February discussion.

God's Hotel, Untethered Soul, Attending, or The Inner Work of Racial Justice

If you would like more information or to join a future SFMMS Book Discussion, please contact Molly Baldridge, MPH, Director of Engagement at mbaldridge@sfmms.org or Dr Jessie Mahoney, jessiemahoneymd@gmail.com.

SFMMS Women in Medicine

We will be starting a SFMMS Women in Medicine Group to provide opportunities for women physicians who are SFMMS members to create connections and support one another. We hope to create a welcoming space for SFMMS women physicians to come together in community.

The first meeting of this group will take place on April 29th at 6:30 pm.

It will be a Meet and Greet over Zoom.

And we will discuss the book, *Good Morning, I Love You: Mindfulness and Self Compassion Practices to Rewire Your Brain for Clarity and Joy*, by Shauna Shapiro PhD.

If you would like to join us, please contact Molly Baldridge, MPH, Director of Engagement at mbaldridge@sfmms.org.

Keep an eye out for additional physician wellness events coming soon!

If you have feedback, thoughts, or recommendations, please send them to Dr. Jessie Mahoney at jessiemahoneymd@gmail.com or Molly Baldridge, MPH at mbaldridge@sfmms.org.

LETTER TO MY YOUNGER SELF

Shieva Khayam-Bashi, MD

Dear Younger-Self-as-a-1st-Year-Medical-Student,

There will come a time when you are long past this era of your training, and you will become who you want to be. This part you are in now is both hard and thrilling, for so many reasons. Just remember you are on your path. You will live your way into the future and into the answers you seek. Be patient with yourself. It will get better.

With love and light and hope,

Me/Your Future Self

ON COMPARING YOURSELF

- You are not an impostor. You do belong here. And, you are smarter than you think.
- Resist the urge to compare yourself. It's easy to think everyone is doing better than you are. They aren't. Keep your mind focused on your own studies and inner growth. If you must compare yourself, only compare where you are now, as compared to before. You have come a long way. Remember being pre-med?
- You are your own worst critic. No one is thinking the terrible things about you that you are thinking about yourself. Talk to yourself as you would to a friend— with kindness, understanding, and compassion. Practice self-soothing language: "It's alright. It will be okay. I am smart enough to do this. I have done tough things before. Things will get better. I can ask for help. It's just one exam…"
- Remember Eleanor Roosevelt's words: "No one can make you feel inferior without your consent." (corollary: No one can make you feel *anything* without your consent!) You decide how to feel and what to think, no one else controls this.

ON EXAMS AND GRADES

- Exams and grades do *not* mean as much as you think. No one exam or class will dictate your entire career.
- You can fail a class and still be okay. It happens sometimes. Don't make a big deal out of it. Ask for help.
- Everything in med school *that is really important* to learn will be *repeated*—constantly! No one can retain this much information. You will retain what's important. Eventually you will.
- Don't let cramming the details take away from the wonder and awe of the human body and all of its intricate and miraculous workings. What you are learning is absolutely amazing!
- When you are in doubt, look at the current 2nd year students. Just last year, they were insecure 1st years, just like you. *They* got to the other side, and they are now more confident. *You will, too.* And many of them didn't pass a class or two, but they still made it. Trust in the process.

ON YOUR OWN MENTAL AND PHYSICAL HEALTH

- What you think and how you feel—these are your *choices.* Be aware of your choices in each moment, and choose to think the best of others and yourself—*especially* yourself.
- Always ask for help when needed. It is a sign of strength to know yourself and to ask for what you need.
- Make friends and ask deeper questions about their lives. Some are dealing with a lot more than just med school. Listen with compassion, and offer support when you can.
- Both your mind and body need care and respect. Take breaks to play, laugh, be creative, dance, sing, make art or music or poetry, journal, and just be happy.
- Whatever feeds your soul, take the time to do that. A little can go a long way.
- Don't ever say, "I will be happy when this exam/block is over." There is always going to be something else. It is up to you to enjoy *these* moments in between.
- Keep your sense of perspective. Look for the big picture. "This, too, shall pass."
- Work on your inner peace— find ways that help you to cope with stress. Right now, it's mainly stress of school, but soon you will be faced with stresses of intense clinical scenarios—life and death issues, suffering and pain. You will need a source of strength and coping mechanisms.
- "Nurture strength of spirit to shield you in sudden misfortune. But do not distress yourself with imaginings." (Desiderata poem)

ON ANXIETY ABOUT THE FUTURE

- Don't worry about not knowing what your specialty will be. Most students don't know till much later. It will find you. It takes time. One day, you will know. 3rd year rotations help a lot.
- Don't let yourself become too fearful or anxious about 3rd year. It's the reason you came to med school. This is when you will learn the *most*, because the learning is attached to real people's lives—your patients are now your teachers, and you will not forget them or the lessons they teach.
- Just before you start 3rd year, someone should tell you: "Don't worry—you are not expected to *know* everything yet. You are here to learn. And, what you lack in knowledge, you can more than make up for with *enthusiasm*."
- Start writing in a journal every day—write about it all, the good, the bad, the amazing, the tedious. Process these moments, write about what you are learning—about yourself and life.

- You will see and experience both the miraculous and the tragic. It's impossible to be fully "prepared"—intellectually or emotionally—for all the places life will take you. Trust in yourself, and trust in life.
- "Let everything happen to you: beauty and terror. Just keep going. No feeling is final." (Rainer Maria Rilke)

ON DOCTORING

- There will be times when you make a mistake or get things wrong. Learn to forgive yourself. Be as kind to yourself as you would be to others.
- Be loving toward everyone you meet. You never know what they are going through.
- Listen more than you speak. Listen to understand, not just to reply.
- *"What questions do you have?"* is inviting. *"Do you have any questions?"* is not (they usually say no, to be polite).
- Ask at least one question in each visit, to get to know who this person is, really. Like, *"What do you do as a hobby?" "Where did you grow up?"*
- Make it a habit to ask everyone: "What is helping you to cope with this?" You will help them think about and identify what helps them, and you'll understand them better.
- Don't be afraid of emotions—yours or your patient's. Learn how to embrace them and grow. You can be emotionally moved and *still* be professional. You are human. You will figure out how to manage.
- There *are* times that it is appropriate to cry with a patient. Don't let anyone tell you otherwise.
- There will be conditions that you and your team cannot fix—serious things, like catastrophic events, terminal illness, death. You must accept this. Let yourself feel what you feel. Be present with the patient and family, and bear witness to their pain. Let your humanity sit beside them. Hold a hand. Offer tissues. *Who you are* is what matters, not whether you had all the answers. They will remember you.
- Maya Angelou said it best: "I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
- "The bad news is you're only human. The good news is your humanity counts for a lot." Don't lose your humanity in your quest to become a competent clinician.

ON EMPATHY AND ROLE MODELS

- Your knowledge curve will be exponential—make sure your *empathy curve increases in parallel.* Don't let external pressures make you lose your empathy or "become jaded."
- Read poetry and literature and narratives—reading helps build empathy, as you try to understand from the perspective of the author. Reading the humanities can help you become a better doctor.
- You will run into some negative role models on your path—usually it is because they are stressed, time-pressured, exhausted, and struggling in their own ways. Don't be affected by them. Show them compassion. Do not become them.
- There will also be many positive role models on your path, who are like-minded and like-spirited. Seek them out, and don't be afraid to ask them for guidance and support. You never know when you may be helping others in reaching out for help yourself.

ON BELIEVING IN SOMETHING THAT HELPS YOU

- Believe in something bigger than yourself. It can help a lot.
- "Beyond a wholesome discipline, be gentle with yourself. You are a child of the universe, no less than the trees and the stars; you have a right to be here. And whether or not it is clear to you, no doubt the universe is unfolding as it should." (Desiderata poem)
- Stay connected to your deeper source of inner strength.
- There is one thing that is stronger than death, and that is love.
- When it is dark, look for the light, and be the light: "For there is always light, if only we're brave enough to see it. If only we're brave enough to be it." (Amanda Gorman)
- Always do your best, but know that you are not in control of outcomes.
- Practice hope and optimism every day. And gratitude.
- Make it a practice to look for positive news every day. In your own life, and in the world. There are far more good things that happen each day than bad. Choose your focus.
- "Not to spoil the ending for you, but everything is going to be okay."

Shieva Khayam-Bashi MD has been a Clinical Professor in the Department of Family & Community Medicine at UCSF for 20 years. She has recently retired and now she greatly enjoys focusing her attention on continued mentoring and teaching medical students. She was the former Medical Director of the Skilled Nursing Facility at San Francisco General Hospital, where she loved working with her amazing colleagues and friends. She also has a therapy dog, Shamzi, who has visited and helped many patients along the way. She believes that, as Aristotle said, "Educating the mind without educating the heart is no education at all." You can reach her at shieva.khayambashi@ucsf.edu.

WHAT I WISH I HAD KNOWN AS A RESIDENT

Jessie Mahoney, MD

A Compilation of Other Tips and Wisdom for those Starting Their Journey in Medicine Shared by a Group of 6,000 Women Physicians in January 2021.

As you embark on your journey in medicine, remember it is a long journey.

You must above all else take care of your human needs.

Being a resident won't be easy but there is much you can do to improve your experience of it.

Learning to manage your mind now will serve you well your entire career.

Be a friend to your fellow residents and colleagues and support one another.

Choose to be in it together and on each other's team.

All of you will benefit.

There is more than enough room for all residents and all physicians to do well.

When we take care of each other well, we all benefit.

Choose a narrative about your experience and life as a resident that serves you.

This will help you show up as the best version of yourself.

Decide that you are not a victim.

You are also not an imposter, you belong, and you bring great value no matter what level of training you are at.

Work is part of life and life includes work, especially when you work in medicine they are hard to separate and balance is often elusive.

Try to find ways to make things work all well together. Aim for work-life "integration"-- even in residency.

If you don't care for yourself well, you won't be able to care for others well.

Remember your why; notice and appreciate what's going well and what brings you joy.

Move your body and take a few intentional long, deep breaths of fresh air every day, no matter what.

Your Personal Life

Prioritize Your Health:

- Don't forget to take care of yourself— you're the only one that can.
- Learn mindfulness and practice it every day!!!
- Exercise.
- If you are sick, stay home.
- Eat and sleep.
- Plan a way to have healthy food available instead of hoping a healthy meal will happen on the fly.
- Don't drink to feel better - sleep is better for emotional health than alcohol.
- Prioritize your mental health. Now.

Develop yourself as a person:

- Learn problem-solving, conflict resolution, and communication skills.
- Be kind to yourself, learn balance, forgiveness, and compassion.
- Asking for help is a sign of courage and strength.
- Nurture a growth mindset.
- Learn to recognize when people's fixed mindset limits the amount you can get done or the difficulties that arise. Know it's not your fault and it's not your responsibility to fix them.
- Believe in yourself.
- Follow your passions.
- Keep some hobbies.
- Use residency rotations as experiments of what type of work life balance you need to feel happy in the long run, rather than just learning challenges and achievements.

Prioritize Your Own Happiness - Don't Wait for The Future:

- Be with your friends and family as much as you can.
- Don't put your happiness on hold for medicine. As doctors, we tend to think, "after I accomplish X, then I will do Y," and a zillion years later we still haven't done Y. Travel NOW. Get married. Have kids. Maintain friendships. Visit your parents. There is never a perfect time. Life is short. Work where you are valued as a human being. Corporations can replace you. Loved ones cannot.
- Enjoy your moments now.
- Thank your friends and family for supporting you through this.
- Get rid of the mundane tasks: hire a housekeeper, set auto-pays, subscribe and save.
- Simplify and declutter your life: buy all of one sock (no more matching)... clear room in your life for what really matters.
- Medicine is a marathon, not a sprint.
- Be satisfied and practice gratitude every night in what you have achieved in life.

Career

Ask Questions:

- Be a sponge but also cultivate your role as a leader as you learn.
- Practice good communication.
- Know your limitations.
- Know when to ask for help.
- Ask questions and ignore faces which make you feel that "you should have known it by now."
- Ask your curious unclear questions NOW, then keep asking them to colleagues you can go to.
- Imposter syndrome is real and can be overwhelming.
- Trust your instincts. Trust your training.
- Trust your gut.
- Ask for help if you need it.
- Find a good mentor.

Have Fun:

- Try and have fun. I know this sounds crazy— but do it.
- Enjoy your fellow residents: you don't get to be a "professional student learner" much longer and the friendships can be lifelong.
- Be less serious with patients... patients love to laugh, too.
- Take a deep breath and don't let the small stuff stress you out.
- Don't take criticism too seriously.
- Enjoy the patients. They are challenging and sick and need you. They need someone to listen to them. Sometimes you're the only one who can/will.

Build and Maintain Strong Relationships:

- Be a friend and a colleague.
- Form relationships with your colleagues—eat meals together and chat.
- Watch out for and care about your colleagues. Someone will be very depressed and even a quick greeting may help save their life. There really is not much more devastating than losing a colleague to suicide. Or cancer. I had both experiences in my training.
- "When I was an upper-level resident, I used to tell my interns that sometime during this first year you will break. I share the struggle I had in my first year NICU nights when I wasn't sleeping, my marriage was suffering, and I couldn't find time for myself. My third year at the time told me I need to read more and I broke out crying. Even though the other residents and staff may seem like they have everything together, most don't and that first year I guarantee you they all broke to some degree. It helped me immensely to know I wasn't the only one. Once I knew that I was able to share more with my other residents and learn how to help myself."

Finances

- Educate yourself on finances BEFORE the end of residency.
- Start investing now. Don't make excuses. This is more important than buying a house or a car. Invest.
- Be frugal financially until your loans are paid off.
- Contribute to your 401(k) or 403 (B) now.
- Purchase an own occupation disability policy now.

Dr. Jessie Mahoney is a Board-Certified Pediatrician, a certified life coach for physicians, and a yoga instructor. She is the Chair of the SFMMS Physician Wellness Task Force. She practiced Pediatrics and was a Physician Wellness leader at Kaiser Permanente for 17 years. She is the founder of Pause and Presence Coaching where she supports her physician colleagues using mindfulness tools and mindset coaching. She is a founding leader of the Mindful Healthcare Collective and is a co-host of the Mindful Healers Podcast. She teaches virtual weekly yoga to physicians and other healthcare providers and in non-Covid times, leads yoga and wellness retreats in beautiful locations around the world. You can connect with her at jessie@jessiemahoneymd.com.

SFMMS Physician Wellness Taskforce Update: January 2021

This quarter our SFMMS Physician Wellness Taskforce is continuing to grow our efforts to nourish and support physicians in Marin and San Francisco. We are beginning to build SFMMS wellness programming and will be starting with book club discussions and Women in Medicine gatherings this spring. In summer 2021 COVID permitting, we are hoping to offer opportunities to gather and exercise outside—in nature—with fellow local physicians and their families—on the water, in the trees, and on the trails.

For now, our team is meeting monthly to identify and intentionally direct SFMMS wellness efforts. We strongly support physician wellness being seen "as a value rather than an issue."

We are working to change perceptions around physician wellness and hoping to make it so that physicians see taking care of their health and wellness as non-negotiable and part of being a healthy and effective physician.

Our wellness team is specifically working to increase engagement in wellness events. build community and strengthen collegiality, and find ways to support physicians in taking care of their own physical and mental health. We also hope to encourage physician leaders to consider physician wellness in all operational decisions and to join us in this important work. We would love to include more physician leaders on our wellness task force.

Please continue to share your perspectives and suggestions for how SFMMS can help support your health and wellness so you can show up as the best version of yourself for you, your colleagues, your patients, and your loved ones.

MEDICAL EDUCATION IN THE COVID ERA

John Davis, MD, PhD

Medical education, as with education in general, is often a field that is marked by its cyclical nature: welcoming a new group of learners, the starting of classes, a usual series of courses, graduations, and the excitement of new journeys for one group leaving, just as a new one begins. This past year, the cycle wasn't as smooth as in years past.

The COVID-19 pandemic has touched – and significantly altered – all of us and many aspects of our profession, including our role as educators. There have been interruptions to the classroom learning environment. There have been interruptions and changes to usual clinical activities and our ability to engage with learners in that clinical setting. And there have been interruptions to the usual operations of transitioning learners as they progress along the medical training pathway. At each point, the changes have been challenging, and have simultaneously taught us important lessons.

At the start of the COVID pandemic early in 2020, our medical school, like many others, moved all classroom-based learning to the remote environment. This was a heavy lift to be sure, though in the current age of technology, the transition itself was not the hardest part. In fact, it allowed us to reassess just how much medical curriculum could be delivered remotely, mostly with the help of webinar software, new instructional apps for subjects like anatomy, and others. Much harder was finding a way to continue instruction around things like the physical exam and others that require presence and touch. Eventually, with enhanced protocols and increased availability of personal protective equipment (PPE), we were able to offer the most critical elements of in-person education to allow learners to progress to the next level.

The clinical environment proved to be more challenging. Issues with PPE availability, cancellation of some elective patient procedures, the transition to telehealth, and limitations in physician bandwidth to provide educational experiences combined to lead to an interruption in clinical education for some of our students. This allowed us to explore options of delivering remote learning content related to what students would be doing when they did return to the clinical environment – a way of previewing, or setting the stage, for more significant learning when in-person activities resumed. Likewise, the broader shift to telehealth allowed our students to participate in ways they hadn't in the past and allowed them to gather skills in this mode of care that will likely play a larger part in the future for all of us.

During the time of curricular interruption, many of our students expressed a common and driving need to be involved with the effort to help at this very unique time in our profession. In the context of the increased calls for social justice in the country and the pandemic-driven exposure of ongoing inequities in health and healthcare experienced by marginalized communities, our students expressed a desire to help these communities that were suffering. They organized mask drives, blood drives, translated health information into multiple languages, and volunteered to help with contact tracing and, when it was available, vaccination efforts. In light of the excellent examples these represented of both community service and the application of lessons from the classroom, we developed a mechanism to help this work count toward their educational progress.

While we are members of this profession, we are first and foremost humans. We and our students experienced the same types of challenges faced by all living in these times. Dealing with uncertainty, whether from curricular change, or changes in what we are able to do as members of society, is a constant. And dealing with the lack of social interaction has been hard for us all. The lack of the routine encounters we would normally have with each other has led us to be creative in our efforts to find ways to combat social isolation, including at the curricular level with things such as small-group, socially-distanced outings in Golden Gate park, or virtual chocolate tasting events. As with any challenging time, we must be mindful of the toll these combined stressors can take on our own health and wellness. Part of the educational opportunity afforded by these times is the ability to focus on and role model self-care and teach the next generation of physicians about the critical importance of physician wellbeing.

This pandemic has been, and continues to be, horrible. The loss of life has been devastating. There are those who are suffering long-term effects after otherwise recovering from COVID. The effects on lives, including from a health perspective, due to financial and economic consequences of the pandemic are enormous. The disproportionate burden of all of these effects on marginalized and oppressed communities is unconscionable. And yet there is hope. Hope in the form of vaccines and treatments for

the pandemic. Hope in the form of a renewed commitment at all levels to combat disparities in health and healthcare. And hope in the form of lessons that those of us living through these times will carry with us as we go forward.

Ultimately this pandemic has taught those of us in medical education many important lessons: further clarification on what we can and should be teaching and doing in a curriculum; just how far we can push remote learning; creative ways to try to maintain connectedness and care for ourselves; and inspiring examples of how, even in these times of challenge, we can be of service to those around us. These are lessons we will all carry with us – lessons that will ultimately benefit ourselves, each other as professionals, and the patients and communities we serve.

The cycle that is present in medical education was indeed different this past year, but it did not stop. Despite the pandemic, a medical school class graduated, a new class started, and another successfully navigated remote interviewing for residency and will match and then graduate this spring. The cycle is resilient primarily because of the resilience of our students and educators. Those of us involved in education of our students are fortunate to have such inspiring examples to buoy us in these times.

John Davis, MD, PhD, is the Associate Dean for Curriculum and Professor of Medicine in Infectious Diseases at UCSF.

RESOURCE CORNER:

Physician Wellness Book Recommendations:

"Good Morning, I Love You" Mindfulness and Self-Compassion Practices to Rewire Your Brain for Clarity and Joy,
by Shauna Shapiro, PhD

"Just One Thing: Developing A Buddha Brain One Simple Practice at a Time"
by Rick Hanson

"The Untethered Soul: The Journey Beyond Yourself"
by Michael A. Singer

"God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine"
by Victoria Sweet, MD

Free Wellness Resources for Physicians:

Free Mindfulness Apps: The following are mindfulness apps recommended by your physician wellness team that are currently FREE for physicians.

- Ten Percent Happier
- UCLA Mindful
- Headspace
- Calm

Podcasts Created By Physicians to Support Physicians Recommended by Physicians.

The Nocturnists, Emily Silverman, MD

The Mindful Healers Podcast, Dr. Jessie Mahoney and Dr. Ni-Cheng Liang

Wish Well Podcast, Dr. Michelle Dang

The White Coat Investor, Dr. Jim Dahle

Medicine Marriage and Money, Dr. Kate Louise Morena Mangona

Doctor Me First, Dr. Erinn Weissman

Write Your Last Chapter, Dr. Faryal Michaud

The Physician Philosopher, Dr. Jimmy Turner

Your Path in Focus, Dr. Christina Arnold

Entre MD, Dr. Nneka Chineme Unachukwu

Weight Loss for Busy Physicians, Dr. Katrina Ubell

More recommendations coming soon….

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THE SFMMS 2021 MEDICAL TRAINEE ESSAY CONTEST

"What patient has had the biggest impact on you so far, and why?"

This year's medical trainee contest – open to students, residents, and fellows – drew 29 usable entries. Once again we asked a very brief question about a wide-open subject – their most memorable patient encountered thus far. Two winners are being selected by vote of SFMMS leadership, to be read aloud at our annual gala, but we trust you will find all of these worthy reading. – The Editors

I met you during my first year of residency training. You came into labor and delivery at 22 weeks, just as I was learning the steps for a preterm labor evaluation. You had noticed abdominal cramping earlier in the day while preparing for your daughter's 4th birthday party. You looked at my name badge and asked if I spoke Vietnamese. I responded "chút xíu thôi – just a little bit," which was enough to put us both at ease.

As soon as the examination began, my heart sank into the pit of my stomach as I came to the realization that you were imminently delivering a nonviable fetus. When I told you what was happening, your cries immersed the room and spilled into the hallway. I could only manage "xin loi chi – I'm sorry" before joining in your sorrow. That day, you gave birth to your son and said goodbye to him in the same moment.

Two years later, you returned in labor with your third child. I was afraid my presence would resurface your grief. As I hesitantly walked into the room, you called out to me, "Bác sĩ Lê," and eagerly introduced me to your family. You thanked me for caring for your son, exclaiming it was a blessing that I was here with you again. That day, we erupted in laughter together when your newborn daughter took her first breath and instantly wailed.

Amy Le MD, PGY-4
Kaiser San Francisco OB/GYN Residency Program

He had just graduated from college, earned a consulting job, and was moving into his first apartment in "the city." He had a girlfriend he told his little brother years ago he would marry.

But I only learned these things later.

The day I met him was the first day of my residency: he was intubated with unresponsive pupils. He had arrived just the day before after being struck by a car while riding his bike home. The days that followed were a blur of arrivals - his girlfriend, his siblings, and finally his mother, all the way from Australia. We waited for his father as long as we could. The week ended with me, alone, telling his loved ones that honoring his wishes for organ donation meant we needed to proceed, that day, with declaring brain death. The sound his mother made was unreproducible and unforgettable.

In the end, he would never start his shiny new job or marry his childhood sweetheart. In him, I saw my friends. In his family, I saw my own. From them, I learned that medicine is as much about the human aspects of patient care as it is the technical ones. From him, that patients do not have to speak in order to impart something remarkable.

Before she left for the last time, his mother took my hands and asked me not to forget her son. Already choked up, I just nodded. I wish I had been able to tell her that I never would.

Kirea Mazzolini, MD
UCSF-East Bay General Surgery

I chuckled uncomfortably the way a medical student does when the surgery resident lectures on "reapings," aka end of life discussions with families. Deep breaths.

It's the early AM. Though not early enough for a 45 y/o paraplegic M to arrive after a motor vehicle accident. The driver in a desperate bid to flee the crime scene, caught the patient's wheelchair under the bumper, dragging his body and chair down the highway for two long miles. The patient presented unresponsive GCS3, multiple skull fractures with his skin hanging loosely in matted shreds of noodle confetti. We spoke to his family, recommending comfort care. "Full code. We want everything to keep him alive."

A failed reaping.

Over the next week, he coded twice, resuscitated on epinephrine, compressions, and defibrillation. Would he have wanted this? Tethered to a gurney, incontinent, artificially breathing? "Full code. We want to keep him alive."

Third arrest. Third resuscitation. Witnessed by family member. "Full code… alive?" Now, seeing the trauma and chaos of resuscitation, family wants palliative measures. The team has a date planned when patient's father will be in town.

Two days pass, and with his family present, we withdraw care, initiating the morphine drips and extubation. It has been nearly two weeks since our first family discussion and the pain just as visceral, but tinged with relief— as if the car had only now stopped dragging his corpse down that empty street and he could finally breathe, sighing one final breath.

Billy (Thien) Nguyen, MD
UCSF Pediatric Resident PGY-1

Holding purple nitrile hands

The muffling echo of the gymnasium turned field hospital, was not designed for private conversations. In Imperial, a small rural California county sharing a border with Mexico, COVID-19 overwhelmed limited medical resources. As an aspiring disaster medicine physician this was my dream job — supervising a disaster system, caring for patients.

One night, a patient was transferred from the local hospital to our gymnasium. Her phone battery died last week. In that time, her husband, brother, and brother-in-law had all died from COVID-19. She didn't know yet. Her son asked us for help to deliver the bad news.

A chaplain arrived to the hot-zone with small ziplocked holy-water. An EMT volunteered to translate Spanish. A nurse donated her i-pad to video extended family. I asked our patient to share memories of her late-husband. "Tell us more, what kind of man was he?" Tears rolled off the paramedic's N95.

Holding her hand through double layer purple nitrile gloves felt unnatural. A generation of healthcare workers have heart-breaking

COVID stories about the tragedy of dying and mourning alone. The social fabric that brings friends and family together to comfort the process of death and grief has been covered with purple nitrile gloves and N95s. No physician is alone in carrying this weight. It's a burden we all share as healthcare workers -- nurses, paramedics and EMTs. Although the hallmark of COVID has been social isolation, we have a tremendous opportunity to find new healthcare allies. In this, none of us are truly alone.

Amelia Breyre, MD
UCSF Emergency Medical System/Disaster Fellow

He was young. He wasn't a candidate for a liver transplant because he was still drinking. He was an artist, and unhoused. No one expected Mr. S to live for more than a few weeks.

When I introduced myself, he was wary of me, but agreed to a physical exam. I took note of his tense abdomen and his edematous legs. As I checked for asterixis, his yellow eyes glared frustratedly at his flapping, disobedient hands. "That shit is why I can't draw anymore," he said. I continued, and an ease quickly grew between us.

That night at home, I imagined Mr. S staring at the blank walls of his hospital room. I printed out some art, tucking the colorful pages in amongst my notes for pre-rounds the following morning.

He was friendly when I woke him. I finished my assessment, and then held out the prints. "I brought you something for your wall," I said. He took one look and threw them back at me. Anger flashed across his face. "I'm not fucking moving in!" he said, turning away.

His honest, unexpected response has always stuck with me. It taught me an important lesson about not trying to take a patient's experience and make it "nice." It helped me learn how not to impose my ideas about what a patient's experience should look like, but rather to let it be exactly what it is. Mr. S helped me understand what it is to serve, rather than to fix.

Johanna Glaser, MD
UCSF Internal Medicine Resident, PGY 1

"End stage, is that bad?"

Turn on fluorescent glaring lights
Sound check – CRRT alarms, Impella hum –
And a window view?
No; walls of beige, stark and immense and inorganic.

White coats, scrubs, gloves, masks;
Costuming wants a sterile aesthetic.
Paperthin bluegreen gown – clutched at crumpled corners –
Fear never follows our designs.

Stethoscope hangs just so
Flush syringes scattered in the bed on the table
No chairs, one monstrous bed whirring of its own accord.

Blocking last –
Nurse stage right, patient downstage.
I enter stage left. At the end. Final act.
"I didn't know I was end stage."
A tear down her face, traversing an eyecrinkle and pausing midroute on a smileline.

I hold her hand, I hold her story.
Curtains close 12 days later.

Ann Rohlfing, MD
Hospice and Palliative Medicine Fellow, UCSF

For the entirety of my training until March 2020, I had perceived telemedicine to be a bridge: a temporary bridge between hospitalizations and follow-up visits, or perhaps a temporizing bridge for patients who had forgotten about their in-person appointments. Given the lack of telemedicine incorporation in most program accreditation requirements, we had never been expected to create these bridges as residents or fellows. More importantly, I believed that physician-patient bonds were stronger when forged physically through handshakes and healing touches.

Then, of course, came the COVID-19 pandemic and the ensuring chaos with video-based visits: technologic issues, legal questions regarding non-California residents, and malfunctions with breakout rooms to facilitate trainee participation. But we persisted, and our patients prevailed. Indeed, a silver lining of the pandemic has been its establishment of telemedicine as a lasting bridge to care – ironically enough, a metaphorical bridge that has saved many patients from literal bridges en route to and from San Francisco. For every healing touch that is no longer feasible, I can instead offer a healing gaze: not toward the patient, but toward something in their video background (plant, painting, pet, or person) that inevitably reminds them of their life beyond their illness. I have been surprised to find that my patients and I actually enjoy these telemedicine visits. Telemedicine can indeed be conceptualized as a bridge, as I've now realized – not so much a bridge between appointments, but rather a bridge between my role in clinic and my patient's identity as a person.

Rahul Banerjee, MD
Fellow, Division of Hematology/Oncology, UCSF

When a Psychiatrist Says Goodbye

We sit with so much love in our hearts beneath the branches of the tree prominently placed in the courtyard. We decided to meet at the hospital where we first began work together two years ago as psychiatry resident and patient. She gently holds her notebook with plans for her future already written, I with my legs crossed, demeanor forever open. We sit with our masks firmly in place – we're in a pandemic, after all.

Soft tears of affection glisten in our eyes.

This our last meeting. I'm about to depart Massachusetts to start my fellowship in California. This is what is known in psychiatry as our "termination" meeting, but it's so much more.

"I have my life back for the first time in years."

She said those words one year ago. She was one of my first clinic patients, and, through nuanced medication changes combined with deep discussions every week, she entered remission after years of living with depression. Our work together always reminded me that my being myself was the best I had to give, and that was eternally more than enough. She changed my life as much as she says I changed hers.

Thus, our tears are ones of fondness, memories, lives intertwined now separating.

With our final words, where we both wish each other the best, we part ways. As I walk down the hill, I realize that now my time in residency is officially over.

I wouldn't have had it any other way.

Chase T.M. Anderson MD,
UCSF Fellow in Child and Adolescent Psychiatry

You talk slowly, carefully. It gives the impression that you artfully pick the words to say, like a poet putting pen to paper. I know it is because the cancer is in your brain, making thoughts foggy and words hard to harness into sentences.
Your wife says there is a saying in your family, "in a few minutes". It means we'll deal with it later, as a way of prioritizing what's important to deal with first. Especially if that "it" is difficult, especially if that "it" is cancer, especially if that "it" is you dying far sooner than she anticipated. Sometimes "in a few minutes" means "never". When it comes to the cancer, we'll deal with it in a few minutes.

I know that I should address it, that we should talk about the cancer—but I'm drawn into you and I see you much in the same way your wife does—strong and magnanimous, like a force of nature. I see you picking up your granddaughter, swinging her over your shoulder.

I see you building the garden that now gathers your family. I see you sitting at the head of the table, calling everyone to gather. I admit that I only see this version of you. I admit that I don't acknowledge the cancer that ravages your body, stealing away your strength, and eventually taking your life. I'll deal with it in a few minutes.

Caroline Nguyen, MD
UCSF Internal Medicine Resident, PGY-2

Living like kings

Skin creasing into four
layers around his
yellowing eyes,
he asks in jaundiced
voice, is it bad?

His palms clear
the seven bottles of
straw-colored fluid
and signal for me to sit
by his side.

I see, cholangiocarcinoma…
and a muffled, obstructed pause.
An icteric refraction
from the dewdrops resting
in the crevices of his canthi.

And suddenly, a smile. He licks the
upperside of his lips, revealing a sliver
of his tongue's aurelian underside.
A glimpse of upswelling peace.

Well, I have lived simply. I was not wealthy.
But I flew on a plane once or twice.
I have enjoyed my favorite films.
I have had many meals from my wife's native China.

Even the kings of old could not have imagined flight,
personal entertainers at my beckon,
or food from a faraway land.

My life has been gold.

Andrew 익현 Kim, MD, MPhil
UCSF/ZSFG Resident, Internal Medicine–Primary Care

We weren't a trauma hospital. But he must have not known that as he scooped his lifeless adult daughter up, carrying her across a busy street toward that big letter H.

The intern barged into the chief office to tell us there was a stab victim in the emergency room.

Rushing down to the ED I noticed the father in shock looking on. And what I saw almost derailed me from my ABCs (Airway, Breathing, Circulation).

A beautiful young pastry chef had carefully filleted her own body. Clean and deep symmetrical slices of her neck revealing perfect anatomy of her vessels. Muscles hanging off both arms like a Renaissance anatomy image. Struggle-free perfect stab wounds of her abdomen and a knife piercing over her heart.

Shockingly her airway was clear. She needed a chest tube but she was otherwise stable.
As we turned her for secondary survey, I hugged her extra tightly. Her eyelash extensions were perfect. Her makeup was perfect. Everything about her mutilation was horrifyingly precise. Even her voice was unwavering.

Once she was packaged for transfer, my attending called to hear what had happened and I began to tell her story. Five years of keeping it together under pressure devolved into a face full of tears in the emergency room.

I don't think any amount of training would have ever prepared me for that day.

Sarah S. Sims Pearlstein, MD
Clinical Fellow | UCSF Department of Endocrine Surgery

My public hospital represents a final landing zone for the accumulative effects of quotidian structural violence in inner city Oakland. My patient, Mr. M, captures this reality. As the second-year surgical consult resident I was called to see his 'leg wound' for possible operative debridement. As I entered his ED room, a deeply pungent, musty smell flooded me. I saw an elderly black man with his left leg raised. It was hastily, loosely wrapped in white gauze, as if whoever dressed it could not bear to stay. Beside Mr. M, a shopping cart filled with the entirety of his life's belonging formed a vertical tower of black garbage bags. As I spoke with him I unveiled the dressing to find an ossified, ashy foot covered with an active colony of maggots, parts of bone visible underneath. I was filled with an immediate aversion, which I resisted to examine his wound.

Over the next several days Mr. M would daily refuse surgical debridement of his foot wound and I would daily sit by his bedside and learn his story, his humanity. Steadily we traversed the gulf between us. My assumptions and false ideas about Mr. M melted as I witnessed his struggled journey from Louisiana, the lack of parents in his young life, his complete isolation on the streets and, through it all, and a deep abiding faith in a higher power. Though he never accepted surgical debridement, Mr. M taught me so much more than any operation would have – our common humanity.

Mihir Chaudhary, MD
Surgery resident, UCSF East Bay

Like most of my patients, I met you through the lens of my microscope, searching your cells and tissues for the answer of "What's that mass on CT?" or "What could explain the bleeding?"

I will likely never meet you in person, and you might never know I exist. Even to my colleagues, I am sometimes a faceless, report-generating entity— "pathology pending." But I have read through the notes in your chart and imagined the conversations you've had with your other doctors that led to this point. I know the biopsy was painful and probably bled, because the tissue cores are thick and contain a large vessel. I know you are anxiously but patiently awaiting your results.

Your cells tell a story, and we agonize over them frequently. Lymph node by involved lymph node, I am the first person to know that your cancer has spread. My heart drops. I see your life unfolding before my oft-bleary eyes, and I wonder how you will take the news. Sometimes, I find no residual cancer or a benign lesion, and I wonder how you will celebrate.

Even though I can only imagine your smile and what your voice sounds like, I see what few others ever get the privilege of seeing. Little did I know that as a pathologist, I would know your life story without you ever speaking a word.

Constance "Connie" Chen, MD
UCSF Pathology and Laboratory Medicine Resident, PGY-3

As if trying to uncap a tightly sealed jar, she worked to get her words out. "I'm…afraid," she mumbled, stilted. "Of what?" I asked as she sobbed, our bodies splayed outward toward the windows at the end of the hall. "Growing up." Clear as day, she spoke to me through her fog-blanketed brain. I wanted to lasso those words, round them up and hold onto them, grasp tightly to that sliver of herself.

These were not the first words I had heard her speak. Wading into her world of catatonia, I'd sat and smiled as she recited Bible quotes energetically, Little House on the Prairie looping quaintly in the background. I'd nodded along as she declared seeming nonsense about boyfriends and iPods and a friend named Lauren. These words came from a part of her brain we did not understand, were not truly hers.

Afraid of growing up, she and I together faced the brief morning. Sixteen years old, she was lost in a mind belted and cinched by stillness. At 27, I was not catatonic like she, but I was lost somewhere too. She hugged me long and hard, and her arms became home, snuck up on me like dawn.

Sadness sticks with us longer and harder than joy. Her giggles were gone, evaporated into thin electric spikes, but her tears planted themselves behind her pink frames. I watched her click the pen over and over, and it was I who was clicking the pen. It was I who was afraid of growing up, and she looked me in the eye and understood.

Ranya Platt, MD
UCSF Pediatrics, PGY-1

I was an awkward third-year medical student. He was an insightful, funny man, victim of so many pandemics: opiate dependence, homelessness, racism, HIV. I spent hours practicing my cardiac exam on him. He had great heart sounds, and was patient while I puzzled out his S1 and his S2. Then he spiked a fever. We took blood cultures, and sixteen hours later they grew the dreaded gram-positive cocci –staph bacteremia. But, in horrifically bad timing, he impulsively left the hospital before we could tell him. He was out there, in New York, with a compromised immune system and a deadly infection in his blood. He had no phone, no fixed address. I was so afraid for him. Couldn't focus on studying. So I became a sleuth. I badgered social workers into helping me pore through his paper chart and called every emergency contact I could find. I left the same message: please tell him to call us, it's serious, this is my number.

That night, when I ran, I deliberately went through the neighborhoods where people without homes would sleep, staring into shadows, hoping a miracle would happen and that I would find him. The next morning, he called my cellphone. One of his contacts had found him and passed on my message. I begged him to come in. When I met him at the hospital entrance, amid the honking of taxis, and walked him in, it was a moment of extraordinary brightness.

Natasha Spottiswoode, MD
UCSF Internal Medicine R3/Molecular Medicine

I had mentally practiced an emergent thoracotomy innumerable times in my head, prepared for and naively excited that I would one day run a scalpel quickly between the 4th and 5th intercostal space amidst the chaos of a trauma bay. I never imagined it would be on a six-year-old body that I would first crack open a chest, your chest, as your mother screamed at the door.

Hurriedly gowning myself, I heard the overhead call ringing out for a pediatric shock trauma. You arrived on the gurney, so small, already intubated, pulseless, and pale, with a single gunshot wound in the midclavicular line of your chest. It was chaos, but not the chaos I imagined. I poured betadine on your chest and neck. My hovered knife met your skin on the recoil of your last chest compression. I am sorry if it hurt. Placing the retractor as I spread your ribs, I couldn't hear if your bones broke, but I could hear your mother sobbing at the now closed door just steps away from you. We found the transected trachea and bullet shorn brachiocephalic, and we knew you were unsavable and dead. I am so sorry for you, for your mother, for your family.

The silence and situation were devastating as I closed your chest with an intern. Inevitably, the next trauma call rang out and time continued, a spree of stabbings and gunshots on a busy COVID summer night. I think about you every day and I am sorry.

Caroline Melhado, MD
UCSF General Surgery, PGY-3

Sick and Not Sick

During one of my first nights as a pediatric intern, a battle-hardened senior resident told me, "The most important thing you'll learn is figuring out whether a patient is sick or not sick." Emerging from my adult neurology year, I tried to reinhabit this mindset during my first few nights as a child neurologist. Seizing or not seizing? Stroke or not stroke? For overnight purposes, the principle generally held true. But with every family I've come to know, the line separating sick from not sick has grown progressively thinner.

The one-year-old with a degenerative neurometabolic disorder seemed incredibly sick at first glance. She had refractory seizures every few minutes and could barely maintain her oxygen saturations. But for months, her parents saw the potential for her to be healthy, because she seemed to respond to her world. When she could no longer track her mother's face, this was ultimately their sign that she was suffering, despite all the other measures by which many physicians would have described her as "sick."

I wondered when a different family might have come to the same conclusion, but soon realized it didn't matter – every family had the right to their own place on the continuum, and to a neurologist who would meet them there. What I previously saw as a dichotomy in pediatrics has become an ever-evolving, extraordinary paradox in child neurology. I now cherish the opportunity to sit with families in what is not a division, but a tenuous, unique, and beautiful "and."

Madeline Kahan, M.D.
UCSF Child Neurology, PGY-5

"The new admit is a 16-year-old with ARFID, but I think he'll be diagnosed with anorexia nervosa," the fellow signed out to me that night. As I entered the room, an emaciated adolescent and his mother looked at me with sad, yearning eyes as they told me the story that brought him to the hospital.

Eight months ago, around the start of the COVID-19 pandemic, a stray bullet entered their apartment, nearly missing him. At first, he prayed to god to thank him for saving his life. Then, he prayed to ask for safety for his family. But eventually, the prayers became compulsive and he needed to pray a certain number of times for a certain number of seconds before he could eat, or else something horrible would happen to him or his family. Months passed, and his weight dropped to the point where he was bradycardic to the low 30s. He could no longer do the things he loved, like play soccer. "I feel horrible, and all I want to do is make it stop so I can get better" he told me that night.

I left the room, and I cried. I cried for him, for his family. For all the families who are disproportionally negatively impacted by this pandemic and by poverty. For the stigma surrounding mental health challenges, and the barriers families face to get mental health care. And I cried for all the patients who I hadn't yet let myself cry for this year.

Sarah Bourne, MD
UCSF Pediatrics Resident, PGY-1

Mr. D was an artist and Black man with a history of childhood trauma, head injury, and schizophrenia. His medication list on admission was already long, and it grew longer still as the weeks went by and we struggled to balance treating his psychosis with the hazards of side effects. The spectre of his neurobiological decline hung over us.

"He shared that he was deeply afraid, not just of the demons he heard through the windows, but of incarceration or worse. We talked about the tension in my keeping him involuntarily hospitalized while also trying to reduce his fear and distress, and about the additional vulnerability that he faced as a Black man with schizophrenia. Once when I acknowledged this, he told me, "That's not on you." I said, "Sure, but I'm part of the system," and was caught off guard when he replied "Dr. He, you're not part of the system."

What we seek in an inpatient stay, jarringly brief when set against the entire arc of a life, is some measure of stability that will enable the patient to continue on without us. As Mr. D's case reminded me, our job is neither to "fix" nor to "cure." Many disorders have no cure, and are made intractable by devastating systemic inequities that cannot be addressed with psychopharmacology. Yet I need to believe in the importance of recognizing this limitation, for it may still allow for moments of shared grace and humanity.

Cynthia He, MD, PhD
PGY-2, UCSF Psychiatry

Badge Angst

My badge only works half the time. When I tap it to call the staff elevator the motion appears casual, but internally I tense as I wait to see if I'll be granted access. I don't mention this to anyone. Intern year is supposed to be hard, right?

"I've taken care of him before," I hear myself say to the paramedic as he begins to sign out a medically complex patient who I'd become familiar with on previous rotations. The confidence in my voice surprises me. I don't quite understand the pathophysiology of his disease process, but I know what orders he needs and who to call for help.

I consult a subspecialist for this patient. "It's good to hear from you!" she says, "I haven't seen you around the hospital recently." She's right, I've been at another site for the past few months. It feels good to be noticed.

I'd never consciously acknowledged my badge angst before. It was a lurking anxiety that I was vaguely aware of, but hadn't yet named. Leaving the hospital that night, buoyed by a new sense of belonging, my experience with my badge crystallized as one of shame. My badge had been subtly but consistently confirming my fear that I hadn't yet earned access to these doors.

At lunch with a co-intern, I sheepishly tell her about my badge. "I had the same problem!" she laughs. "You just have to remove any other cards from the holder."

My badge works every time.

Aly Levine
UCSF Pediatric Resident, PGY-1

You are a retired pediatrician I am a new geriatrics fellow. If this irony gives you any pause, you are kind enough to not mention it. I "meet" you on the phone on my first day of clinic and introduce myself as your new primary care doctor. I hope you cannot tell that I am nervous.

I start the visit with questions that I have asked many patients in hopes of getting to know you better. Your story is one that you have shared with other fellows before me. I learn that you have been married to your wife for 60 years. You have been her caregiver since she was diagnosed with dementia 6 years ago. You love her so much. You worry about your declining health because no one else will be able to care for her, definitely not better than you. I hear your pain. I imagine your grief. At the end of our call, you say, "Thank you for listening, Doctor." You hang up but I keep worrying about you and wondering what I should have said.

There is nothing on UpToDate that teaches me how to be a doctor for someone who has cared for more patients than I have or how to ease their suffering when the person they love most no longer recognizes them. However, you show me that it is possible to be resilient while admitting vulnerabilities, and to offer empathy while being at a loss for words. Thank you for trusting me.

Lingsheng Li, PGY-4
UCSF Fellow in Geriatrics and Palliative Care

It's 11:00pm in the ER on the first day of my Family Medicine residency. Preparing a thorough differential for "abdominal pain," I review my first patient's chart: psychotic, meth abuser, homeless, verbally abusive, trans woman; all words that ignite unconscious biases.

Like my married name, the "Dr." title is brand new. Being "Dr. Eisenstein" is so foreign, fueling raging imposter syndrome as I walk in the room.

The following happens quickly: the patient states she wants to be called Rhianna as medical staff disrespectfully continue to use he/him pronouns. Voices rise, the sheriff gets physical. The nurses search for the patient's doctor to request chemical sedation. Who is the patient's doctor, I think? Then I realize, it's me.

Hiding in my obliviousness, I stepped back from my patient. My premeditated differential had not prepared me for the inextricable link between mental and physical health, let alone dosing for psychiatric medication. I had an inadequate foundation in transgender health care, the importance of intersectionality, and the complex relationship between law enforcement and racism in a medical facility. Identifying gaps in knowledge is the first step towards growth; and in this humility it is still possible to be a compassionate provider.

At the beginning of my third year of residency my first patient walks in and states her request, "I need a primary care doctor and I want to start hormones." This time I step up and say, "I'm Dr. Talia and it would be my pleasure to accompany you on this journey."

Talia Eisenstein, MD
UCSF-SFGH Family and Community Resident Physician, PGY-3

You won't be able to save every patient.

I was eighteen, working as a nursing aide to ascertain whether I wanted to pursue a career in medicine. I was completely enthralled with daily life on a surgical unit – from watching dressing changes to lingering in patient rooms when I knew the surgical team would be rounding. Mr. B presented after committing harakiri, an ancient Japanese form of suicide that involves plunging a knife into one's abdomen. He was a polite, soft-spoken businessman who had recently been under tremendous stress. His family, including a daughter my age, was an unwavering source of support as he recovered from his multiple injuries. One day, I realized I hadn't seen Mr. B for some time. As I paced the hallways and enquired at the nursing station, I became increasingly worried. Deep down I think I knew, even before finding the open window, with his IV pole and slippers. Before seeing him. The subsequent weeks I was in a haze, numb to any emotion except guilt. One of the few things I do remember is my mother, a nurse, telling me that if I wanted to become a doctor, I would need to accept that I wouldn't be able to save every patient.

Over the past five years of surgical residency, several patients have reminded me of Mr. B. I experience such joy and satisfaction from fixing patients' problems. But I also realize that my mother was right (as always). Not every problem can be solved, and not every patient will be saved.

Marisa Schwab, MD
UCSF General Surgery Resident

Your Face

As I stand in front of my team, with flowing tears, I see your face. When I walked into your room last night, I knew you were dying. You couldn't respond to your name--breaths shallow and ragged, face scared and mind distant. What happened? It's as if you knew your time was coming when you took off the oxygen mask moments before your death. As if you knew something I did not. I knew the prognosis, but I never thought it would be now.

The faces of the code team look to the senior resident. What do we do? You no longer have a pulse. We had discussed what you want in this moment and we agreed on comfort.

The end.

You died on my watch. My first patient to die unexpectedly as a senior resident.

I see your face. How am I going to tell the medical student that has been spending an hour with you each day? Or your family? How will I lead my team through your death?

I see your face on rounds, tears streaming down my face. Does crying make me weaker? Stronger? Why is this the death that makes me cry?

Sometimes, when it's quiet, or I am on a walk or reading a book, I see your face.

I don't know what the lesson is. I don't have a story wrapped in a bow to tell myself or pass along with some insightful message. I see your face. And that is enough.

Kathleen Marie Raskob, MD
UCSF Internal Medicine, PGY-2

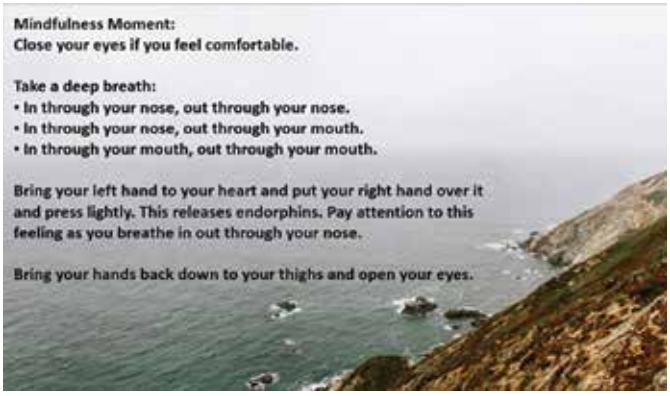
My new patient in clinic was recently discharged from the psychiatric emergency room at San Francisco General Hospital for suicidal ideation, meth use, and homelessness. It's a story I have heard countless times now that I am in my fourth year of psychiatry training. I usually meet someone who is hostile, or at least help-rejecting, with discharge back to the street an unsatisfying yet inevitable plan. Mr. H laid in bed, moaning in pain. The left side of his face was overtaken by a parotid tumor. He looked imposing and frail. I introduced myself as the medical student. He sighed in annoyance.

I was ashamed when I was surprised at how eloquent and likeable my patient was. She has always suffered from anxiety, and found meth as a way to escape the unbearable panic attacks. After needing to make a change in her life, she boarded a flight from Ohio to Hawaii. She had not anticipated the required two week quarantine in Hawaii and could not afford the hotel stay, so was put back on the plane back to Ohio. Instead of giving up, she took control of her destiny and got off the layover in San Francisco. She reasoned San Francisco seemed like a better fit for her given its resources for transgender folks. However, while here, she became extremely overwhelmed and suicidal after her bags were stolen and she lost her glasses, unable to navigate the bus system without them.

Though her life was so different from mine, I could relate to her so much on at least this one issue: if I didn't have something as simple as access to my glasses, I have no doubt I would feel like giving up. I invited her to a writing group I helped facilitate, and she continued to surprise me with her introspective poems, witty riddles, and creative ideas for next week's writing prompts. I cheered her on as she made gains every time we met, setting up Medi-cal, securing her own housing, remaining sober, and finding relief from anti-anxiety medications I was prescribing. When she realized my elective at Chinatown North Beach clinic was ending, she connected with Alliance Health Project, a mental health clinic that specialized in LGBTQ and HIV+ individuals that would better serve her needs.

I realize now that she didn't need me, not really. She was so self-motivated that anyone in my position could have helped her. I'm the one who needed her: to keep me doing this hard work, to hold onto her story and keep like a talisman while there are many others I cannot reach.

Kristin Nguyen, MD
Chief Resident for Clinical Programs, UCSF Psychiatry, PGY-4



"Hi, doc," you feebly greet me. Your smile belies the pain inscribed across your face. "How are you?" I timidly ask. "Okay," you whisper. As I gently press my stethoscope to listen to your heart, I avoid the suppurating mass that envelops your chest wall, an omnipresent reminder of the breast cancer that ravages your body. "I'm scared," you suddenly interject, awakening me from my ritualized pre-rounding routine. My breath catches as I peer into your glistening eyes and see my own mortality refracted in yours—you are but a few years older than I am. I kneel and gently squeeze your hand, hoping to convey what words cannot. "Courage," I silently beseech.

Amidst the mountain of medical knowledge and physical exam maneuvers, medical school prepared me little for the emotional toll of residency training, for how illness and infirmity stalk the hospital halls. As a newly minted physician, I thought my duty was to solve the many puzzles presented to me as inchoate "histories of present illness." You reminded me, though, that there is care beyond cure, that humble listening, empathic witnessing, the laying of hands, and attending to the debility that accompanies pain can be their own healing salve.

When you pass two weeks later, I cry for the first time since starting residency. I curse the cruelty that is cancer. I think of your family's grief. And I pray that, in your life's last chapter, I helped you reclaim some dignity in the face of death.

Anand Habib, MD MPhil
UCSF PGY-2, Internal Medicine

My patient's health deteriorated within a week. At the beginning, I saw photos of who my patient was before her current illness. She recently turned 15 and had just celebrated her quinceñera. Her mother showed me numerous photos that emanated joy, an alternate reality from this ICU room.

Several days later, the oncology fellow and child life specialist told this patient that she was going to die. I was so impressed by their supportive yet truthful words: "We are going to do everything to make you comfortable" and "you are not alone." While at the bedside, I could not bring myself to speak. I simply held our patient's thin hand.

Later that evening, the patient's three siblings came to say goodbye. I explained what was happening. By the time I told them that the patient was not going home, I paused. Without fail, tears fell and crying ensued. I watched the youngest sister, who was meek and pudgy at 11-years old, cover her face with her hoodie. I could see her breaking into despair. That moment broke me. How could life be so cruel to her? She had lost her father previously, and now her sister. How much pain can a child take?

My patient died two days later with her family. I remember her, her sister, and her family who taught me that my care in one patient is often inextricably intertwined with others, whose lives are also at their most vulnerable state. Our care has unknownable ripples.

Greta Solinap Peng, MD
UCSF Child Neurology Resident Physician, PGY-2

As the nurse prepared the skin biopsy tray, Mr. A and I chatted about the current state of the world. He explained how trying the last year had been – the immense impact his skin disease had on his quality of life, the isolation from loved ones as he resided in an assisted living facility during the pandemic, and the profound sadness caused by the recent and continuous episodes of police brutality and killings of Black Americans.

He went on to tell about his near 100-year experience of being a Black man on this earth. He spoke about growing up in 1930's Alabama where he had to step off the sidewalk and into the street if a white woman was approaching, how he ate his meals on the outdoor porch of his white friend's home rather than having a seat at the table, how he served as a member of a Black battalion during World War II, but failed to garner the same honors as his white counterparts.

As I placed the final suture to conclude the biopsy, I thanked Mr. A for sharing these painful memories. I thanked him for his service to this nation, one that has failed him too many times. I have never experienced what he has nor can I ever fully understand—I recognize the privilege that accompanies being white and male. And I know we can do so much better. That day I vowed to make sure his life story would never be forgotten.

Daniel Klufas, MD
UCSF Dermatology Resident, PGY-4

Showing Up

"G" was a veteran in my Thursday longitudinal clinic at the SFVA, which specializes in treating co-morbid psychiatric illness and substance use. I dreaded every Thursday, frantically rounding and finishing my notes by noon, almost choking on my lunch, then driving embarrassingly fast down Lincoln Ave to make it to Land's End by 1pm. The Thursday that I met G, I showed up in my typically flustered, Thursday best. G showed up, bearded, his sleeve tattoo peeking beyond his right cuff, looking at me with desperation and guardedness behind his brown eyes. G presented with an intimidating bouquet of PTSD, bipolar disorder, alcohol use disorder, and cannabis use disorder. I wringed my hands, wet with anxiety as he looked at me intently, "What are we going to do, Dr. Alcid?" Honestly, no clue.

When G terminated treatment with me, his symptoms were stable, and his substance use was in remission. He repaired relationships with family. He found a steady job. He had a romantic partner, his first in years. Recently, we had discussed issues with supervisors and romantic partners, topics that are universal to the human experience but are de-prioritized for the emotionally unwell, who are trying to survive the day without relapse, or self-harm, or both. He used to tell me contradicting statements often made in the throes of addiction: "I'm fine," and "I might become homeless." In thinking about G and his remarkable recovery, I cannot help but laugh at the elegance of what helped him the most. Just show up. Show up even though he is intoxicated. Show up even when he has disappeared for 3 months and I fear the worst. Show up when he's ready to quit drinking. Show up when he tells me, "Dr. Alcid, I found a job" and "Dr. Alcid, I have a girlfriend." And finally, show up when he says "goodbye," and "thank you."

So, what did I do for G beyond just showing up? Honestly, no clue.

Eric Alcid, MD, PhD
Chief Resident for LPPHC, UCSF Psychiatry

RESOURCE CORNER: cotinued from page 17

SURVEY FINDS HEALTH CARE WORKERS ARE BURNING OUT

Health care providers, on the frontline of the COVID-19 pandemic, are burning out in large numbers.

That's the finding of a recent survey conducted by the California Health Care Foundation, which surveyed 1,202 health providers from Jan. 4-14.

Half, 50%, of providers are frustrated at their job, while 57% say they are overworked, 59% say they are burned out and 68% say they are emotionally drained as a result of the pandemic. All of these numbers are either the same or higher than when the last survey was conducted in September.

A majority, 85%, of providers said that they either have already received the COVID-19 vaccine or are planning to do so. But tellingly, just 62% expressed some level of confidence that the vaccine will be widely distributed — down from 75% in September.

High levels of providers, 45%, report that they are still reusing personal protective equipment, while 39% say that they do not have enough medical-grade N95 masks to go around. Just under half, 48%, said that there are not enough beds available, while 44% said there are not enough staff to handle the current COVID-19 levels.

"California's health care providers are under strain and fed up," Kristof Stremikis, director of Market Analysis and Insight at the California Health Care Foundation, said in a statement. "Too many report that they still lack basic supplies, and we're seeing rising levels of burnout and exhaustion. And providers are increasingly frustrated with the public for not doing their part to save lives."

IT'S NOT TOO LATE: A DOZEN IMPORTANT TOPICS TOO OFTEN NEGLECTED IN MEDICAL TRAINING

Philip R. Lee, MD, Steve Heilig, MPH, and Gordon Fung, MD, PhD

Note: In honor of the late Phil Lee, MD, UCSF Chancellor Emeritus and so much more, who died recently (his obituary appeared in our last issue), we are reprinting this article he co-authored for us years ago. There have been varying degrees of advances regarding some of these topics; but in any event it is a list worth keeping in mind as medical education evolves with the times. We know UCSF is a leader in this regard and in at least some way we can all thank Phil for that.

Medical Education is filled with important topics, and as knowledge increases, it is ever more difficult to "triage" what is most essential. Thus it is problematic to suggest that even more be taught in those finite years of formal medical education. However, there is also much evidence that historically, some important topics have been too often neglected. What follows is a somewhat subjective list—but one based upon research, reports and experience.

1. ADDICTION: The AMA long ago called drug abuse our nation's number one public health problem, and our opioid abuse epidemic sadly seems to confirm that. The addicted are not just the stereotypical street junkie, but everyday patients misusing legal drugs such as alcohol, tobacco, and prescription medications. Co-diagnoses of depression and other psychiatric issues are also often neglected. Many MDs are not very knowledgeable about addiction and are uncomfortable addressing it.

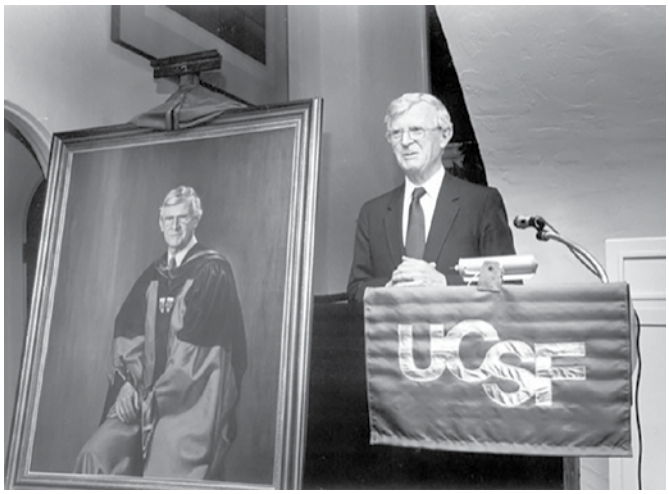
2. NUTRITION AND COMPLEMENTARY THERAPIES: Many patients can benefit from improvements in what they eat, and many utilize nutritional supplements and other "alternative" or "complementary" approaches most physicians know little about —and patients often suspect that. Physicians should become informed about and counsel their patients regarding nutrition.

3. SEXUALITY: How comfortable is the average MD in talking about sexual practices and health? Homosexuality? Sexual dysfunction? Sexually transmitted infections? Contraception? Taking the time to delve into the "uncomfortable" realms of sexuality can not only strengthen rapport but will allow an MD to address specific health needs that tend to go unrecognized.

4. PAIN: Pain, particularly chronic pain, is often under-treated in this country, particularly toward the end of life. On the reverse side of the equation is the epidemic of prescription drug abuse, which often requires a delicate balance of needs. Much improvement in measuring and treating pain has taken place in recent years; more physicians need to become current on such skills.

5. END-OF-LIFE CARE: Medicine is not only about "cure," but also about caring for patients when that is no longer an option. Palliative care is a growing discipline with great rewards. Physicians need to know how to help ease patients (and their loved ones) into a palliative mode, to use therapies and medications in optimal ways as death approaches, and to work with skilled hospice and other such professionals.

6. PHYSICAL FITNESS: We all know exercise is good. Our bodies are built to be used vigorously. But too many people are sedentary, which is reflected in our nation's obesity problem. How many MDs are able to effectively address and motivate patients towards fitness and weight loss?



7. MEDICAL ETHICS: Ethical questions are common in clinical practice. Hospitals are required to have an ethics committee to address ethical issues. But ethics education varies widely in quality, and as with other clinical skills many MDs need training about current ethical standards and practice.

8. VIOLENCE: We unfortunately live in a violent world. Anyone who has spent much time in an emergency department knows that, but most violence is more concealed. "Domestic" or partner violence is endemic in our society. And it too often goes unrecognized, untreated, and unreported. Physicians need to learn optimal methods of recognizing and treating intimate/partner abuse.

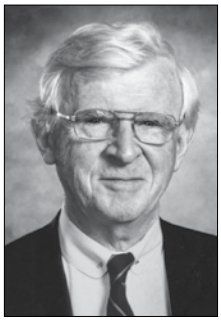
9. ENVIRONMENTAL HEALTH: Our environment affects our health in many ways. Knowledge is rapidly growing about the impact of pollution, chemicals, and the "built environment" on our health, and an "environmental history" may become a part of good clinical assessment—particularly for children, who may be more severely impacted. Physicians have the unique opportunity to link personal and environmental status.

10. HEALTH POLICY: Clinicians may wish that their practices exist in social vacuums, but decisions made in legislative arenas impact clinical problems. Public health and prevention have long been neglected factors in medical education and practice. Yet physicians have high credibility among the public and legislators, and that prestige is heightened when a respected clinician speaks.

11. THE "BUSINESS" OF MEDICINE: Physicians are often not taught much about how to run a medical practice, or at least about the financial side of medicine. Depending on what type of practice environment a doctor works in, this is more or less important, but all should know about managing a practice, health insurance, managed care, and so on, including details of the "medical market" where one intends to practice.

12. YOUR OWN WELL-BEING: Physicians can be at elevated risk for depression, substance abuse, and even suicide. Frustration in meeting expectations both external and internal, stress, and the challenge of leading a balanced life are common problems. Combine that with a reluctance to show or share such problems, let alone seek assistance, and many physicians may struggle with an unrewarding life and career. Physicians need to be aware of resources available to address their needs, able to define and maintain priorities, and recognize the numerous daily rewards that are unique to the medical profession—because there are indeed many!

Again, there are resources to help clinicians become adept in addressing all these issues (as needed) as you practice and continue to learn; we wish you a most rewarding career.-||



Philip R. Lee, MD, 1924-2020 was Chancellor Emeritus of UCSF, former United States Assistant Secretary of Health, and Professor Emeritus at both UCSF and Stanford. Steve Heilig is Director of Public Health and Education for the San Francisco Marin Medical Society, and Co-editor of the Cambridge Quarterly of Healthcare Ethics. Gordon Fung is Professor of Medicine at UCSF and Editor of San Francisco Marin Medicine.

ALLYSHIP WITH NATURE AS A PATH TOWARD COLLECTIVE HEALING

Anna O'Malley, MD

Much is on my heart as a person of medicine at this planetary moment. Perhaps this is true for for you, too. Navigating pandemic illness superimposed on epidemic chronic disease inflamed by rampant socioeconomic disparities while facing into existential peril, maybe even extinction, on a planet changing due to the human actions; it is much to bear. As a family physician—caring for patients within the context of their families, their communities, their ecologies in the home and the world—these realities come into the room while caring for my patients. I imagine you can relate.

While we do our best to counsel, guide, support, diagnose and treat, so many of our efforts are directed at mopping up the downstream effects of anthropogenic forces impacting our human beings in ways for which we are simply not evolved. Environmental pollutants, chemicals in processed foods and industrial agriculture, toxic stress of all kinds including racism and socioeconomic inequality, social isolation and loneliness, estrangement from the natural rhythms and cycles to which our bodies respond, all drive dysregulated immune responses and create systemic inflammation, the final common pathway of so many chronic diseases,[1,2] as well as risk of mortality from COVID-19. These anthropogenic ravages are costly in many ways, leading to premature mortality and diminished quality of life. Treating complex conditions experienced by complex human beings at a dangerously fast pace in a fractured system contributes to our epidemic physician burnout, not to mention medical error. Further, our heroic allopathic efforts to intervene have a heavy ecological toll; in the United States, 8% of carbon dioxide emissions are attributed to the medical system.[3]

Reflecting on the complexity of the challenge and the limitations of our current approach, questions arise. How do we in medicine respond, and lead, in this planetary moment? As we recognize the imperative to evolve our practice to that which is less ecologically harmful, what opportunities for innovative approaches would allow us to support our patients and communities to be optimally healthy and resilient in these challenging times? (Surely of just as great ecological importance as greening our hospitals is reducing the demand for such resource-intensive interventions.) How can we make meaningful strides in addressing the structural root causes of physician burnout (hint-it's not lack of meditation practice)? Are there emergent models of practice that could satisfy a "quintuple aim," adding ecological non-maleficence to the enhancement of patient experience, improvement in population health, reduction in cost and improved work life of healthcare providers and staff?

Core to the practice of good medicine is deep listening. On a societal level, healing of various traumas and wounds will only come with deep listening. On an ecological level, only when we attune ourselves and "listen" to the profound wisdom of nature will be truly be able to turn toward a regenerative, sustainable future on a planet with intact life-supporting ecosystems. What, then, does nature have to say to medicine?

A lot, actually. Fortunately for those of us most at-home with the language of science, many aspects of the way nature communicates with humans has been translated for us in peer-reviewed journals. What emerges in study after study is intriguingly relevant in addressing physiological and psychological ravages of living in our post-industrial, consumerist society. Practically every measurable outcome, from blood pressure and depression to immune function and experience of pain, is improved with time in nature. While the mechanisms by which this happens are complex, nature (be it time in the forest, exposure to natural beauty, taking in the myriad phytochemicals found in and transpired by plants) opposes the anthropogenic drivers of chronic disease by mediating the immune response, dampening inflammation, and decreasing the chronic stress response and "allostatic load" and the subsequent physiologic changes that follow.[4] As physicians, we are acculturated to positing questions about "dose" and "response," which are important. However, listening further moves us beyond anthropocentricity and opens possibilities for therapeutic reciprocity, which on a societal level brings us closer to the evolution required to achieve healing. This is about more than "what nature can do for us"; healing of upstream drivers of disease will require a substantial shift in

human behavior and what we value in society. Nature supports healing relationship building with ourselves, each other, and, importantly, with nature her-(non-binary) self.

Consider these examples from the literature: being in nature quiets the materialistic impulses to consume.[5] The extent to which one is moved by beauty in nature affects the degree to which he or she will experience health benefit.[6] The more one spends time in nature the more moved one is to care about and act on environmental issues.[7] Being in nature supports prosocial human capacities of connection, helpfulness and empathy.[8] People living in neighborhoods proximate to green space in the same urban, under-resourced housing development as neighbors without grass and trees nearby were, among other beneficial things, much less likely to experience violent crime and more likely to have better health.[9] In nature, we are supported in connecting with meaning, and the profound perspective that comes with understanding the smallness of self in the face of the infinite. And so much more. At a moment at which so many challenges are converging on humanity and all beings on this planet, nature emerges as a powerful ally in healing on so many levels.

How can medicine be in allyship, in supportive and reciprocal relationship, with the natural world, rather than the outmoded commodifying, anthropocentric, extractive way that is a hallmark of our modern society? Being an ally requires examining our power and privilege, our biases and unchecked assumptions, the ways we inadvertently do harm, and the forces that shape all of the above. It also invites examining the existing structures in which we operate, designed to achieve some results while making others more difficult, as well as visioning alternative paradigms, partnerships, and practice settings that get people-physician and patient alike-reconnected to the natural world. Bringing awareness to the biases implicit in our medical education and training opens the door to the humility and grace that comes with recognizing the tremendous non-pharmacologic healing forces with which we can align our efforts.

This is deeply personal. Perhaps you, too, feel the weight of being complicit in a system that is depleting, which squanders the precious resource which is the dedicated healer within medicine, does violence to vulnerable patients in rushing them through complex landscapes, and does harm to our imperiled planet. While an "n of one," nature has been essential in keeping this at risk (female, mother, primary care) physician from burning out.

As is so often the case, moments of crisis allow innovation to emerge. Outdoors, clearly the best place to be around others in a pandemic, may well also be a practice setting to explore, beyond the pandemic. In my collaborative work between the FQHC in which I practice and the land-based non-profit program I direct, there are abundant opportunities to draw connections between the health of the soil, the food we grow, and our bodies, and to explore alternative models for patient and community engagement. We convene twice monthly "Community Medicine Circles" (now on Zoom), exploring how to bring one's body into balance from an integrative and ecological perspective. From this ground of deeply informed dialogue, shared decision making about treatments, prescribing and deprescribing can be made with a mutual commitment to minimize harm and support the wellbeing of all life, not just human. Making health something we do together, in community with nature, takes pressure off of the beleaguered health care system and providers therein. It also brings deeply meaningful joy.-||

Anna O'Malley is a family and community medicine physician in West Marin, and the founder and director of Natura Institute for Ecology and Medicine, located in the Commonweal Garden in Bolinas. She graduated from the Medical College of Wisconsin in Milwaukee, Wisconsin, and completed her residency training at UCSF. She was certified in Integrative Medicine in 2010 upon completion of the University of Arizona's Program in Integrative Medicine.

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THE GLARING GAP IN CHEMICAL SAFETY TESTING

William H. Goodson III, MD and Shanaz Dairkee, PhD

Not many of us would advise a patient to take aspirin, ibuprofen, and clopidogrel at the same time. In combination, these chemicals – and all drugs are just chemicals with identified clinical uses – interact such that the effect of the combination is much greater than the effect of the chemicals individually. Adverse effects are anticipated if these three drugs are taken simultaneously.

Most of us wouldn't personally consider taking three antiplatelet drugs simultaneously. However, every day, each of us is exposed to mixtures of chemicals, and there is no reason to expect that these mixed environmental chemicals won't also interact in ways that exceed the effects of the individual chemicals. Yet, almost all research by the FDA, IARC, etc. has either studied chemicals individually - or dry labbed the effects of mixtures by assuming that the combined effects of the component chemicals can be calculated in silico, i.e., by computer, from the observed effects of individual chemicals.

In 2015, the Halifax Project proposed the Low-Dose Mixtures Hypothesis of Carcinogenesis. Behind this hypothesis was an international group of 168 specialists in Hallmarks of Cancer who reviewed published data on how a variety of supposedly safe chemicals affected different Hallmarks of Cancer, with the specification that reviewed chemicals were not considered carcinogens. The group found published research supporting concern that mixtures of low concentrations of supposedly safe chemicals might activate individual Hallmarks of Cancer (one or more Hallmark by each chemical) such that the mixture of supposedly safe chemicals might activate all Hallmarks and function, in combination, as a virtual carcinogen.

At the California Pacific Medical Center Research Institute, we have measured the effects of chemical mixtures on non-malignant, human breast epithelial cells. For example, we measured effects of three common chemicals of commerce (methylparaben = MP; bisphenol-a = BPA; Perflurooctanoic acid = PFOA) on S-phase as a marker of cell growth rate (1). In the figure, the y-axis is S-phase expressed as the number of times control (1 is the same as control S-phase, 2 is twice control, 3 is thrice control, etc.). On the x-axis the Intermediate doses[1] are levels measured in humans. Low (L) doses are one tenth of Intermediate. High (H) doses are 10 times Intermediate. As anticipated, the mixture caused higher S-phase.

More important, however, mixtures of chemicals behaved like they were present at ten-times higher concentrations. A mix of Low doses of the three chemicals cause increased S-phase equal to any of the individual three chemicals at the ten-times higher Intermediate dose (left arrow in figure). Similarly, a mix of chemicals at the Intermediate dose was equal to any of the three chemicals at a ten-times higher, High dose (right arrow).

The next frontier is whether new effects occur after exposure to mixtures. Do we just see more of the same? Or, do mixtures cause unique effects, not seen after exposure to any of the individual chemicals alone.

Available research indicates that unique effects occur after exposure to chemical mixtures. The founders of the Halifax Project, Drs. Leroy Lowe, David Carpenter, and Michael Gilbertson, and I reviewed the literature of empirical observations of actual mixtures[2]. There was a worrying paucity of research using chemical mixtures. However, eight papers reported that mixtures of chemicals caused effects not observed after exposure to the component chemicals alone. Such unique effects of mixtures are missed when researchers dry lab results.

Safety data concerning chemical mixtures is clearly insufficient, and providing scientific advice is nearly impossible. However, every time we avoid one chemical we reduce the complexity of the mixture to which our bodies must adjust. My personal choices for 2021 are to limit my intake of residues of agricultural chemicals and to avoid the chemicals used for scents in personal care products.

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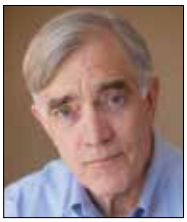

William H. Goodson III, MD is past President of the San Francisco Medical Society, former Professor of Surgery at University of California San Francisco, a Senior Scientist at the California Pacific Medical Center Research Institute, and a practicing physician in San Francisco.

Shanaz Dairkee, PhD is a Senior Scientist at the California Pacific Medical Center Research Institute and a member of the California Proposition Assessment Committee.

TIME TO WAKE UP TO THREAT OF CLIMATE CHANGE, AND TO ACT

Sarah Schear, MS, MS-4

As pediatricians and trainees, we have all experienced moral awakenings that have compelled us to take action to protect children. As I step outside each day in San Francisco during the pandemic, putting on my mask reminds me of a time of moral awakening: the fall of 2018, when the Camp Fire raged through Paradise, California. I remember the sharp smell of smoke seeping through my apartment windows in San Francisco and wearing an N95 mask as I walked through haze to and from the labor and delivery unit for my OB-GYN rotation. It felt so wrong to me that the babies born in that unit would soon breathe such air. And now, wildfires rage again in the West, darkening the skies and threatening our respiratory health.

Back in 2018, I had only started to grasp the link between climate change and the worsening wildfires in California. Earlier that year, monsoon flooding displaced a million people in the state of Kerala, India, where I had done research in a community-based palliative care organization. The gut punch of considering the patients with serious illness I had met and the care teams I had interviewed being displaced from their homes and workplaces was too much. I finally sat down and read about climate change.

"With so much at stake for child health and equity, climate change demands a moral awakening in us as pediatricians and trainees."

The justice implications of what I read pierced me: Of all nations, the United States has emitted the most planet-warming carbon dioxide into the atmosphere — predominantly driven by the wealthiest Americans — while island nations and largely Black and brown communities around the world and in our own country bear the worst health impacts, from heat waves and air pollution, to (un)natural disasters and changing patterns of infectious disease. As I read, I realized that the many issues I already cared deeply about as a medical student — from human rights and child health, to building more just and compassionate care systems for marginalized patients — were irrevocably linked to climate change.

The Lancet Countdown, an annual tracker of the health implications and solutions to climate change, reported in 2019 that "the life of every child born today will be profoundly affected by climate change. Without accelerated intervention, this new era will come to define the health of people at every stage of their lives." With so much at stake for child health and equity, climate change demands a moral awakening in us as pediatricians and trainees. Thankfully, we have a special role to play, since many of our own teen and young adult patients are leading the movement. Youth across the United States and globally are spearheading activism to tackle climate change in an intersectional manner that focuses on racial and economic justice. Pediatricians have a uniquely powerful voice to lend to their movement, as guardians of children's health and spokespeople for how social and structural problems manifest in poor child health. Indeed, the AAP has issued a policy statement reviewing the serious implications of climate change for child health and offers resources for members who want to speak out. What's more, our presence as health professionals in solidarity with youth climate activists is also meaningful to them.

During a youth-led rally in San Francisco last fall, an acquaintance approached me and said: "Seeing the doctors here makes me feel safer. It gives me hope." We still have time to make a difference, if we act swiftly. According to the global scientific consensus of the United Nations Intergovernmental Panel on Climate Change, the coming decade is our critical window to prevent the worst impacts of climate change, which are expected to persist for many generations. The policies and technologies needed to address climate change are becoming broadly available and increasingly understood. We just have to fight for them.

Physicians are among the most publicly trusted professionals, and our voices truly can make a difference on climate change. We can write op-eds to explain how ambitious climate policy is vital to providing safe health care, achieving racial justice, and protecting the health of children. We can connect with local youth and environmental organizations and lend a medical voice to their advocacy by giving public comment at local hearings on issues from air quality to the importance of

green, energy-efficient buildings. And in our own health systems, which account for nearly 8% of U.S. emissions, we can identify and cut pollutants, including by sourcing more plant-based foods and minimizing waste. In this critical election season, when the candidates we elect hold the future of our climate in their hands, we can show up to town halls and ask the vital questions from the AAP's 2020 Vote Kids campaign. And in our care of patients, we can use resources like The Voice Project and Vote Kids to incorporate a question on civic engagement into our adolescent visits and to help our eligible patients register to vote. We can start small by talking more with our families, friends, and colleagues about climate change. Most Americans care about climate change, but few hear it discussed regularly. Talking is foundational to movement building. Through sharing openly, we can help each other and our patients channel fears into meaningful action.

I used to feel helpless when I thought about climate change, but now I see the faces of the youth climate activists I've marched beside. I hear the words of my colleagues advocating to our leaders and the public. I feel courage, rooted in the youth-led movement that is building for a just and healthy climate future — a movement in which there is a role and need for each of us.-‖

Sarah Schear, MS, is a UCSF medical student and UC Carbon Neutrality Initiative Fellow for 2021 focused on UCSF Health Engagement. She is co-chair of the American Academy of Pediatrics, California Chapter 1 Task Force on Climate Change and Health. This was originally posted on the AAP Voices blog, and in the UCSF student newspaper, the Synapse.

PANDEMIC MOMENTS

CATCHING UP

Jeff Newman, MD, MPH

Sorry to bother you. I have two reasons for the call. It was so great to see you at the Medical Society dinner last year. I'm so sad. Who knows when we will all get together again!

I feel the same way. Am so busy with the patients and research. And family of course. Miss you and the rest of the crowd.

The other reason is that our shared patient is having a lot of problems with the study treatment you have her on. She respects you so much that she'd like to tough it out. But the new symptoms seem to be from the treatment.

While I'm not surprised to hear this, I would like her to come in see me so we can carry out the protocol procedures.

I have encouraged her to do this. She called your office, and was told she needed to come in. But it's a long haul for her, and she's financially strapped. She wants me to give her permission to just stop.

Well, thanks for letting me know. I'll reach out to her.

Ok, thanks for understanding. But I would also like catch up when convenient. Maybe we could schedule a call some evening over a glass of wine.

…

Am glad our assistants were able to work out this time. So, what are you drinking?

I liked the wine we shared at our last dinner together. It has put me in the mood!

Isn't that funny! I'm having it also. Feels like we're on the same wavelength.

I keep hearing about all the isolation and loneliness from the pandemic, but that's not what I'm feeling. So much patient and family time. But I still miss connecting with colleagues and friends. Don't even stop to talk much with neighbors on my daily walks.

Yes, my patients and staff want me to understand what they're going through. And I try my best. But as this all drags on, it's taking a toll on me too. My family says I'm giving it all to my patients, and not saving enough for them.

That's a problem for me too. Being forced together at home has us on edge.

I'm a film devotee, so catching up on lots of old ones - you know, the classics. Can't interest the kids though.

I tried re-reading The Plague by Camus. We read it for a seminar in Med School. But it wasn't as good without the discussion.

There's a new translation coming out soon. *(https://www.capstan.be/new-english-version-of-camus-the-plague-during-covid-19-how-historical-context-can-affect-translation/)*
Maybe we could read that together.

How much longer do you think this will go on?

My prediction is that it will continue to feel like it's lasting forever, but afterwards it will seem like it wasn't that long.

Do your patients and family let you get away with that?

Jeff Newman MD, MPH is Adjunct Professor in the UCSF Institute for Health & Aging, and Co-Director of the SF Palliative Work Group. He looks forward to writing post-pandemic stories.

MANAGING YOUR MANAGER

Debra Phairas

Physicians find it challenging to supervise practice managers as they often fail to adequately assess their abilities during the initial hiring process. As a result, many physicians engage the help of consultants when recruiting and hiring for this position.

"Managing is like holding a dove in your hand. Squeeze too hard and you kill it, not hard enough and it flies away."
—Tommy Lasorda

Traits of an Effective Manager

An effective manager is a leader; someone who has the capacity to monitor the various facets of managing a practice. This person:

- **Should possess a sound understanding of practice operations,**
- **Must be driven to accomplish practice goals and**
- **Must have a vision.**

In addition to these attributes, an effective manager is an excellent **relationship builder and communicator:** one who can facilitate information exchange and partnerships throughout all facets of the practice.

While managers cannot be expected to be adept in all the areas they manage, they should be able to lead the team to perform optimally, while creating a cohesive work environment.

Hence the most important attribute of a good manager is being a good leader: someone who inspires the team to perform to their fullest.

Hire the Best!

Good managers must have managerial talent, mutually respectful staff relationships and the ability to "manage up" effectively with their physicians. A skilled and effective manager can "pay" for their salary many times over by saving or making the practice money, so invest wisely.

Often, practice managers start in other areas of a practice, such as in the clinic, in billing or at the front desk. Some practices have successfully promoted individuals from within the organization into management positions, while others have not. This is called "The Peter Principle" or rising to the level of highest incompetence. For this reason, careful consideration and evaluation of the potential candidate and their skills must be made. Furthermore, reevaluation of practice needs must be made periodically, as growth occurs. In some instances, a practice manager will be successful when the practice is small but will fail to grow or increase skill levels with the practice.

Compensate Accordingly

Don't be pound-foolish. Survey local practices of similar size for salary ranges, and access industry-specific salary survey comparables that break down administrator/manager salary ranges by size of practice, revenues and other factors. www.salary.com and www.mgma.com are resources.

Set Expectations

Before hiring a candidate, set specific expectations and boundaries.

Determine the areas of the practice that you want to be involved with and the responsibilities and authority completely delegated to the manager. For example, many physicians completely delegate human resources and operational issues to the manager but remain involved in other areas such as strategic planning, considering a new provider, opening/closing offices, marketing, web site content, equipment purchases, EHR, and other IT decisions.

Expectations for work hours, demeanor, behavior and dress should be clearly defined in writing. They should include such requests as:

- Greeting staff members each morning.
- Team huddles to build relationships with staff and to plan the day.
- Monthly or quarterly meetings to proactively manage the practice.

Define Success

Frequently managers perceive a lack of realization or attention to their accomplishments.

It is imperative that physician owners set time-defined objectives, which meet owner needs and challenge the manager and track progress. Both the physician and the administrator must agree on ideally quarterly goals/objectives for the practice or the manager's professional growth in writing. This document will become the outline of goals for their annual performance review.

Provide Professional Tools

Most managers cannot directly supervise more than eight staff members effectively. Therefore, a front office, clinical or billing supervisor may be necessary to support the practice manager and avoid burnout. It is important that the owner/physician provide this support and encourage the manager's professional development as well.

Continuing education courses keep the manager's skills

sharp, just as CME helps increase a physician's knowledge. Encourage your administrator to join Medical Group Management Association, (MGMA) or your medical specialty society administrator organization and attend the joint meetings. Encourage the manager to seek out other professional opportunities that may become available locally, state or nationally.

Develop Working Partnerships

Managers should be treated like non-owner partners in the organization and should fully participate in all owner meetings, including annual strategic planning meetings.

All projects should have target dates, checkpoints to monitor progress and periodic updates in between. Utilize tools such as Microsoft Outlook, which has a task feature to assign and track tasks, set deadlines and requests for updates.

Create a Collaborative Culture

Remember, as physicians, you set the culture of the practice. Don't let actions speak louder than words.

If you want your manager to build a cohesive team, look to build a cohesive team with your manager and other staff members.

Provide Positive Feedback

Reward your manager with sincere thanks, praise and creative perks such as:

- Spa day.
- Sports tickets.
- Extra time off.
- A monetary bonus.
- Gifts that you know the manager will appreciate.

A personally planned, thoughtful way of expressing appreciation often means more to your manager than just a bonus. Even a note of thanks is appreciated.

Encourage Team Spirit

It's important to remember, a manager is not just a task master. He or she is also a team builder and a leader.

Set goals for quarterly team building/morale events or hold periodic contests with various themes such as the "best idea" that increases revenue or reduces expenses.

Assess Performance Regularly

If you have clearly outlined your goals in written form, it is simple to transition this document into a performance review checklist and ascertain progress in terms of how goals are being accomplished and if timelines are in order.

It is important to assess relationship and team building efforts as part of the evaluation process. **Acquiring feedback from employees is one way to assess these attributes.** This is called a 360-degree review.

This is accomplished by asking staff to evaluate management abilities anonymously via a web site–based survey such as www.surveymonkey.com or www.formsite.com. This survey will provide the physician(s) with information regarding strengths and improvements from the staff's perspective. However, keep in mind that poor performers may use this as a method to get even, so watch for ratings that are out of line with the norm and eliminate them. The survey should be structured to measure both strengths and weakness in a constructive manner.

The annual performance review should start with positive performance areas first, then "sandwich" in constructive feedback to avoid defensiveness. End with positive praise for tasks/projects well done.

The manager should leave the discussion feeling positive and ready to tackle areas where improvements are needed.

Cross-Train

Too many physicians will not discipline or fire managers because they are the only person trained to accomplish most administrative tasks. This is holding the practice hostage and not recommended.

Insist that the manager train another staff person to perform certain tasks such as accounts payable. This will minimize embezzlement exposure and enable the organization to function in the absence of the manager if necessary.

Read Financial Reports

Anticipatory budgets should be prepared by the third quarter of each year by the manager. Financial reports to be shared with owners should be ready no later than one week after the close of the month. These reports should include the following:

- Dashboard report with key highlights.
- Profit/Loss report and MD productivity report.
- Your medical specialty benchmarks:
  - > A/R Aging, Turnover, Gross and Adjusted Collection percentage.
  - > Staffing Ratios, Staff wage percentage to collections and Full Time Equivalents.
  - > Recommendations for overhead expense ratios.

When purchases or contracts are involved, managers should prepare cost-benefit analysis for physician meetings and give three top ranked recommendations.

Say Goodbye

If the manager is not able to function or perform on the level communicated clearly during the interview process after numerous discussions and attempts to correct the situation, it may be time to consider cutting your losses.

If a decision is made to terminate employment, documentation of performance deficiencies via performance reviews and written warnings is essential to protect the practice.

Obtain legal advice if there has been little or poor documentation of substandard performance to avoid legal difficulties.

An attorney can suggest severance pay amounts based on length of service. These are usually conditional upon waiving the right to sue.

Debra Phairas is the president of Practice & Liability Consultants and has over 35 years of healthcare administration and consulting experience. www.practiceconsultants.net.

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Health Update for SF Providers: COVID-19 Vaccine Access and Allocation

February 4, 2021

The following information is issued on behalf of SF COVID Command

Situation

On 1/22/2021 the California Department of Public Health (CDPH) issued Revised Allocation Guidelines for COVID-19 Vaccine to include all Phase 1a healthcare workers plus adults age 65 years and older, and further prioritizing those over 75 years of age due to limited supply.

SF COVID Command, which is a collaboration between the San Francisco Department of Public Health (SFDPH) and several other City departments, continues to follow the CDPH vaccine allocation guidance.

The current supply of COVID-19 vaccine allotted to SF is still very limited and supply may remain insufficient to meet demand for several more months.

Further, we note that SF COVID Command has allocation control over just a portion of the vaccine coming into SF; most doses are allocated directly by CDPH to several large, multi-county health systems (University of California, Dignity, Kaiser, and Sutter) without prior review by SF COVID Command or SFDPH, and those systems in turn apportion their supply to local facilities within their systems.

Please see below for several other important updates.

SF Providers Approved or Enrolling as COVID-19 Vaccination Providers

CDPH decommissioned COVID-Readi and replaced it with **CalVax** (soon to be renamed **MyCAVax**) as the enrollment and ordering system for providers seeking to administer COVID-19 vaccine.

Updated information and links are posted by SF COVID Command at www.sfcdcp.org/covidvax-getready. In addition, CDPH maintains FAQs for vaccine providers at https://eziz.org/covid/.

- Note: recently, the State indicated it will take a greater role in coordinating with local health departments and providers. We will continue to adapt to the quickly changing landscape and aim to keep healthcare providers informed. In the coming weeks providers may receive additional direction from the State, rather than from SF COVID Command or SFDPH.

Meanwhile, due to the very limited amount of vaccine available to our county and under the allocation control of SF COVID Command, we regret that SF COVID Command is able to allocate vaccine to only a **subset** of CalVax-approved SF healthcare providers at the current time.

Providers currently approved in CalVax may submit **requests** for vaccine (referred to in the CalVax system as "orders"). However, please be aware that at the current time, due to low vaccine supply, most such requests cannot be authorized or can at best be only partially authorized by SF COVID Command.

The guiding principles of the SF COVID Command vaccine allocation strategy include a focus on equity, speed, scale, and sustainability. Given the low supply of vaccine and the unequal impact of the disease, SF COVID Command is more likely to authorize vaccination requests from sites able to:

- Administer all allocated doses quickly and to individuals in alignment with CDC and CDPH guidelines for prioritization
- Prioritize vaccine administration to communities and neighborhoods with the highest COVID prevalence, including among individuals who do not have ready access to health care
- Commit to ongoing, weekly vaccination
- Contribute to the strategy of increasing vaccine access across the city and to all San Franciscans.

SF COVID Command will continue to allocate directly to select existing partners who are vaccinating at-risk populations directed to them by SFDPH, including health systems, federally qualified health centers and community clinics.

Due to the extremely limited supply, SF COVID Command is not currently allocating to specialty clinics and is not generally recruiting additional providers to serve as vaccinators. SFDPH may directly contact select providers serving at-risk populations to invite their participation. We are also not regularly allocating to private practice primary care providers.

Vaccination Options for SF Healthcare Workers (HCW)

"Frontline" HCW (those who have the potential for direct or indirect exposure to SARS-CoV-2 through their work in any role in direct health care or long-term care settings) are classified in Phase 1a and are eligible to receive the vaccine now.

Eligible SF HCW (those living or working in SF) who cannot be vaccinated by their employer may access vaccine at other locations, listed here and updated as additional sites become available. Please note that documentation or self-certification of eligible HCW status may be required.

Eligible SF HCW who are having difficulty scheduling appointments for vaccination may email dph.doc.outpatientunit@sfdph.org to request assistance.

Vaccination Options for SF Residents Age 65 Years and Older

SF residents age 65 years and older are now eligible to receive the vaccine, per CDPH guidelines. However, with the vaccine supply severely constrained, **demand for vaccine greatly exceeds supply right now, and many or most elderly individuals will need to wait** for vaccine supply to increase in order to receive the vaccine. Given this situation, some providers and health systems are further prioritizing people age 75 years and older. Please promote patience; as vaccine supply increases, vaccination opportunities will become more robust.

Addressing the Shortage of Vaccination Slots. In coordination with the City, our larger health and hospital systems are developing several high-volume vaccination sites, which will greatly facilitate vaccination of the public. Eligible patients may now be directed to https://sf.gov/get-vaccinated-against-covid-19 to check for available vaccination locations and to schedule appointments as they become available. Other options for COVID-19 vaccination will soon include retail pharmacies (under a new federal program) plus specified community clinics and neighborhood vaccination sites.

SF providers will be able to direct the majority of their eligible elderly patients to these sites, regardless of insurance type or medical home.

MEET YOUR SFMMS STAFF

Conrad Amenta

I joined SFMMS as its Executive Director in May 2020 (choosing an extremely interesting time to do so). I've worked in organized medicine for most of my career, formerly with the California Academy of Family Physicians and the Canadian Medical Association. My work has tended to be policy- and research-oriented, with an emphasis on health information technology. I lived most of my life in Canada but moved to the Bay Area in 2016 (again, choosing an extremely interesting time to do so) after meeting the woman to whom I'm now married. Though I've worked with physicians for many years, I studied English Language and Literature in university, where I wrote my MA thesis on Kurt Vonnegut and Richard Rorty. I intended to teach and write before taking a three-month research contract at The Ottawa Hospital in 2004 and backing into a career. I'm still an avid reader and writer, and most recently, an essay I wrote about digitization in medicine resulted in my invitation to a conference on physician education in Copenhagen, Denmark. In my spare time, I like to cycle in the Berkeley Hills and take my 90-pound Flat-coated Retriever/Bernese Mountain Dog mix, Louie, hiking.

Molly Baldridge, MPH

I began my work in public health over 18 years ago, as a peer health educator for a relationship abuse prevention program at my high school's health center in Berkeley. This early exposure informed my pursuit of an undergraduate degree in Community and School Health Education from California State University, Long Beach and subsequently a Master's degree in Public Health from San Francisco State University.

Over the past 14 years, I have worked in a variety of roles that have supported initiatives, coalition building, and learning among a variety of populations that have supported communities in being healthy. Increasing access to medical services for the underserved has been the main underpinning of my public health work since the beginning of my career.

As a San Francisco Bay Area native, I have a deep passion for contributing to healthy places in a region that raised me. Before I had the language to describe inequities and social justice issues, I understood how privileged I was to have access to safe places, quality healthcare on my school campus, and a healthy neighborhood. My professional health experience and my education have helped to develop my professional philosophy that community building, education, and access are vital at ensuring the health of all communities.

As your Director of Engagement, I hope to support our amazing physician members in improving the lives of the people in San Francisco and Marin Counties by working to address the social inequities that exist in our communities. When I'm not working, I enjoy surfing in Pacifica, cooking elaborate meals for my husband, and doing as much yoga as possible.

Steve Heilig, MPH

I arrived in San Francisco in the 1980s to continue my education in public health, with the vague aim of becoming an academic epidemiologist. But HIV exploded here and I took a "temporary" job with the San Francisco Medical Society, helping coordinate the response to that pandemic. All these years later I remain here, as I learned that such a group of physicians could have a truly positive impact in many arenas. Long on a part-time basis with SFMMS, I am managing editor of San Francisco Marin Medicine and help coordinate our delegation to the CMA. I have worked at the health and environmental institute Commonweal in Marin for decades as well, and am co-editor of the Cambridge Quarterly of Healthcare Ethics, and a former director of Planned Parenthood, the San Francisco AIDS Foundation, the Zen Hospice Project, and chair the advisory board of the Chinese Community Healthcare Association, have served on the ethics committees of UCSF, San Francisco General Hospital, and California Pacific Medical Center, and on IRBs there too.

I co-founded the San Francisco End-of-Life Network and the Collaborative on Health and the Environment, was faculty on the UCSF/UC Berkeley Joint Medical Program; and at many healthcare conferences around the world, including the San Francisco Addiction Summit. I've served many organizations and individuals as a consultant in philanthropy. I was a book critic for the San Francisco Chronicle for many years and a music journalist for many other publications; plus, for fun, the head MC of a leading world music festival. Among various awards, I was most honored to be, I believe, the only non-physician recipient of the California Medical Association's annual award for service to medicine and public health. The SFMMS has been my primary organizational home for my whole career, and I am proud of that.

Ian Knox

Before joining SFMMS in 2018 and becoming Director of Operations and Governance, I had managed operations for non-profit organizations including San Francisco's only co-working space for non-profits/social enterprises, as well as an East Bay Grammy-winning music academy.

In 2006, I co-authored a book on basic political and environmental activism, *The Ten-Minute Activist: Easy Ways to Take Back the Planet*, published by Nation Books. Shortly thereafter, I decided to live and travel extensively through South America for the remainder of the decade. In a post-pandemic world, I'm looking forward to spending time exploring Portugal and Croatia.

Currently, I'm keeping busy writing/recording music, watching classic films, record shopping, taking unplanned journeys through the urban landscape, and working towards becoming a scratch handicap.

Patient Informational Handout: Answers to Your Covid Vaccine Safety Questions

As a physician, I received the COVID-19 vaccine and strongly recommend my colleagues and patients do as well!

Top Patient Concerns

I've already had COVID, so I don't need it.

Multiple strains of COVID and cases of people contracting twice.
Unknown how long natural immunity lasts.
The vaccine has proven effective against multiple known strains.

I fear it'll give me COVID/I don't understand mRNA vaccines.

Messenger (m)RNA vaccines cannot give you COVID, and do not contain a live virus.
Does not affect DNA; mRNA does not enter cell nucleus.
mRNA contains a blueprint on how to make the coronavirus spike protein. The protein is released into the body and the body then makes antibodies against it. mRNA then breaks down and is disposed of.
Analogy: Vaccine sends an email to cells with instructions to copy a small piece of the coronavirus. This action prompts our bodies to make antibodies to fight COVID-19. The email is then deleted.

Are the vaccines safe?

Most people do not have serious problems after getting vaccine.
The vaccine is expected to produce side effects, especially after 2nd dose. These can be indicators that it is working.
Arm may be sore, red, or warm to the touch. Symptoms usually go away within a week. Some people report headache, fever, fatigue, or body aches after getting vaccine. No significant safety concerns identified in clinical trials.

What about the misconception the vaccine is being used as an experiment on communities of color?

First two mRNA vaccines that received emergency FDA authorization tested in diverse group of people. About 30% of U.S. participants were Hispanic, African American, Asian, or Native American. About half were older adults. No significant safety concerns identified in these or any other groups.

I want more people to get it first.

Over 31.5 million Americans already received the vaccine, mostly physicians and other healthcare professionals.
"I recommend you get the vaccine as my colleagues and I also received it."

What about long-term data?

CDC will continue to monitor and address any rare long-term side effects. But COVID19 would be worse than vaccine.
At least 8 weeks of safety data were gathered in trials. It is extremely unusual and unlikely that side effects appear more than 8 weeks after vaccination.

The vaccine was developed too fast.

While the vaccine was developed quickly, no "corners were cut."
mRNA technology was developed in the 1990's, it is not new.
Over 70,000 Americans were part of clinical trials. The vaccines were manufactured while conducting clinical trials to speed up process, however, were still subjected to same rigorous FDA testing as all other vaccines.

I fear it will affect my pregnancy/ability to get pregnant.

The vaccine does NOT cause infertility.
Recommend enrollment in CDC's v-safe program to receive information as soon as available.

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COMMUNITY MEDICAL NEWS

Kaiser Permanente

Maria Ansari, MD

The new year is traditionally a time when people resolve to make healthy lifestyle changes often involving exercise and fitness. With the COVID-19 pandemic pushing physical activity even further to the forefront of many peoples' priorities, it's a good time to talk about the important role played by the relatively new specialty of sports medicine in helping patients pursue fitness activities with maximum gain and minimal injury.

Filling the gap between primary care and orthopedic surgery, sports medicine has seen a rapid rise in popularity, with membership in the American Medical Society for Sports Medicine growing from 400 just 20 years ago to more than 5,000 today.

Sometimes referred to as "activity medicine", the specialty has been a growing area of focus and expertise here in Kaiser Permanente's northern California region, with more than 100 fellowship-trained, sports medicine specialists currently practicing.

In addition to treating injuries, sports medicine physicians help patients optimize performance, educating them on physiology and kinesiology and helping them modify, adapt, and build base strength and flexibility to protect against injury or re-injury. Patient groups with the highest demand for sports medicine care include scholastic athletes; fitness-focused millennials; and older adults seeking to overcome the limitations of aging.

In 2019, we opened a 16,000-square-foot sports medicine facility in Mission Bay. Located close to Chase Center arena, Robert Nied, MD, medical director, Sports Medicine and orthopedic surgeon Chris Lehman, MD, serve as lead physicians for the Golden State Warriors.

Recently, clinicians from our Sports Medicine Center hosted a six-part series of virtual classes covering numerous aspects of safe and healthy exercise including diet, sleep, recovery after injury, and how to exercise safely during the pandemic. And this fall, more than a dozen Kaiser Permanente physicians collaborated in creating the Return to Sports Playbook, which presents comprehensive sport-specific guidance for youth, high school, and collegiate athletes on how to return to sports safely during the COVID-19 pandemic.

With each new generation showing increased enthusiasm for exercise and outdoor activities, it seems clear that the need for sports medicine will only continue to rise.-||

Marin Community Clinics

Melanie Thompson, DO

Marin Community Clinics, the largest Federally Qualified Health Center in Marin County, has five clinics with locations in Larkspur, Novato and San Rafael. Comprehensive health services include primary care, oral health, vision care, behavioral health, nutrition and health education, specialty care, health insurance enrollment, and referrals to specialty care. In 2019, the Clinics provided health care to 38,529 unduplicated patients, including approximately 20% without health insurance.

With over 120 medical providers (physicians, nurse practitioners, and physician assistants) and a fully integrated dental clinic, we provide over 206,000 visits annually. While there is great wealth in the county, economic disparity is jarring and contributes to health disparities among those who Marin Community Clinics serves. With the majority of our patients (95%) being low-income Marin residents and approximately two-thirds being Latinx, we saw firsthand disproportionate rates of COVID-19 infection and effects on the larger community.

A year ago, Marin Community Clinics saw all patients in person; phone calls to patients were something we did at lunch or after hours. At times, this model was a challenge in providing comprehensive care for some of our most vulnerable patients, many of whom work multiple jobs or lack transportation. For an organization without a telemedicine model, it took a pandemic and a weekend for us to do an about-face and identify ways to serve a vulnerable population. Our first week may have been a little rocky, but soon we were sitting on Zoom calls designing new workflows to provide all aspects of care. We focused on keeping an "eye" on our elderly population and not letting our pediatric population fall behind on vaccines. We spent a lot of time reviewing priority visits and developed a "phone first" model in order to gather relevant history first and then provide focused in-person visits. One silver lining was our ability to conduct more behavioral health outreach and reaching more patients utilizing telemedicine.

The implementation of respiratory clinics at Marin Community Clinics provided a way to streamline sick visits, either by phone or in person, and to provide regular COVID-19 testing. During the first surge, we implemented a drop-in testing clinic every day of the week. We have recently scaled back on drop-ins in favor of scheduled testing visits. We also held some immunization clinics. By prioritizing Well visits in specific age groups, by the end of the year our childhood immunization rates were some of the best in our region. We continue to focus efforts on primary prevention, and run outdoor Health Hubs for fresh food distribution to approximately 1,000 families weekly. We will resume health screenings and nutrition information at the Health Hubs as soon as we can safely do so. At present, Marin Community Clinics is leading one of Marin Public Health's COVID-19 vaccination clinics as well as vaccinating our own patients in accordance with the tiered system. Finding our resilience along the way throughout this pandemic, our team works diligently to carry out our mission to promote health and wellness through excellent, compassionate care for all.-||

FIRST DO NO HARM– INCLUDING TO YOURSELF

Jessie Mahoney, MD

In order to be the best healers possible for others, we have to show compassion for and take care of ourselves. This means not engaging in behaviors that can hurt us. This includes not criticizing ourselves, judging ourselves, and harshly blaming and/or shaming ourselves. It means refraining from perfectionism, and addictive substances to feel better. Doing no harm to yourself includes showing yourself grace and compassion when you are imperfect.

In 2017, the World Medical Association voted to unanimously approve an additional clause to the Hippocratic Oath that states "first do no harm." The addition reads: "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard."

In a recent coaching session with several Anesthesia Fellows, we worked on how to respond to perceived mistakes in a healthier way.

Asking the question, "What would compassion do?" is a powerful tool.

Compassion for the patient and for you. Compassion for future patients, for your colleagues, for your loved ones and family, and for the world. In the face of perceived or actual mistakes, this question can open you up to learning and growth.

"Unlike self-criticism—which asks if you're good enough, self compassion asks what's good for you."

– Kristin Neff, PhD.

"Self compassion provides us the life raft we need to navigate through tough times. By deepening self compassion, we discover untapped reserves of strength and resilience and wisdom that help us survive the storm—and we strengthen our resources to better navigate future storms."

– Shauna Shapiro, PhD, *Good Morning, I Love You*

It's a phenomenon of modern culture, and especially medicine, to be hard on oneself. We are compassionate towards others--our patients, loved ones, and colleagues, but rarely to ourselves. Showing ourselves compassion is often seen as self-indulgent in medicine. It is common to hold ourselves to unattainable expectations of perfection. When we fall short of perfection, which is inevitable, we often feel shame and sometimes are shamed by others. When we think we may have fallen short in any way as a physician, almost all physicians, ruminate and perseverate in ways that don't serve them. It's almost a universal experience to lose sleep, worry, become anxious, depressed and feel shame. Feeling shame makes it hard to learn and grow from these experiences, which is exactly what would help our future patients and us as physicians and humans the most.

In Dr. Shauna Shaprio's book, *Good Morning, I love you*, she explains that:

"Shame robs our brain of the resources it needs to respond directly to the challenging situation." "When we feel shame, the amygdala, the part of our brain that is central to memory decision-making and emotional responses, triggers a cascade of NE and cortisol chemicals that increase our cortisol level, narrow our perspective on perceived threats and inhibit our cognitive flexibility. "

"If we want to learn from our mistakes and keep from repeating them, we need a compassionate mindset, not shame."

Mindfulness and self-compassion change our neural connections. They make it easier for us to learn. When you bring a compassionate response to a difficult situation, you are more likely to be able to learn from your mistakes.

In my coaching work with a physician who is a Quality Lead in a large academic Emergency Department, she shared that it was easy for her to show compassion for her colleagues during quality case reviews, but not for herself. She almost always believes that her colleagues are smart and did their best to provide "the best care with the information they had in the moment." She sees their case reviews as learning and growth opportunities for everyone. She rarely sees case reviews as failures or anything of which anyone should be ashamed. But, when she or anyone else, has a question about her own care, she immediately turns to self-judgment and shame. "What did I do wrong?" If a patient has an unexpected outcome the question is "what did I miss?" "Did I make a mistake?" As a quality lead, she felt it was necessary to hold herself to a higher standard than her colleagues. And her experiences and beliefs are not unique. It's the culture of medicine to hold ourselves to a higher standard than our colleagues and grant others compassion that we do not show towards ourselves.

What if our quality leads modeled self-compassion, kindness and curiosity in the face of their own perceived short comings? What might change in the culture of medicine?

The following is a reflection I wrote to help physicians start to become their "own inner ally, rather than inner enemy."

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A TRADITION OF ADVOCACY FOR PHYSICIANS, PATIENTS AND THE COMMUNITY

As the only medical association to represent the entire spectrum of medical specialties and modes of practice in San Francisco and Marin, the San Francisco Marin Medical Society (SFMMS) has been a champion for community health issues since its formation in 1868. Our policymaking efforts through collaborations with state and national medical societies and political leaders, as well as articles in our award-winning journal, *San Francisco Marin Medicine*, have given us a reputation for being influential far beyond the Bay Area. The SFMMS advocacy agenda continues to focus on public health and the following areas:

ENSURING ACCESS TO CARE: With ongoing vigilant efforts to preserve programs and prevent cuts in Medi-Cal reimbursement, SFMMS leaders have long advocated that everyone should have access to quality medical care. SFMMS joined in the lawsuits to preserve the Healthy San Francisco program, an ultimately successful battle that went all the way to US Supreme Court. SFMMS advocated for, and has provided assistance to, community-based organizations including the Haight-Asbury Free Medical Clinics, San Francisco Free Clinic, Marin Community Clinics, Operation Access, and many others where members have donated medical care and treatment for the uninsured and underserved.

"The SFMMS helped save the Haight free clinic from the start, and I've been a loyal member ever since."
– David Smith, MD, Founder,
Haight-Ashbury Free Medical Clinics

ANTI-TOBACCO ADVOCACY: SFMMS was a loud voice for cracking down on tobacco promotion and use, and supported the early 1990s ban on smoking in San Francisco restaurants, a landmark policy that spread nationwide. SFMMS has also advocated for stronger protections from secondhand smoke, higher taxes on tobacco products to provide additional funding to Medi-Cal, and the removal of tobacco products from pharmacies. Recently, SFMMS has supported a ban on flavored tobacco products adopted in San Francisco and unincorporated Marin County, which is now also being considered by other Marin County municipalities.

HIV PREVENTION AND TREATMENT/HEPATITIS B: Having been among the first to push for legalized syringe exchange programs, appropriate tracking and reporting processes for clinical data, optimal funding and more – SFMMS has been at the center of advocacy for responses to the AIDS epidemic since the 1980's, including drafting several resolutions that would evolve into CMA and AMA policies, as well as statewide ballot initiatives.

SUGAR-SWEETENED BEVERAGES: SFMMS has long been on record combatting overconsumption and marketing of sugar and soda, especially to young people. To help prevent and battle obesity, diabetes, heart disease, tooth decay and other associated diseases, SFMMS endorsed the SF vs. Big Soda coalition and supported the landmark local tax on sugar-sweetened beverages, approved by voters, with revenue slated to help fund programs to prevent or reduce the consequences of consumption of sugar-sweetened beverages. These and other local efforts has led to a 2020 California bill package aimed at reducing consumption of sugar-sweetened beverages that targets soda, energy drinks, sweet teas and sports drinks.

ANTIBIOTIC RESISTANCE: SFMMS leaders have presented at national meetings and contributed to policy on antibiotic resistance, including the AMA's first statement on antibiotic overuse and agriculture.

San Francisco Marin Medical Society ▪ 415.561.0850 ▪ www.sfmms.org

SCHOOL AND TEEN HEALTH: SFMMS helped establish and staff a citywide school health education and condom program, removed questionable drug education efforts from high schools, and has worked on improving school nutritional standards.

VACCINATION ADVOCACY AND EDUCATION: In response to increased outbreaks of vaccine-preventable diseases in the Bay Area and across the state, the medical society emerged as a leader in supporting policy to increase school vaccination rates. Through education about the safety and efficacy of vaccines, and support of legislation which eliminated personal belief exemptions from required childhood vaccines, vaccination rates have increased significantly in both San Francisco and Marin. SFMMS has authored several resolutions for the CMA, including a resolution allowing minors to receive vaccines to prevent STIs without parental consent.

END-OF-LIFE CARE: SFMMS leaders have developed numerous policies and educational efforts to improve care toward the end of life, including publishing guidelines on medical futility or nonbeneficial treatment that have been widely adopted by regional health systems. SFMMS was one of the early adopters of Physician Orders for Life-Sustaining Treatment (POLST) in California and has been active in the local community coalition to ensure successful use of the form. As medical and public opinion evolved, SFMMS became neutral on the option of physician-assisted dying and advocates for physicians and patients to exercise their own judgment as part of the patient-physician relationship. SFMMS' position helped influence the CMA to also take a neutral stance, allowing for California's End of Life Option Act to be enacted in 2016.

REPRODUCTIVE HEALTH AND RIGHTS: SFMMS has been a champion of reproductive choice for women, including supporting the use of RU486 and the medical termination of pregnancy. SFMMS continues to be a state and national leader in advocating for women's reproductive health and choice, including access to all medical-indicated services.

ENVIRONMENTAL HEALTH: Among SFMMS' many environmental health efforts are establishing a nationwide educational network on scientific approaches to environmental factors in human health, and advocating for reduced exposure to mercury, lead and air pollution.

SFMMS leaders and members meet with legislators each year during the CMA's Legislative Advocacy Day as champions of health care.

GUN SAFETY/DOMESTIC VIOLENCE INTERVENTION: SFMMS has contributed to the national debate on gun safety, including ending censorship and allowing physicians to discuss gun safety with their patients. Our policies on gun safety have been adopted by the CMA and AMA. The medical society published guidelines on domestic violence screening and intervention for physicians and other clinicians which were cited in the *Journal of the American Medical Association* as one of the best such resources.

ORGAN DONATION: SFMMS has been the vanguard in seeking improved donation of organs to decrease waiting lists and deaths due to the shortage of organs through educating the public and proposing new policies regarding consent and incentives for organ donation.

DRUG POLICY AND OPIOID SAFETY: SFMMS has been a leader in exploring and advocating new and sound approaches to drug abuse, including some of the first policies regarding syringe exchange, medical cannabis, "treatment on demand" policy that supports immediate entry into drug treatment for those requesting it, and treatment instead of incarceration. SFMMS was integral in the development of CMA's landmark report on decriminalization and regulation of cannabis. In collaboration with the public health department, SFMMS has helped develop guidelines for safe opioid prescribing that have been adopted in primary care settings.

PRESERVING PHYSICIAN AUTONOMY: Working together with the CMA, SFMMS advocates for policies that protect physician autonomy and the patient/physician relationship, scope of practice and reimbursement.

PARTNERSHIPS: SFMMS works closely with many local specialty and health organizations such as the Chinese Community Health Care Association, Marin Community Clinics, Marin Department of Health and Human Services, RxSafe Marin, San Francisco Community Clinic Consortium, San Francisco Department of Public Health, and others.

San Francisco Marin Medical Society ▪ 415.561.0850 ▪ www.sfmms.org

FIRST DO NO HARM–INCLUDING TO YOURSELF

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When we honor ourselves, we also honor those who have nurtured and supported us along the way.

When you choose to focus on all that you are, instead of all that you are not, with kindness and curiosity, you plant seeds of presence, compassion, and acceptance.

When you look at a tree, you can see both its imperfections and its beauty.
Maybe it has too many branches on one side, or is bare and straggly in places, but it's perfectly itself.
You can see what's beautiful in its imperfections.

You are also perfectly imperfect.

The ocean and its mix of calmness and wildness is perfectly imperfect.
A child's toothy smile is perfectly imperfect.
The moon with its craters and bumps is perfectly imperfect.
Every human body is perfectly imperfect.
And so is every mind.

Perfectly imperfect makes you unique.
In your uniqueness, lies your strength.

Below are some perspectives on mistakes and the role of self-compassion that particularly resonated with the next generation of physicians. These perspectives were shared anonymously by attending physicians—specifically with the intent to support physicians in training.

"I have learned that beating myself up doesn't get me the results I thought it did. I used to believe that if I made a mistake, beating myself up would prevent another error. Now I know all it creates is more pain and no meaningful action! I call this 'instrumental self compassion.' I will be kind to myself because it frees up my energy to help others."

"Compassion is at the core of my mission and vision in all that I do. I realize that offering to others without first to myself creates an unsustainable practice. Granting ease, peace and understanding for all that I do, say, think, feel, allows me to extend that more freely to others. Seeing and honoring our common humanity, remembering that includes me!"

"The best thing I did for myself is change my self-talk from doubt and negativity to confident and hopeful. Simply put, admit mistakes and learn things you don't know. Be kind to yourself. You are with the person (yourself) life long. Others come and go."

"All great physicians stand tall on the graves of the people who died because of them.

Share the stories, learn from your mistakes, & honor the ones you lost by never repeating the same mistakes twice."

Self-compassion is a kind and friendly presence in the face of what's difficult. It allows us to be with both the good and the difficult. It allows us to approach challenges in medicine by turning toward them, not away from it. When we approach these challenging moments mindfully, with kindness and curiosity, we can more effectively choose an effective response.

My wish for all of my colleagues is to be kind to yourselves.

Give yourselves the compassion that you need. Learn to accept yourself as you are. Forgive yourself. Be strong, patient, and curious. This is key to doing no harm to yourself--and to others.

Dr. Jessie Mahoney is a Board-Certified Pediatrician, a certified life coach for physicians, and a yoga instructor. She is the Chair of the SFMMS Physician Wellness Task Force. She practiced Pediatrics and was a Physician Wellness leader at Kaiser Permanente for 17 years.

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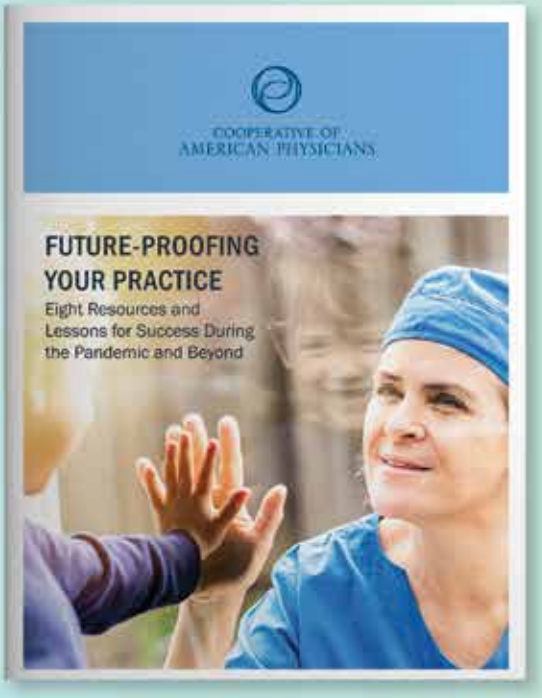

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