Family Medicine Updates

From the Society of Teachers of Family Medicine

Ann Fam Med 2020;18:376. https://doi.org/10.1370/afm.2574.

STFM PODCASTS LAUNCH WITH A CELEBRATION OF FAMILY MEDICINE'S CRITICAL FRONT LINE LEADERSHIP

In STFM's inaugural podcast series, *Academic Medicine Leadership Lessons: COVID-19*, family medicine educators are rising to the challenges of the COVID-19 pandemic by redesigning health systems, inventing new ways to train learners, and providing the best possible care to patients. Much has been accomplished quickly and with great ingenuity, and we're sharing some of those stories of adaptability, resourcefulness, and learner engagement.

"Our goal with this COVID-19 series is to celebrate the work that family medicine has done around the country, specifically our membership. We're so proud of them, and we know that so many are either dealing with a surge, or thinking about how best to prepare for another wave," said Brian Hischier, manager of online education, at the Society of Teachers of Family Medicine. Mr Hischier serves as host for the COVID-19 series podcasts.

Recent episodes within this COVID-19 series include:

- Judy Washington, MD, on *Working With Residents on a COVID-19 Floor*
- Chip Taylor, MD, on *Rapid Rural Response to COVID-19*
- Saria Saccocio, MD, on *Rapid Change in Residency Programs*
- Emily Soni, DO, on the *Importance of the Human Connection*
- Tim Graham, MD, on *Residency Program Challenges*

"STFM looks forward to a new normal, and hopes to begin featuring our members on more general topics as well. We will also welcome the return of our regular podcast host, Dr Saria Saccocio, hopefully later this summer," added Mr Hischier.

Future *Academic Medicine Leadership Lessons* podcasts will include in-depth interviews with family medicine leaders, giving listeners insight into pivotal experiences that have led to opportunities for personal growth and the development of leadership skills during times when health care professionals are addressing:

- Motivation and mentorship
- Burnout and transitions
- Milestones and meaning
- Barriers and bureaucracy

Listen to upcoming episodes by subscribing to STFM's *Academic Medicine Leadership Lessons* through Apple Podcasts, Spotify, Google Play, or on the STFM website at https://www.stfm.org/podcasts.

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Society of Teachers of Family Medicine

From the Association of Departments of Family Medicine

Ann Fam Med 2020;18:376-378. https://doi.org/10.1370/afm.2576.

ON MIRACLES AND MOVING ON

When Hurricane Katrina hit New Orleans in August of 2005, it brought depths of destruction to New Orleanians not previously experienced by an American city. Eighty percent of the city was flooded for weeks and at least 1,800 people died. Pictures still haunt our minds of the Superdome shelter and stranded families on roofs. Planning was inadequate and response from government at all levels was inadequate. People were stranded

at shelters without food, and toilet paper, too, no doubt. As often happens, the poorest were hardest hit.

We are all in a similar place with the COVID-19 disaster, this pandemic storm which has caught us ill-prepared and has shuttered all vestiges of normalcy. For some, it has taken our loved ones and colleagues. It has affected us all, shredding plans for vacations and graduations, for national meetings and family get-togethers, and leaving us empty and grieving. We are grieving together, grieving a previous life that will not return and a loss of safety we cannot recapture.

And yet there are positives. Thrown into a dangerous storm we did not see coming, the importance of our work is being honored and appreciated by hospitals, communities, and patients. Factories donate masks, military planes fly overhead in formation, police officers and churches hold drive-in appreciation events, and suddenly we feel appreciated. Our schedules may be a bit more flexible and a bit more controllable, and perhaps work RVU benchmarks and quality requirements have been suspended for a glorious moment.

We have an opportunity to use this as a wakeup call, to examine the old normal and decide if we can create something better. That is not to say that we give up or minimize the grief of the moment, or that we forget those patients or family that we've lost. Rather hold on tight to that grief, wrestle with it, and, through it all, plan for something better—something that honors what was lost, improves our professional lives, and improves the lives of others moving forward.

We have a health system that is incredibly unfair and inequitable, and which deprives the poor of basic preventive care, denies them primary care, and relegates them to the worst, last-minute, costliest care. We measure our success by effort and quality metrics that pale in comparison to the impact we could have on our patients and communities. Care is expensive, inequitable, and difficult to access. Primary care physicians are burned out. Despite this, in response to COVID-19, we and others were able to transform the health care system in a matter of weeks. Can we use this crisis to retain the virtues of this new existence?

There seems to be at least a temporary awareness brought about by the pandemic that people without insurance need care, are more vulnerable due to lack of care, and that it's not their fault. Can we take this opportunity to advocate with our state governments to expand and improve Medicaid drawing on the Families First Coronavirus Response Act for the additional resources needed? Can we ask Congress to make this expansion permanent?

Medicare and Medicaid have modified reimbursement regulations to allow payment for telemedicine which had heretofore been limited. As a result, many on Medicaid and Medicare are able to see their family doctor without the barriers caused by transportation, disability, or cost. Can we advocate to make this permanent and to make the payment equitable?

We now know that obesity and poorly controlled chronic illness contribute to the disproportionate death rates in people of color. We know that if we lessen the impact of social determinants of health on our patients it will improve the health of our most vulnerable patients and allow our specialty to fulfill its pivotal role as our patients' primary health advocate. Can we advocate for improvements in the social fabric such as education and access to healthy foods that will allow our patients to be more resilient when the next pandemic comes?

Another opportunity is to revise our medical student and residency curriculum to take advantage of more adult learning styles. Perhaps we shouldn't "return to normal." Can we eliminate hours of sitting and listening to lectures in favor of having students explore topics on their own and using a wide range of instructional design models—flipped classrooms and case-based experiential learning with built in feedback loops to improve their ability to see patients in a wholistic manner?

There is a writer by the name of Frederick Buechner that talks of the curse of "everydayness" —that tendency we all have when things are "normal," where we get in a rut, and barely notice how we got to work much less the beauty of the sunrise or the music of a child's laugh. We forget to notice these tiny miracles happen to us each day—the smell of the roses, the thanks or even blessing we get from our patients as we go about our work, amid our harried, busy work.

We have an opportunity now, shaken out of our everydayness, our rut, to appreciate and be mindful of the small miracles—to hold more sacred our in-person time with family and friends, to notice the life in front of us, to practice more compassion for the grieving—the loss that everyone is feeling in one way or another. And we have the opportunity—perhaps a once in a lifetime opportunity—to transform our health care system, and the teaching of our students in one fell swoop.

Life is a fragile miracle—and while the pandemic is disruptive, and devastating for much that is important to us, it cannot deprive us of each other (at least virtually) nor keep us from transforming medical care and medical school into something better. "Its hardship is its possibility," Wendell Berry wrote. Transforming health care is hard but possible, and this disruptive pandemic might just be the ticket.

In our states, the motto is Wash your hands, Wait 6 feet apart, and Wear masks. I would add to that: Advocate for those less fortunate, Admire your friends

and family from afar, and Advance adult learning teaching methods!

We have transformed everything in our world—and will likely be asked to do so again as we create a new normal. Why not create something better than normal?

Stay safe and make change.

Chelley Alexander, MD; R. Allen Perkins, MD, MPH

Ann Fam Med 2020;18:378-379. https://doi.org/10.1370/afm.2575.

HIGHLIGHTS FROM THE INNOVATION SHOWCASE

Leaders of family medicine residency programs often feel torn between the desire to innovate and the need to stay within the structure based on the requirements of the American Board of Family Medicine (ABFM) and the Accreditation Council on Graduate Medical Education (ACGME). Innovation is essential to the growth of our discipline and our training programs.[1]

For over 15 years, the American Academy of Family Physicians Program Directors Workshop (PDW) and Residency Program Solutions (RPS) Residency Education Symposium has featured an Innovation Showcase. At this showcase, 10 presenters share, in a rapid-fire format, innovations they have implemented in their family medicine residency programs. In 2020 the in-person meeting was cancelled due to the COVID-19 global pandemic. We share a brief summary of 3 interventions here that would have been presented at the 2020 Innovation Showcase. We hope that these implemented ideas encourage other family medicine educators to innovate to improve care for diverse communities, improve our well-being, and master evidence-based practice.

Diversity OSCE (FD)

We developed an innovative way to introduce culturally responsive care and direct observations through a Diversity Objective Structured Clinical Examination (OSCE.) First-year residents see 3 standardized patients while being directly observed by a faculty member in the room. The residents learn to respect other's cultural beliefs and to use interpreters effectively. Residents are given immediate feedback after the session.

The goals of our Diversity OSCE are:

1. Emphasize the importance of culturally responsive care
2. Set the expectation for direct observations and immediate feedback from faculty
3. Prepare the new residents to see real patients

Resident evaluations of this activity have been overwhelmingly positive. Residents feel it is an effective way to ease back into patient care (some fourth-year medical students lack direct patient care for months before starting residency) and get one-on-one feedback.

To ensure your Diversity OSCE is successful:

1. Adequately prepare the mock patients (we use staff)
2. Explain the educational value of this activity to the residents in advance. Debrief with the entire group after the OSCE to discuss the importance of culturally responsive care
3. Do not evaluate the resident's medical knowledge

This activity is intended to help residents grow!

Arts and Humanities (AH)

Arts in Medicine has circulated in the literature and curricula for some time, but our innovation started in 2018. The initial session was impulsive—without prior analysis of needs assessments or return on investment spreadsheets. We made kindness rocks. Simply, Arts and Humanities is an attempt to bring creativity, beauty, thoughtfulness, and fellowship to our practice.

Studies indicate integrating an arts programs can have impact on stress reduction, whole person orientation, professionalism, empathy, higher level observational skills and teamwork/communication.[2]

Our voluntary 40-minute sessions occur on Fridays over lunch every 4 weeks in the group visit room with size ranging from 5-20 faculty, students, residents, medical assistants, nurses, nurse practitioners, and front office staff.

It is a low-stakes, low-pressure activity. Cost is minimal (could be free) depending on the activities chosen; typically, $30 for "craft-heavy" sessions. Hospital resources (eg, art and music therapists, mindfulness coach) and local contacts (elementary school art teachers) have been utilized, all donating their time. Outside facilitators relieve the need to coordinate supplies and teach, but many successful sessions have been run by internal staff (eg, administrator-led knitting workshop.) Food-based sessions (cupcake decorating) are best attended.

Final impact? Kindness Rocks are still found scattered around our practice!

Text-Based Friendly Competition to Increase Engagement in Evidence-Based Medicine (MRH)

Understanding evidence-based medicine concepts and staying up to date with the literature were struggles for our faculty and residents and were identified as areas for improvement department wide at our 4 Family and