## Title
Advocacy: Transforming Our Understanding of Physicianship



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those staff and preceptors who spread stereotypes or display racist beliefs or practices should not be overlooked. They must be identified and held accountable for their actions, and those students and others who are the targets of this discrimination must be supported.

This letter only begins to touch on the challenges Black male applicants and medical students face. They need a village to support them as they complete the pathway to becoming a physician.

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Reference

1 Association of American Medical Colleges. Altering the Course: Black Males in Medicine. Washington, DC: Association of American Medical Colleges; 2015. https://store.aamc.org/downloadable/download/sample/sample_id/84. Accessed September 6, 2022.

## Far Too Late: A Call to Action From the Trauma Bay

**To the Editor:** The first time I felt a bullet was in the trauma bay, in the chest of a young boy. As we rolled him on the table, I reached across his chest and felt the hard cylinder lodged just beneath his skin. The bullet had traveled through his chest, hitting multiple great vessels before being caught by his ribs. That night, I took care of a patient without a name or story and despite extraordinary and invasive medical and surgical interventions, he never regained a pulse. Even if we had been with him as he was shot, we would have been far too late.

When thinking about gun violence, perhaps one remembers the shudder-inducing news stories, like the horrific mass shooting of children and teachers in Uvalde, Texas, in 2022. However, behind the loud staccato of shootings that make the news is the unrelenting roar of gun deaths echoing across the United States every day. I live in Philadelphia, where at the time of writing, there have been 401 gun-related deaths so far in 2022—that is, on average, a mass shooting on the scale we witnessed in Uvalde, Texas, every 14 days.[1]

On most days of the year, it is easy to look away from the horrors of this daily massacre, especially for those privileged by white skin or wealth. As medical trainees and members of a profession entrusted to witness and intervene in these atrocities, how can we be good stewards of the responsibility given to us by our patients? I would propose that the answer to this question may lie outside the hospital. I believe we must be outspoken advocates for policies, including a ban on assault weapons and high-capacity magazines, that would protect the lives of our patients and embrace prevention through policy just as we do with prophylactic medications and screening tests.

When we force ourselves to look at this problem, we can see the shadow of gun violence stretching to include the tragedies in the trauma bay, the firearm suicides of our patients in crisis, and the catastrophic injuries of our patients who survive gun violence. What will we do for tomorrow's patients? How can we possibly justify our silence amid this critical illness?

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Reference

1 Office of the Controller. Mapping Philadelphia's gun violence crisis. https://controller.phila.gov/philadelphia-audits/mapping-gun-violence. Accessed October 21, 2022.

## Advocacy: Transforming Our Understanding of Physicianship

**To the Editor:** "Hello, my name is Teva and I'm calling from the County Public Health Department because you were exposed to someone with COVID-19," I said, pausing for the interpreter to translate. I continued, "We recommend that you quarantine for 2 weeks." I heard hushed murmurs and a child crying in the background. Then the line went dead, and when I redialed it went straight to voicemail.

I had actually been surprised our conversation lasted that long. In April 2020, at the beginning of the pandemic when, with clinical rotations canceled for the spring term, I started working as a contact tracer, outbreaks were mostly confined to nursing homes. Back then people were scared and desperate for information. Now it was May, and many of my calls went unanswered. But what was often worse was when people picked up the phone and told me their stories.

They were migrant farmhands, landscapers, and workers at food processing facilities. They lived in multigenerational households; many were their family's sole breadwinner. And here I was, a disembodied voice from the government telling them they could not go to work. Very few were hostile. Most said nothing. Their silence spoke for itself.

I can understand the temptation of some physicians to eschew politics. But—from the unhoused elderly gentleman hospitalized with hypothermia, to the teenager in the trauma bay exsanguinating from a gunshot wound, to the housekeeper and single mother faced with the impossible choice of exposing others to a deadly communicable disease or feeding her children—policy issues, such as housing, firearm, childcare, family leave, immigration, and food security cannot be separated from that which has been understood as *strictly medicine*. To be a physician today is to confront the profound social, economic, and political questions of our time; whether we like it or not, *these are our lanes*.[1]

So as precarious as this moment in history may feel, it has clarified the vision I have for my future. As an aspiring physician and advocate, I am inspired to pursue a career that blends the healing power of physical touch and intellectual curiosity, interpersonal humanity, and public purpose: the ability to save a life and change society.

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Reference

1 Ranney ML, Betz ME, Dark C. #ThisIsOurLane—Firearm Safety as Health Care's Highway. N Engl J Med. 2019;380:405–407.

## Eschewing Perfection in the Quest for "Net Good"

**To the Editor:** "Glasses would help," he replied. I had asked the patient what he needed. He responded accurately (a house, a less-stigmatizing criminal record, a large bank account balance), but with a list far beyond the resources available. I encouraged him to think smaller, which led us to glasses. It was not much, but it was achievable. Before medical school, I worked for an organization supporting unhoused individuals with complex medical needs. Once more urgent health care needs had been addressed, I was able to obtain glasses for him. We also worked together to secure him a job interview.

As a medical student, I no longer do a lot of case management work, but the experience changed my outlook and taught me the power of the "net good." In my previous role, it could be easy to become discouraged by the sheer discrepancy between what was needed and what was available. Despite this dichotomy, it was always possible to be a force for net good and have an incrementally positive effect on the individuals with whom we worked.

As future physicians, a quest for this net good is important to keep in mind, as a "cure" or some perfect intervention is frequently an unattainable goal for many of our patients. Regardless, we can always work to help patients more effectively manage chronic conditions, or at the bare minimum, provide them with empathy. This felt abundantly clear on a palliative care rotation, as many of the patients had reached the bounds of what medicine could offer. Even then, it was possible to impart net good, which could simply mean offering compassion once clinical interventions were exhausted.

In the face of rampant structural inequality, it is easy to feel discouraged by the sheer weight of the disparities our patients face. The medical field is increasingly recognizing the impact that the social determinants of health have on health outcomes and medical school curriculums are increasingly incorporating these topics. I am now a teaching assistant for a course that reinforces these ideas as they pertain to the clinical context. Courses like this can be a force for net good by leading to incremental improvements in the way we treat patients and practice medicine. Systemic, radical change is needed, but we can still help to empower a healthier population one set of glasses at a time and work to become a more thoughtful and inclusive field one course at a time.

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## Change Begins at the Bottom

**To the Editor:** In health care, we often try to change practice from the top down. Far-reaching regulatory policies impose rules and quality metrics that push clinicians to improve performance. Unfortunately, these efforts rarely improve quality and can even cause unintended harm.[1]

As a trainee, I witnessed the power of a radically different approach: bottom-up change. In 2016, my institution began focusing on combating the opioid epidemic. In true top-down fashion, leadership mobilized, millions of dollars were invested, and entire research centers were established. I was a fourth-year medical student interested in surgery and had witnessed how often opioids were prescribed after surgery. I wanted to contribute, but how? I was far closer to the bottom than the top.

So I picked up the phone. I called patients who underwent surgery and asked: How many opioids were you prescribed? How many did you take? I discovered that patients were typically prescribed 40 pills after surgery but only took 6. I shared these results with our department, and within a few months the size of postoperative opioid prescriptions at my institution fell by 63%.[2] Over the following year, this work spread throughout Michigan, and postoperative opioid prescribing fell by 44% across the state.[3] Patient satisfaction remained excellent, and millions of excess pills were kept out of our communities.

Since that experience, I have realized that no matter your position in the hierarchy, you can change practice. In fact, those lower in the hierarchy are often the ones who can make a real impact. Whereas those at the top are far removed from day-to-day care delivery, those on the ground see opportunities for improvement firsthand. Now, as a surgical resident, I continue to see myself as a change agent. My most frequent advice to medical students is that you too can be a leader for change. Do not underestimate the power of your position. More likely than not, you will see the opportunities that become obscured when you are all the way at the top.

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References

1 Rosenbaum L. Reassessing quality assessment–The flawed system for fixing a flawed system. N Engl J Med. 2022;386:1663–1667.
2 Howard R, Waljee J, Brummett C, Englesbe M, Lee J. Reduction in opioid prescribing through evidence-based prescribing guidelines. JAMA Surg. 2018;153:285–287.
3 Vu JV, Howard RA, Gunaseelan V, Brummett CM, Waljee JF, Englesbe MJ. Statewide implementation of postoperative opioid prescribing guidelines. N Engl J Med. 2019;381:680–682.