

## Self-Reflection

Unaware of the opportunity to provide this overall career Self-Reflection as part of my promotion package, I took advantage of the Professional Development in Education section of my Teaching Portfolio to reflect not solely on my career in medical education, but also my clinical and research career paths. The rough winds and clear sailing I have experienced are highlighted, as is my slow discernment of the areas in medical practice, research, and education best matched to my experiences, skills, and passions. This section complements those reflections by identifying some of my key strengths and weaknesses, as well as my career vision.

My central strengths revolve around my ability to communicate in culturally and interpersonally sensitive ways that invite openness, maintain human dignity, encourage grappling directly with difficult issues, and respect individual decision-making. Whether I am with patients, medical students, residents, practicing physicians, administrators or policy makers, I am able to apply communication principles and practices from the fields of behavior change counseling and non-violent communication to move relationships forward in constructive ways. My undergraduate and medical school study of western and eastern philosophy, psychology, and ethics gave context and interest in learning skills that emerge from motivational interviewing, cognitive behavioral therapy, harm reduction counseling, and spiritual disciplines that inform 12-step work or eastern meditation. These skills apply to drug-using patients who have been mistreated or abused within or outside the medical system, physicians who feel manipulated by drug-seeking patients, rural physicians working the toughest chronic pain management cases, students struggling with professionalism issues, and administrators or policy makers who need encouragement to break down structural barriers impeding integrated care for multi-problem patients. I am able to provide an occasion for people to feel that their story is heard, however painful that story might be, and this invites an opportunity for change.

Related to these communications skills, and growing from them, is my expertise in addiction medicine and the integration of addiction medicine into medical practice, especially primary care. My interest in addiction medicine arose in residency as I experienced how large that particular elephant was in the rooms of vulnerable medical patients and how exquisitely the elephant could be ignored and the patient abandoned. I understand this field from the perspective of the doctor-patient relationship, the care teams that are essential to providing excellent care while maintaining healthy providers, and the state and federal policies that affect care access and effectiveness. I have been working in addiction medicine since residency and have had a front row seat as the opioid epidemic emerged (at least in part) from medical prescribing practices. In response, I have also become an expert in the management of chronic pain so that I can provide a broader range of tools and strategies to assist patients, students, doctors, and medical practices as they grapple with some of the most challenging and suffering patients. I have used these addiction-related skills in the research through collaboration with and education of multiple investigators; in varied teaching settings at the local, state and national levels; and in envisioning and implementing novel primary care systems of care for patients with addictive disorders. My many teaching opportunities and generalist clinical background give me the tools and perspective to communicate addiction medicine skills and content to medical providers from the first days of medical school through their careers of practicing with underserved patients in rural or urban settings.

Perhaps the strength that has been most important in my career is my ability to develop and work with teams. These include the Colleges faculty, the small student groups I mentor, the clinics in which I provide care, the telemedicine communities in which I teach, the multiple research labs with which I collaborate, and especially the many clinical teams I have helped create. These clinical teams cross disciplines and have become true communities as they address primary care opioid management, primary care opioid addiction treatment, specialty addiction treatment, chronic pain management, and HIV. In all these efforts, the synergy and reciprocity between case-based team decision-making and clinical policy-making is front and center, requiring a type of creativity and collaboration in which I thrive and excel. My most recent team effort was an exciting three-week tag-team collaboration with two researchers in writing a large NIH grant proposal as co-PIs, where the proposal was worked on by one of us for numerous hours each day, our skills and knowledge building on each other as we witnessed rapid progress.

I certainly have areas of weakness and I am fortunate to have had enough personal, family, spiritual and professional support to navigate these weaknesses without too much catastrophe or depression. (I also do a lot of yoga!) I have often been held back by lack of confidence, as I see too clearly the problems with the methods or the generalizability of what I have done to date, and I let that get in the way of moving forward or reporting valuable findings. I fail to consistently write for first author publication, instead prioritizing helping others or the next project. As a clinician, my inbox can get too full. As a teacher, I can be too kind and not communicate negative information clearly enough, though I have improved in this area. As an administrator, I can worry too much about a project and have trouble cutting my losses and moving on. If there is a pattern in these weaknesses, I rationalize that it is my curiosity for the novel, my impulsiveness, and my yearning for the big picture that trips me up. Sounds a little addictive, but who's asking?

My vision for the next phase of my career revolves around strengthening leadership skills to promote teams that can advance the causes toward which I have been working. While I see progress in the integration of addiction medicine into general medical practice, I am humbled by how far we have to go in communicating the knowledge, skills, and attitudes necessary for practicing physicians to effectively address the devastating consequences of addiction. I am energized by a threefold "master plan": 1) leading a network of primary care and specialty clinics that can effectively treat substantial numbers of patients with opioid addiction and be expanded state-wide, 2) creating an Addiction Medicine consultation service at Harborview (and perhaps elsewhere in the UW system), and 3) gathering the resources to initiate a UW Addiction Medicine Fellowship program. These activities have already attracted a strong interdisciplinary team and spawned research projects and proposals that aim to advance addiction medicine within the general medical system, both inpatient and outpatient. While this vision will certainly keep me busy for quite a while, I can also imagine that before my career ends, I may well turn my focus again to the areas of philosophy, ethics and spirituality that began my journey towards addiction medicine, considering how they inform and are informed by the study and practice of addiction medicine.