encounters, we also want to highlight the extreme importance of nonclinical efforts to address the SDOH. In our experience, we have found that clinical encounters are most often where we bear witness to the impact of the SDOH on people's lives, but are often not where we can most effectively impact the SDOH. Addressing the SDOH requires social change to remedy the structural, more upstream etiologies of health inequities. A call for social change implies participation in social movements, health policy advocacy, personal reflection and community dialogue on issues such as racism, and use of community-based participatory action research. Incorporating such curricula will put students on a path towards the practice of social medicine.

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Creating a Humanistic Surgical Theater: The Patient-Centered Pause

To the Editor: Surgery is one of the only medical fields where health professionals can interact with patients who they know almost nothing about and whose faces they may never have seen. Often, anesthesiologists, medical students, scrub technicians, and nurses pass in and out of an operating room (OR) having never met the patient in a preoperative setting. This is less than optimal because team members should be treating the patient—not a surgical field—and focusing on shared objectives. This lack of communication can also create patient safety issues, sometimes resulting in wrong-site surgeries and death. While pre- and postoperative briefings have attempted to address these issues, they fail to incorporate an integral element into surgical care: patient-centeredness.

There exists a unique opportunity to introduce a humanistic moment in the surgical theater. The goal of this concept is to improve patient safety and surgical outcomes. In this "patient-centered pause," following the standardized surgical time-out, a one-sentence statement would be read to all team members. This sentence would be provided by the patient in the preoperative setting, if possible, or by a surrogate. The patient would be instructed that the purpose of this sentence is to inform all members of the operating team what makes him or her and this operation unique. The patient would receive the following simple instruction: "In one sentence, tell us what you would like the OR staff to know about you and your operation." An example of such a patient-provided statement might read, "Vicki is a teacher and the goal of this procedure is to get her back on the playground with her second-graders." By adopting this patient-centered pause, institutions can catalyze positive deviance by creating a more humanistic surgical atmosphere.

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Social Science and Humanities Research in MD–PhD Training

To the Editor: As three of the few MD–PhD students completing PhDs in social science and humanities disciplines, we would like to add our voices to those of Ryan O'Mara and colleagues[1] in calling on MD–PhD programs to train graduates in disciplines beyond the biomedical and clinical sciences. The authors convincingly argue that clinician–researchers trained in diverse disciplines such as public policy, management, and social sciences can promote health and health equity specifically through addressing their social determinants. To improve health and health equity for our patients, we must also train physicians in the knowledge and expertise to properly achieve these ends. We would like to highlight two ways that social science and humanities research in MD–PhD training can contribute.

First, as a research community we must answer the question, what are the *components* of physician knowledge and expertise? The components surely include clinical reasoning, clinical judgment, narrative competency, empathy, professional and ethical behavior, leadership, and advocacy. Many of these elements are considered part of the ineffable art of medicine, elusive and resistant to analysis. Yet they are in fact researchable by social scientists and humanities scholars.[2] Psychologists, bioethicists, and philosophers of medicine study clinical reasoning and judgment; English and narrative medicine scholars study narrative competency and empathy; and finally, historians of medicine, medical anthropologists, and medial sociologists study professional, cultural, and ethical norms, the politics of practice, and the origins of health inequalities.

Second, educators need research on how to best train physicians in this knowledge and skill set, including how it is acquired in medical education, how the culture of training influences its uptake, and the effectiveness of various strategies to teach and assess it. Here again these questions can be answered through a social science lens, using theory and methodologies—experimental, observational, quantitative, qualitative—from various disciplines.

As medical students and future physicians, MD–PhD trainees have a unique perspective from which to undertake these two types of research and are well positioned to become future leaders in education who will help train a medical community in the diverse knowledge and expertise needed to promote good health for all.

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