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SGIM FORUM

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IMPROVING CARE

THE CHALLENGE AND VALUE OF OBTAINING AN ACCURATE HOME MEDICATION LIST

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"*At home, the patient takes Carvedilol, Entresto, Bumex and Farxiga….*" The resident concludes that Ms. O's shortness of breath is due to acute decompensation of her congestive heart failure. But why? She tells us she eats a low-salt diet. There is no evidence of ischemia or arrhythmia. Ms. O takes Bumex…right? At the bedside, we ask *"I know it can be hard to take so many medications. How often do you miss or skip Bumex?"* She lowers her gaze, *"Well, I pick up my grandson from the bus stop, and there is no bathroom there…."* Ms. O reveals that her diuretic adherence has been inconsistent.

Physicians diligently include a home medication list into every hospital admission note. But how often do we acknowledge the challenge and nuance of taking a good medication history? Do we adequately train our learners to appreciate how much can be learned when medication reconciliation is done well? This article reviews the challenges of obtaining and documenting an accurate home medication list, detail what we can learn when medication review is done well, and outline best practices for obtaining a comprehensive and accurate home medication list.

Medication reconciliation gained recognition in 2005 when The Joint Commission named it as one of their National Patient Safety Goals (NSPG). This goal was suspended from 2009-11 due to a lack of consensus over effective strategies to achieve accurate medication reconciliation. Although medication reconciliation was reinstated as an NPSG in 2011, best practices for this process remain unclear.[1] Studies show that more than 50% of hospitalized patients have inaccurate home medication lists, and many of these errors are clinically important.[2]

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What we colloquially call the *med rec* involves multiple steps: gathering an accurate medication list, determining which medications to continue, hold, or discontinue, and communicating these changes with inpatient teams, outpatient physicians, patients, and families. But rarely do we acknowledge the challenges and value of this process.

Challenges in Obtaining and Documenting an Accurate Home Medication List

Polypharmacy contributes to the challenge of home medication review. Medicare patients take an average of 5.6 medications.[3] Prescription labels rarely include indications, generic and brand names are used interchangeably, and manufacturers change the color, size, and appearance of pills. These realities leave patients and families struggling to keep track of exactly what medications they are taking and why.

Care fragmentation adds complexity to this problem. Patients see physicians across different systems, with electronic medical records (EMRs) that may not interface with the inpatient medical record. This disconnect can lead to duplicate, conflicting, or discontinued medications appearing on a medication list. Additionally, the percentage of patients using three or more pharmacies has increased over time, further complicating the process of obtaining a complete list of medications.[4] Prescriptions obtained over the counter or through cash pay programs may also be missing from pharmacy dispense reports. Reviewing prescribed medications is insufficient to ensure an accurate medication list as it misses details about adherence.

Medication review and reconciliation are within the scope of work of multiple members of a care team. As such, there can be uncertainty as to whether pharmacists, nurses, advanced practice providers, or physicians are responsible for the work. For patients admitted to hospitals overnight or on weekends, pharmacies may be closed, families unreachable, and nursing facility staff unavailable. These structural realities can create redundant or overlapping efforts. If the overnight hospitalist reviews the medications with family, then the pharmacist calls the pharmacy the next morning, whose work should be considered the source of truth?

Details about medication adherence are documented variably in EMRs. When patients do not take medications as directed on a prescription, whether by choice or per a doctor's recommendation, some clinicians annotate the medication list while others remove the medications from the list entirely. The inconsistency of this documentation can add confusion when reconciling medications on admission and discharge. The simple task of obtaining a home medication list is complex, requires multiple steps, and yet may still be incomplete.

What We Can Learn from a Thorough Medication Review?

Despite these challenges, a thorough home medication review has the potential to increase diagnostic accuracy, prevent future hospitalizations, promote patient safety, and improve patient experience. Medication review can provide insights into the diagnosis of a patient's current illness. For example, a review of recent pharmacy dispensation data for a patient presenting with diarrhea reveals two recent prescriptions for ciprofloxacin, prompting a suspicion for *Clostridioides difficile* infection. A patient is admitted with nausea and hypotension; in speaking with her pharmacist, you discover that she has been prescribed six courses of prednisone for joint pain in the last year, leading you to pursue an evaluation for adrenal insufficiency.

Understanding recent prescription dispensing data can mitigate the risk of future hospitalizations. For example, a patient admitted with an asthma exacerbation reports using budesonide-formoterol, but review of her pharmacy dispensation history shows her last refill was four months ago. On further questioning, she admits to spacing out doses due to medication cost.

Medication review can also improve patient safety. For example, a patient admitted with recurrent hypoglycemia reports taking Humulin. However, upon speaking with the pharmacist, you discover he is prescribed Humulin 70/30 mixed insulin. When the patient acknowledges that his meal schedule is irregular, you discontinue the mixed insulin and instead recommend a standard basal-bolus insulin regimen.

Many patients, like Ms. O, struggle to incorporate medications and their side effects into their daily routines. Understanding the details of their medication dosing and frequency can help address side effects and improve adherence.

Best Practices for Obtaining a Comprehensive and Accurate Medication List

The following is a list of best practices we developed to use in our approach to home medication review and reconciliation:

1. Use at least two sources—one for prescription or pharmacy data (e.g., electronic dispense records, discussion with pharmacy staff) and one for adherence (e.g., patient, family, caretaker).
2. Review several months of medication history to identify medications that were recently discontinued or prescribed in short courses to provide complete history of recent exposures.
3. Ask specifically about over-the-counter medications, supplements, topical medications, and eye drops to ensure a more complete list.

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4. Normalize adherence challenges with nonjudgmental questions, such as "How many times per week do you miss or forget to take this medication?" Ask about specific barriers to adherence such as cost, side effects, polypharmacy, and pill burden.
5. Document sources and adherence details in the EMR. If a patient is taking a medication inconsistently, keep the medication on the list with the addition of a comment to clarify adherence history. If a medication was discontinued altogether by a patient or outside physician, remove it from the list and notify the prescriber and pharmacy.
6. Review home medications at every transition of care, including admissions, transfers, and discharges. If errors are discovered in the home medication list during a hospitalization, update the admission medication list prior to discharge reconciliation to prevent miscommunication on discharge.

On a systems level, SGIM members should collaborate with pharmacists, nurses, advanced practice providers, and informaticists to design efficient and accurate medication reconciliation processes. For example, EMRs should be designed to allow commentary about adherence. Artificial intelligence tools should be incorporated into EMRs to alert clinicians to discrepancies between pharmacy dispense information and home medication lists.

Our medical team thanked Ms. O for her honesty about the barriers to diuretic adherence. We adjusted her diuretic to a higher, once-daily dose to balance efficacy with her responsibilities.

In sum, medication reconciliation is more than just checking a box. It requires nuance, diligence, and skill. If SGIM members adopt a system of best practices as outlined above to ensure home medication lists are comprehensive, accurate, and clearly documented, we can improve patient safety, patient experience, and quality of care.

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SGIM

FROM THE EDITOR

HOW TIMES HAVE CHANGED—OR HAVE THEY REALLY?

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We are in uncertain and chaotic times. Policies and procedures have changed rapidly since January 2025. The rapid pace of these changes is reminiscent of the military strategy of "shock and awe" that gained prominence during the United States invasion of Iraq in 2003.[1] Military strategists and authors Harlan K. Ullman and James P. Wade describe shock and awe as rapid dominance which attempts "to affect the will, perception, and understanding of the adversary to fight or respond."[1] In doing so, this rapid dominance will "impose this overwhelming level of Shock and Awe against an adversary on an immediate or sufficiently timely basis to paralyze its will to carry on ... [to] seize control of the environment and paralyze or so overload an adversary's perceptions and understanding of events that the enemy would be incapable of resistance at the tactical and

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strategic levels."[1] Parallels can be drawn between these military concepts and the rapidity in which changes are being enacted upon the scientific community in 2025.

American industrialist J. Paul Getty once said "In times of rapid change, experience could be your worst enemy."[2] Evolving and fast-paced attacks on the scientific community will require a different response; we should not rely only on past experiences to guide our response since today's attacks are different. The lack of significantly organized responses to protect research funding and scientific agencies is representative of the shock and awe paralysis and difficulty in adapting to new methods of forced change.

A group of 60 senior U.S. scientists wrote an open letter as members of the Union of Concerned Scientists (UCS) proclaiming "When scientific knowledge has been found to be in conflict with its political goals, the administration has often manipulated the process through which science enters into its decisions. This has been done by placing people who are professionally unqualified or who have clear conflicts of interest in official posts and on scientific advisory committees; by disbanding existing advisory committees; by censoring and suppressing reports by the government's own scientists; and by simply not seeking independent scientific advice."[3] At that time, Neil Lane, who previously served as a scientific advisor to President Clinton, felt that scientific findings were being repressed when he stated "I am afraid that our leading policymakers simply don't know what they don't know, given the manipulation of the science advice process."[3]

The above comments and quotes reflect the scientific community's concern over the hot button issue of the time—the science of climate change during former President George W. Bush's term in 2001.[3] Many of the same concerns exist today with the manipulation and suppression of scientific endeavors. Today, the conversation regarding environmental impacts and global warming still generates controversy, but the pendulum has shifted to a recognition that this problem exists and needs to be addressed. How did this happen? Under President Bush, the U.S. plan for addressing climate change was coordinated by the Climate Change Science Program (CCSP). The CCSP strategy was widely criticized by worldwide governmental agencies after the U.S. withdrew from the Kyoto protocol with a subsequent lack of commitment to reduce greenhouse gases. The British National Academy of Sciences was one of the leading external critics of the CCSP and jointly criticized the CCSP along with the UCS and other U.S. scientists. This led to a revision in strategy as authored by the CCSP which was viewed as moving in the right direction. "I think it does indicate that they have been certainly pressured by the criticism by the scientific community."[3] However, U.S. scientists involved in this protest were repeatedly harassed and many were targeted by special interest groups who filed federal lawsuits against them.

What can we learn from history to address the concerns over similar events happening in 2025? The UCS were a vocal group of scientists and longstanding critics of the Bush administration. In their open letter, they wrote "The distortion of scientific knowledge for partisan political ends must cease if the public is to be properly informed about issues central to its well-being."[3] The UCS and other critics were able to take a stand, raise their concerns successfully, and make a difference so that greenhouse gases, environmental concerns, and climate change are widely recognized (but not universally) as impacting our future with a need to be addressed.

The scientific community in 2025 must follow a similar approach: Identify common themes supported by large groups, unite to amplify our voices, and object to policies that are harmful to our patients, science, and members. SGIM members are critical to spearhead this effort. A concern expressed in 2001 mirrors the concerns expressed by today's scientists "It ignored existing science and a great deal of its planned research would merely repeat work that had been done already."[4] With cuts to the federal workforce, agencies, and research funding, many fear that we are heading down the same path of repeated work seeking answers with predetermined outcomes.

The scientific community made a difference in 2001 through their actions. Can we make a similar difference in 2025? Noted author and cultural anthropologist Margaret Meade said, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."[4] During the darkest nights, when the moon is only a sliver of its normal self, these are the times when the stars shine their brightest. SGIM has many stars among its members. I am confident SGIM members will shine brightly and make a difference.

Disclosures: The opinions expressed in this column are those of the author alone and do not reflect the views of any of his employers or SGIM.

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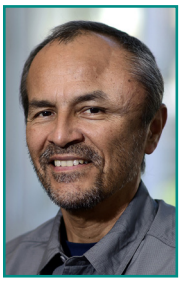
SGIM

DEMYSTIFYING THE ROLE OF AN SGIM PRESIDENT: ANNUAL AND REGIONAL MEETING UPDATES AND OPEN COMMUNICATION

Carlos Estrada, MD, MS, FACP, President, SGIM

"I used the suggestions from SGIM leaders and my criteria to select Dr. Amanda Mixon (Vanderbilt University Medical Center) as Chair and Dr. Eric Yudelevich (Cleveland Clinic) as Co-Chair for the 2026 SGIM Annual Meeting."



As I write this article, the 2025 SGIM Annual Meeting (#SGIM25) is weeks away and planning for the 2026 SGIM Annual Meeting (#SGIM26) is already underway. Preparing for the Annual Meeting takes time as well as an army of dedicated people to be successful. Special thanks to the dedicated SGIM staff as they assist SGIM volunteers to pull it all together!

For the incoming SGIM President, one of the most important tasks is to select the Chair and Co-Chair for the Annual Meeting. Over the past few months, I sought advice from SGIM past-presidents as well as past Annual Meeting Chairs. These conversations yielded three main suggestions:

1. Select someone who is committed to the organization and highly engaged
2. Select someone with experience in planning a regional or national meeting
3. Select someone who represents our membership.

But all discussants agreed with the bottom line—"select carefully."

As I started this critical decision-making process, I considered several important criteria, including candidates' geography and career choice (i.e., medical education, clinical care, research, or administration). I sought suggestions regarding members from smaller general internal medicine (GIM) programs and even international medical school training programs.

After reviewing the list of SGIM members on the Annual Meeting program committee over the previous five years, I used the suggestions from SGIM leaders and my criteria to select Dr. Amanda Mixon (Vanderbilt University Medical Center) as Chair and Dr. Eric Yudelevich (Cleveland Clinic) as Co-Chair for the 2026 SGIM Annual Meeting. I first met Amanda during her internal medicine residency training at the University of Alabama at Birmingham. She then completed a Veterans Affairs Quality Scholars (VAQS) fellowship at the Birmingham Veterans Affairs Medical Center (VAMC). Eric completed medical school at the Escuela De Medicina, Universidad Anahuac in Lomas Anahuac, Mexico, followed by internal medicine residency training and a year as Chief Medical Resident at the Icahn School of Medicine at Mount Sinai.

Amanda and Eric are assembling the 2026 Annual Meeting (#SGIM26) Program Planning Committee as they select and confirm chairs and co-chairs for the many sections that determine the Annual Meeting program content. Each section co-chair is invited to serve as the section chair for the following year's Annual Meeting. This process facilitates a smoother transition for an effective planning committee as lessons learned and institutional knowledge are not lost. To increase the diversity of SGIM members involved in their subgroups, we asked each section chair to review the list of volunteers and invite a variety of SGIM members to serve in the respective groups. I asked everyone to be deliberate in their selections by reflecting SGIM membership as opposed to the section chairs asking people they already know.

The theme of the 2026 SGIM Annual Meeting is "Individual Voices, Collective Impact: Advocating for Excellence in Academic Medicine." As we continue to plan for the 2026 Annual Meeting (#SGIM26), Amanda and Eric will continue to provide updates on the progress of the planning committee.

SGIM Leadership Presence at Regional Meetings

Over the past few years, SGIM leadership has made a concerted effort to attend regional meetings. Drs. Eric Bass, Jada Busey-Jones, and Martha Gerrity attended many regional meetings. SGIM leadership values the regions and their meetings. SGIM wants to hear from

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regional meeting attendees because the regional meetings offer another venue for members to express their concerns and offer suggestions.

I had the opportunity to attend the Northwest regional meeting in Portland, Oregon, on March 7, 2025. Every region has a different leadership structure that works best for them. As Co-Chairs, Drs. Patricio Riquelme and Kaleb Keyserling (both from Oregon Health & Science University) organized a vibrant meeting in collaboration with Co-Presidents, Drs. Lisa Fosnot (University of Colorado) and Jessica Bender (University of Washington). The one-day meeting was filled with plenary presentations, clinical updates, workshops, poster presentations, and the bite-sized teaching competition. At the workshop "What Can SGIM Do for You? And Vice-Versa," presenters and participants shared stories of their engagement within SGIM (in full disclosure, a group of us presented this topic at a prior annual meeting—I was happy to see the adaptation for this regional meeting).

SGIM's success hinges on its members, a strong and kind community of volunteers who support each other. Unlike other professional societies, more than 80% of SGIM members attend national or regional meetings. At the end of the meeting, the sentiment was similar among attendees—it was energizing! The work being done at the regional meetings as well as the current national context will inform plans for the 2026 Annual Meeting as the Program Committee charges ahead.

SGIM Is Not Silent

The current medical and scientific environment is complex. Just as the Annual Meeting Program Committee is monitoring developments, SGIM Council and Executive Leadership continue to assess the evolving political landscape. In response to members' feedback and in the interest of multi-modal communication, I include the following key points from the open forum communication by SGIM Past-President (Dr. Jada Bussey-Jones) and SGIM CEO (Dr. Eric Bass):[1]

"SGIM has engaged in focused advocacy efforts around medical research funding, healthcare access, and Medicaid protections. Our health policy subcommittees and Council have also been working on other priorities while partnering with other organizations in coalition advocacy—here's a partial list:

1. *SGIM submitted a letter to President Trump's transition team, outlining ways we hoped we could work together.*
2. *SGIM leaders, health policy chairs, and government relations professionals developed a streamlined approach to advocacy that focuses on issues where we can make the most difference.*
3. *SGIM Communications & Outreach:*
   - *SGIM adopted a new system to make it easier for members to contact their members of Congress.*
   - *We restarted the Health Policy Interest Group to engage with members committed to taking action and are developing alternative channels of advocacy communication through ACLGIM.*
   - *We continue to post direct messages from the President and CEO to the All Member Forum on GIM Connect.*
4. *We continue our longstanding coalition advocacy with organizations that share our concerns, including the Association of American Medical Colleges, American College of Physicians, and Primary Care Collaborative. We also recently joined Research! America."*

This is a partial list of the ongoing efforts by the organization. More to come!

As I grapple with adapting my personal leadership style during this time of crisis, I found the guidance from Laura Empson, a professor in the Management of Professional Service Firms at Bayes Business School, University of London, to be informative. Her article refers to the metaphor of "hold fast and stay true" where sailors hold onto something and maintain their course during a storm.[2] SGIM remains committed to its core mission in areas where we can be most impactful. In addition to synergizing with other professional organizations, managing organizational capacity (bandwidth) is an important approach to support our members. To maintain organizational health, we also must manage legal exposure.

SGIM has been (and may continue to be) criticized for not being a louder voice in areas such as diversity, equity, and inclusion. While staying true to our principles, SGIM saw the necessity of reviewing our programs to ensure they follow new legal guidance that can be summarized in terms of three Ps: avoid "conferring a *preference* on a *protected group* with respect to a *palpable benefit*."[3] SGIM members will see some changes in the descriptions of several programs and initiatives as we continue to hold fast to our principles during this tumultuous time

SGIM leaders are committed to supporting and updating members as more information becomes available. SGIM will continue to work with other professional organizations to support our mission. We appreciate the efforts of SGIM members and the differences they are making. Thank you for all that you do.

Disclosures: The opinions expressed in this column are those of the author alone and do not reflect the views of any of his employers or SGIM.

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SGIM

FROM THE SOCIETY

Q & A WITH SGIM'S CEO AND LEADERS OF PHYSICIANS FOR HUMAN RIGHTS (PHR) ON REFUGEE AND IMMIGRANT HEALTH

Eric B. Bass, MD, MPH; Michele Heisler, MD, MPH; Monica Peek, MD, MPH, MS

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Heisler (mheisler@phr.org) is the Medical Director of PHR. Dr. Peek (mpeek@uchicagomedicine.org) is on the Board of Directors of PHR.

For many years, SGIM members have been leaders in addressing the healthcare needs of immigrants, refugees, and other vulnerable populations. Indeed, SGIM's first president, Robert Lawrence, helped found Physicians for Human Rights (PHR), an international non-governmental health and human rights organization that works at the intersection of medicine, science, and the law to secure human rights and justice for all.[1] Other SGIM members have continuing leadership roles in PHR, including Monica Peek who serves on their Board of Directors, and Michele Heisler who serves as their Medical Director. I decided to ask Monica and Michele about what PHR has been doing to address the latest threats to the well-being of immigrants and refugees and to solicit advice on what SGIM members can do.

EB: I recently participated in a book club discussion of *The Ungrateful Refugee: What Immigrants Never Tell You*, by Dina Nayeri.[2] The author, who fled Iran with her mother when she was eight years old, shares heartbreaking stories of what it is like to be forced to flee your home country. What struck me as most disturbing was how Western governments make it extremely difficult for refugees to gain asylum. What has PHR been doing to help refugees gain asylum?

MH: Since it was founded in the mid-1980s, PHR has worked to protect the right to seek asylum, a right enshrined in international and United States law. One way PHR has done that is to train clinicians in how to conduct medico-legal evaluations that conform to the Istanbul Protocol for individuals seeking asylum (the United Nations endorsed guidelines for investigating torture and ill treatment).[3] PHR has helped train clinicians to systematically document the physical and psychological sequelae of violence and persecution so they are appropriately considered in the legal review process. PHR has helped medical schools create student-run programs that match trained clinicians with pro bono lawyers representing people seeking asylum. About 30 medical schools now have PHR-affiliated programs, and PHR has a network of over 2,000 trained clinicians.

The PHR team also studies and analyzes violations of the right to asylum to influence policy reforms and increase public awareness of violations. Currently, the right to asylum in the United States has been suspended, so we have been focusing on this issue. I encourage SGIM members who care about these issues to join this network of clinicians even if they are not conducting medico-legal evaluations. We are convening regular Zoom meetings and expanding the role of the net-

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work to engage in other forms of documentation and advocacy.

EB: SGIM has an interest group on Immigrant and Refugee Health. When that group met in the fall, they discussed opportunities to participate in advocacy, medical education, and practice management. In the area of advocacy, they were working on a statement to call for expanding waivers for undocumented immigrants to be able to buy insurance in state marketplaces. In the area of medical education, they were exploring how to partner with the Society of Refugee Healthcare Providers on setting care standards in refugee health care and in sharing curricular resources. In the area of practice management, they discussed sharing information about immigrant health clinic models that engaged navigators or community health workers. What advice would you give to the interest group and to SGIM's Council about how to respond to the current crisis?

MP: The interest group has identified specific areas of great importance for the health and wellbeing of immigrants and refugees. Now there is a great need for documentation and advocacy on how current policies are affecting patients and communities, a role we are well-suited to play as physicians who are front-line witnesses of these effects. The current administration, for example, rescinded guidance that restricted immigration enforcement in health care facilities, religious institutions, and schools. In response, PHR is conducting a national survey of clinicians, many of whom are reporting that even patients who have legal status are afraid to leave their homes for clinic visits. The interest group can play an important role in such documentation.

In addition, the interest group can help inform patients and clinicians about their rights. In a recent *Lancet* commentary, we identified resources that could be useful in these efforts.[4] To restore protections in healthcare systems, members could advocate for their congressional representatives to pass the Protecting Sensitive Locations Act (H.R. 1061/S.455).[5] This would prohibit federal agents from conducting immigration enforcement activities at sensitive locations such as: places of worship, schools, hospitals, courthouses, polling places, and sites of government assistance or emergency relief.

EB: Returning to the book club discussion I mentioned, I want to emphasize the power of the stories that were told. The stories engaged a diverse group of parishioners at my church, most of whom previously had heard little about the plight of refugees. Yet, when they learned that there was a network for communicating concerns to policy makers, many members of the group sent messages to their representatives in Congress. I share this experience in the hope that more people will listen to the stories and take advantage of the opportunities to act.

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HEALTH POLICY CORNER

THE APPOINTMENT CLAUSE AND ITS RELEVANCE TO PUBLIC HEALTH

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The U.S. Preventive Services Task Force (USPSTF) was created by Congress in 1984 to provide unbiased, evidence-based recommendations on preventive services. USPSTF uses a rating system of A, B, C, D, and I based on the strength of the available evidence and the balance of benefits and harms. Preventive services that receive a rating of A and B are generally recommended, those services that receive a rating of C and D are generally not recommended, and a rating of I indicates insufficient evidence to make any recommendation. USPSTF members are volunteers from preventive medicine fields and are appointed by the Director of the Agency for Healthcare Research and Quality (AHRQ).[1]

The original intent of the establishment of USPSTF was for the taskforce to serve as an advisory body to clinicians.[2] However, in 2010, the Patient Protection and Affordable Care Act (ACA) required mandatory coverage of all USPSTF preventive services with a rating of A or B by insurers without cost sharing. This elevated the role of the USPSTF from a purely advisory body to a body that can enact policy that is legally binding.[3] Though this has greatly improved access to evidence-based preventive care services, it has become a source of legal controversy, and this mandate has been challenged again in *Kennedy v. Braidwood* (formerly known as *Braidwood v. Becerra*).[4]

In *Braidwood*, the plaintiffs have raised multiple constitutional and statutory challenges to the USPSTF's authority to mandate insurance coverage without cost-sharing under the ACA. This article will only focus on the substantive challenge claiming violation of the Appointment Clause since this particular challenge is likely to have the greatest impact on public health for decades to come.

The Appointment Clause, found in Article II, Section 2, Clause 2 of the *U.S. Constitution*, outlines how officers of the United States are appointed to their offices. Some officers which the Supreme Court has dubbed "principal officers" must be nominated by the President and appointed with the "advice and consent" of the Senate. Others who are referred to as "inferior officers" by the Constitution may be appointed by the President, the courts, or heads of departments if Congress allows.[5]

However, which officers of the United States are considered principal and which inferior is not fully clear and has evolved over the years. Based on the most current precedent, inferior officers are those who are directed and supervised by others who have been nominated by the President and appointed with the advice and the consent of the Senate (i.e., principal officers).[5]

In *Braidwood*, the crux of the plaintiffs' argument in the Appointment Clause challenge is that the members of the USPSTF are not subject to the direction or supervision of any other principal officer because by law they ought to be "independent" and "to the extent practicable, not subject to political pressure."[2] Thus, the taskforce members cannot be inferior officers; consequently, they are principal officers. Since they are appointed by the

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AHRQ Director rather than through the procedure outlined in the Constitution for principal officers, their appointment is unconstitutional, and by extension, so are their recommendations. Therefore, an unconstitutional body's mandate to cover A and B-rated preventive services cannot be legally binding.

There are counterarguments and legal maneuverings on behalf of the government to save the USPSTF and its function within the ACA in its current form. Arguably, the government's strongest counterargument against this challenge (made by both the Biden and Trump administrations) is that the Health and Human Services (HHS) Secretary has broad authority to remove USPSTF members and determine coverage start dates. This implies that the members of the taskforce are inferior officers—thereby not subject to Senate confirmation—as they are subject to the direction and supervision of a Senate-confirmed principal officer (i.e., HHS Secretary). This interpretation is potentially contradictory to the plain reading and the intent of the legislation to keep the recommendations "independent" and "to the extent practicable, not subject to political pressure."[2] This line of argument creates other legal obstacles, beyond the scope of this article. Nonetheless, taking the government's argument at face value, it still subjects the USPSTF to political pressure, now from the HHS Secretary.

This term, the Supreme Court will opine on this case. Reading the tea leaves with the current Supreme Court (which has been willing to overturn longstanding precedents when it suits its ideology) is difficult. Nonetheless, this case raises two important questions:

1. Can the federal government ever create a body with policy-making powers that is truly "independent" and "not subject to political pressure"?
2. More broadly, is a policy-making body that is independent and free of political pressure, thereby shielded to some degree from democratic accountability, a net positive or a net negative in a liberal democracy?

Although the second question is likely beyond the scope of what the Supreme Court will decide, the *Braidwood* decision will answer the first question and will have long-lasting implications in all public policy matters, but especially in public health at the federal level!

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SGIM

MEDICAL EDUCATION

NAVIGATING ACADEMIA FOR CLINICIAN EDUCATORS SERIES: INCORPORATING A NOVEL MENTORSHIP MODEL INTO A FACULTY DEVELOPMENT PROGRAM

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As Odysseus had Mentor serve as a teacher and advisor to his son, Telemachus, in the *Odyssey*, most academic clinicians search for mentorship either within or outside of their home institutions during their careers. Mentorship is perceived by faculty as crucial for professional advancement.[1-2] A recent mixed-methods study examining the mentoring needs, experiences, and perceptions of clinician educators found: 1) a mentoring team promotes career advancement; 2) peer mentors are important at every stage of a clinician educator's career;

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3) there is inadequate mentoring specific to clinician educator needs; and 4) mentoring involves skill development and protected time.[3]

Early faculty development programs were created to improve teaching skills,[4] but they have since evolved to prepare faculty for new roles, including the acquisition of new clinical or administrative skills.[5] Studies show that the traditional dyadic mentorship relationship is beneficial for project-specific or time-limited mentoring, and peer mentorship is perceived as potentially more valuable as one transitions into mid- or senior-career clinician educators as the pool of available senior mentors dwindles.[3] Recognizing the gap that existed for junior faculty regarding their mentoring needs and desire for formal education regarding academic promotion strategies, the novel Mentoring Triad Unit (MTU) concept emerged, and the Navigating Academia for Clinician Educator Series (NACES) was created. This article will highlight the development and lessons learned in creating this novel faculty development program.

Developing NACES

The academic promotion process can be challenging. NACES was created to prepare early career faculty to successfully navigate the academic promotion process. During the development of NACES, a needs assessment was completed for junior and senior faculty. Junior faculty desired mentorship and formal instruction on strategies for successful senior-level promotion along the teaching pathway. Senior faculty reported that NACES would fill a need at our institution. Both groups viewed a certificate of completion as beneficial for one's CV.

NACES is a unique, eight-month faculty development (FD) program combining a novel MTU and monthly 60-minute interactive workshops led by expert clinician educators. The MTU is composed of a NACES scholar, a peer mentor (who is another current NACES scholar), and a senior mentor. The topics for the MTU sessions and the monthly assignments were created using the needs assessment involving junior and senior faculty and from my time as a scholar within the Harvard Macy Institute's Program for Health Profession Educators. The MTUs met to discuss important topics including career planning, self-reflections, and negotiation strategies for the NACES scholars.

The list of monthly workshops was developed from iterative discussions with expert clinician educators on how to prepare early-career physicians for successful senior level promotion. For the 2024-25 cohort, the monthly workshops are as follows:

- To Mentor and To Be Mentored: Effective Strategies for All (MTU Session: An Exercise on Self-reflection)
- Developing Your Academic Personal Statement
- Updates in the Current Promotion Requirements and How It Impacts Faculty
- Clinician Educator Milestones (MTU Session: Strategies on Career Planning)
- Networking
- Assessment of Educational Programs
- Sponsorship (MTU Session: Return on Investment)
- Your Educator's Portfolio: What Is It and Why Is It So Important for Promotion?

These topics were chosen based upon the prior year cohort's end-of-year surveys and from discussions with the prior year's NACES scholars and senior mentors.

Scholar Experience

NACES has been well-received by scholars, as noted by two testimonials from prior NACES scholars:

1. *"Being part of the NACES Scholar Program has been a transformative experience, particularly through the opportunity to be paired with an experienced mentor. My mentor provided invaluable insights into the field of academic medicine, sharing their expertise and guiding me through its many facets. Their mentorship not only deepened my understanding of the academic and research-oriented aspects of medicine but also inspired me to envision how I can contribute meaningfully to this field. This experience has reinforced my passion for pursuing a career that combines clinical practice with teaching and research, and I am truly grateful for the guidance and encouragement I received."*
2. *"NACES provided an invaluable launching pad as a new faculty member for me to begin to intentionally consider, collaborate and implement my personal path to advance in academia. The interwoven experience of formal didactics and mentorship triads were effective in building foundational knowledge and subsequently providing a platform to put that knowledge into practice."*

These testimonials highlight how NACES fulfills the mission of preparing early-career faculty for a career in academic medicine. The incorporation of a novel MTU maximizes the mentoring experiences of NACES scholars and allows for a deeper dive into the content of the monthly workshops.

Lessons from the 2022–25 Cohorts: Program Improvement and Enhancing Engagement

With every new program, lessons are learned for changes to improve the program. During the 2022-23 cohort, the MTU sessions met outside of the monthly NACES sessions. Due to scheduling conflicts among the MTU

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members, many MTU sessions were missed. Based upon feedback from scholars and senior mentors from the 2022-23 cohort, the MTU sessions were incorporated into the monthly sessions for the 2023-24 cohort, and the number of MTU sessions decreased from five to three for the 2024-25 cohort.

The end-of-year survey response rates were low (less than 20% completion) for the first two cohorts. To improve survey response rates for the 2024-25 cohort, a certificate of completion was created to document career development for scholars. The certificate is achieved when a scholar completes the baseline and end-of-year surveys, attends all three MTU sessions, and attends seven of the eight monthly workshops. We anticipate that the certificate of completion will boost the response rates of the surveys and participation in the MTU sessions and the monthly workshops. Survey responses and attendance rates will be reviewed to determine the effectiveness of awarding the certificate of completion.

Conclusion

As NACES is in its third cohort, it is too soon to know if it will achieve long-term success with early-career faculty obtaining senior-level promotion. However, NACES is fulling its stated mission by preparing NACES scholars for eventual senior-level promotion through appropriate mentorship, development of a professional network of colleagues, and advancement in medical education scholarship. Feedback mechanisms are important for continuous quality improvement. By receiving feedback from scholars and senior mentors and incorporating this feedback into future cohorts, NACES continues to grow and develop. We eagerly await the intervention results of utilizing a certificate of completion documenting leadership development upon participants completion of the end of program survey as well as any increase in participant attendance.

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SGIM

PERSPECTIVE: PART I

YES, NO, MAYBE SO: QUESTIONS, ANSWERS, AND MORE QUESTIONS FROM A MID-CAREER PHYSICIAN EXECUTIVE

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"*Are you pissed at me?*" my intern asked a floor nurse early in my medical school pediatrics rotation. There had been a misunderstanding about a patient, the nurse had moved on. But by asking that question, my intern won her trust and compassion, and she turned into one of our fiercest allies during the difficult four weeks on the wards that followed. The answer ("no") was not particularly important. The question itself hit restart on the relationship and allowed it to flourish. The nurse felt that we trusted her opinion, wanted to build

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a collaborative relationship, and cared how she felt. Since that experience, I've been intrigued by the questions we ask and the answers we give to gain better insights into leadership. Yet, too often, I still find myself advising too much and not being sufficiently inquisitive. This article will talk about some of the best answers and questions.

As a mid-career physician executive, I get a lot of questions from patients, people who report to me, colleagues, and friends. My default approach was to share my knowledge and experience by giving the "best" answers based on decades of classroom work and clinical and management experience. I have come to learn that in many situations responding to a question with other questions is more vital than providing answers. Herminia Barra and Anee Scoular discuss the method of coaching colleagues within an organization is an important way to get optimal solutions while helping others grow.[1] They recommend that by "listening, questioning, and withholding judgment," one engages in nondirective mentoring which can energize those being coached to find their own way out of difficult situations. This has been one of the hardest lessons for me to learn: rather than giving advice, it is better to ask questions to prod those asking me for guidance to discover the answers on their own. This realization has also been the most fruitful by enabling better solutions and stronger relationships with teams.

Dean James Ryan's 2016 commencement address at the Harvard Graduate School of Education featured five "Essential" questions to ask, which he later published in book form.[2] I often reflect on his questions as I try to solve problems:

1. Wait, what? (to obtain more information before deciding on a path forward)
2. I wonder why/if? (to help find creative solutions that have not been previously considered)
3. Couldn't we at least? (to find common ground and start off on the path to a solution of a difficult challenge)
4. How can I help? (to avoid having to feel that I have all the answers)
5. What truly matters? (to focus on the most important guide stars).

Sometimes probing to better understand the problem and potential solutions is the best way to get started.

As we ask questions, sometimes we also need to provide answers—and "yes!" is often the best response. One of the Chief Medical Officers with whom I worked early in my career suggested that I always say "yes!" when invited to sit on a committee or collaborate on a project, especially if it is an opportunity from which I could opt out later. His rationale was that you do not always know how things are going to work out, and a project that doesn't seem interesting in the beginning might lead to something else entirely. It can be hard to agree to more things and eventually I recognized the need to shed the least useful ones for my own wellness. Still, trying projects outside of one's comfort zone can help expand horizons, introduce you to new people, and build more interesting projects for the future.

I was preparing to make my own exciting job transition when the opportunity arose to write this article. I couldn't help but say "yes!" Had I not been able, I would have wanted to turn down the editors immediately: my sales friends would point out that the best thing after a "yes" is a "quick no." If people are not able to agree to something, it becomes important to decide that right away so that both parties can shift focus elsewhere. Although *Getting to Yes* is a best-selling negotiation book,[3] Chris Voss makes a point in his negotiation book of getting people to say "no" early in a conversation.[4] People feel more comfortable when they are given the freedom to say "no." You avoid the risk of people saying what he calls a "counterfeit yes," where they say "yes" but really mean "no," and become resentful. For me, this means creating a supportive team environment where people feel comfortable telling me the truth, even if that truth is a "no" I did not necessarily want to hear.

Skillfully asking questions is important and so is answering them in a way to further open the conversation. For this, even more beneficial than a "no" may be what my eldest child's fifth-grade teacher taught me. She was a big proponent of answering "not yet" in teaching for her class and their parents with a focus on a growth mindset. As with asking questions, answering with "not yet" forces others to think about what the future may hold and how to get there. I use this when collaborating with leaders who have not done a particular task (e.g., coaching a faculty member) or counseling patients who are not able to accomplish something they feel like they should. For the patient who has not yet begun to exercise, today becomes a perfect day to start. A faculty member might "not yet" be ready for a promotion—so what are the steps we can take now to get them ready?

Confucius said that "The man who asks a question is a fool for a minute, the man who does not ask is a fool for life."[5] Although he had this mastered 2,500 years ago, I reflect on my career thus far to figure out how to ask the right question at the right time that I wish I learned earlier.

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SGIM

PERSPECTIVE: PART II

OUR SHARED HUMAN EXPERIENCES IS THE FUEL FOR ADVOCACY

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Physicians are irrevocably transformed by their shared experiences of human suffering, healing, and hope. Throughout the course of training and careers, their knowledge and expertise encompass far more than medical facts and treatments. Advocating for a healthy society becomes just as important as a differential diagnosis in working with patients to achieve a healthy life. My own journey from medical student to physician advocate was a process of evolution in perspective that resulted in a broader, more complex view that human health cannot be achieved without fighting for the rights of all individuals in our society. This article describes the evolution of my personal call to advocacy and encourages physicians to remember our core values as inspirations to demand that all humans have a right to a healthy life.

In the early years of medical school, amidst memorizing pathophysiology and pharmacology, we also hone our interpersonal skills to connect with patients and their families, while we perform the well-known history and physical. We learn qualifying descriptors of symptoms, such as duration, quality, severity, alleviating or exacerbating factors. As medical students, we obtain the most detailed review of systems of our entire career and learn how to conduct a thorough physical exam systematically. As we develop our medical lingo, the shortened term *H&P (history and physical)* is used more frequently as we sense that we won't have enough time to complete the rote task as thoroughly in our not-too-distant future.

As a third- and fourth-year medical student, I distinctly remember applying these newly developed skills on my clinical rotations. I discovered that my best contribution to the team was often sitting at the bedside of my patients and listening. Most often, the patient would open up about how they were feeling, how their disease began, and what was most important to them in their lives with few, if any questions needed. My patients craved human connection, whether in the clinic exam room or on the hospital wards. Many of these interactions highlighted that the burden of disease was not shared equally, and, in fact, factors outside of the exam room impacted their ultimate health outcomes. It was frustrating to acknowledge my lack of control over the effects of culture, race, poverty, and environment.

As I refined my knowledge and expertise, I still relished in residency those human moments when I could just sit with a patient or family and listen to their stories. I often learned more than I could have discerned from a typical medical interview. My understanding of the intricacies of social determinants of health and the idea of health equity started to mature. I began to seek out how I could affect change outside of the clinical space.

I strive to be mindful, as an attending physician, of slowing down and listening to the human being in front of me, despite the pressure to complete such tasks as efficiently and quickly as possible. I understand how vital maintaining these human moments with our patients are for our own career satisfaction and well-being. My clinical focus has become one of working with the most complex patients in the primary care setting, particularly people struggling with severe mental illness. I collaborate with my team daily to meet the needs of our patients by ensuring they have proper housing, food, clothing, and transportation; we model to our learners that all patients are treated with value and respect. Outside of clinic, I

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advocate for social policy that results in the improvement of health for all.

This shared human experience is essential for longevity in the profession of medicine. If that connection was lost, I would follow the path to burn out and leave medicine along with many of my peers. Amid the privatization of medicine driving reimbursement models and "increasing efficiency," SGIM members run the risk of losing the most important part of our role as physicians. We must stand our ground to maintain the ability via time and environment to truly connect with our suffering patients as fellow humans. As a primary care attending with a decade of experience, my patients express their gratitude for me taking the time to listen to them without interruption. Sometimes, this can take more time than I have allocated for their visit, especially if we are addressing social determinants of health. It is always time well spent.

Our challenges today are far greater than I could have imagined as a student or even a year ago. Not only is our professional experience threatened by time and efficiency measures but also human rights are facing the greatest threats in our lifetime. Immigrants are being treated as less than human.[1] The existence of the trans community is being systematically erased.[2] Reproductive health is regressing after the overturning of *Roe v. Wade*. Vaccine misinformation is rampant with a resultant growing measles outbreak. Medicaid and Medicare funding are at risk of such cuts that thousands of our patients may lose health insurance coverage.[3] Food insecurity and housing crises are worsening by the day.[4] Research funding for groups most at risk is being slashed.[5] Our language for describing disparities is being regulated.[5]

The health effects due to the ongoing turmoil are already visible in our patients. It is clear that human rights are intricately connected to human health. I argue that our sense of resonance with our patients in the shared human experience is the heart of medicine and the fuel for imagining change to create a better future. SGIM members must not stand by silently ignoring the human connections we share. Now is the time to be vigilant, advocate, and fight for the rights, lives, and futures of our patients.

Disclosures: The opinions in this article do not purport to reflect the opinions, views, or positions of SGIM or any other entity.

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SGIM

REMEMBERING SHELLY GREENFIELD: AN SGIM PIONEER, LEADER, AND MENTOR

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Sheldon Greenfield (Shelly to many of us), a founding parent of SGIM, died February 26, 2025, at the age of 86.[1] He remained active in medicine seeing patients, completing research projects, and mentoring faculty and students until the last months of his life.

Shelly was a leading figure in the emergence of academic general internal medicine (GIM). Prior to the advent of GIM in the mid-1970s, care for medically complex patients was largely relegated to specialists, and Shelly was one of them (Infectious Diseases). Psychosocial complexity was mostly ignored in internal medicine training at that time. As a young faculty member, Shelly recognized the need for an internal medicine field aimed at comprehensive, continuous care for medically and psychosocially complex patients. He envisioned this new field as encompassing training utilizing the clinical, epidemiological, and research skills needed to provide the best care for a diverse patient population across multiple care settings.

During the early 1970s, Shelly was one of a small group of similarly minded internists who created a Society to support the new field of GIM. This pioneering group included past SGIM presidents Tom Delbanco (1986-87), Tom Inui (1987-88), Steve Schroeder (1985-86), Robert Fletcher (1991-92), Suzanne Fletcher (1983-84), and, later, SGIM Executive Director Elnora Rhodes. The emergence of GIM and its Society ran contrary to the attitudes of many who thought it would be impossible for those lacking subspecialty training to provide excellent care to complex patients. Advocating for GIM was a radical concept in those early days; it took chutzpah for these young professors to step off traditional paths to create SGIM.

Shelly and his research partner/wife Sherrie Kaplan (one of SGIM's earliest PhD members) were determined to reshape care to better address patient perspectives and needs. This was reflected in their early studies of quality of care, in Shelly's leading role in the Medical Outcomes Study with its foundational development of patient centered health status measures, and in training patients to challenge and question their providers. He also sought ways to promote more effective care for neglected populations as a founder of the Venice Family Clinic. Later, he and Sherrie demonstrated the value of sharing medical information with patients in a series of randomized trials. Shelly and Sherrie's research has consistently served to demonstrate the effectiveness of generalists and their teams in providing sophisticated chronic care in an era when specialists fought to dominate both primary and hospital care.

As SGIM's seventh president (1984-85), Shelly worked with Council to create a new journal—*Journal of General Internal Medicine (JGIM)*. Its first issue in January 1986 included an editorial "To Celebrate a New Journal" co-authored by President-elect Tom Delbanco, President Steve Schroeder, and Shelly.[2] Shelly was tireless and loved the work of the academic generalist. He remained active in SGIM and presented at the Annual Meeting as recently as three years ago.

Many SGIM members have shared comments on Shelly and Sherrie's importance to them. At a time when the values that inspire SGIM members are under assault, these comments show the enduring impact of two people who steadfastly stood for these values. The following comments echo the memories sent by other SGIM members whose lives he touched.

Past SGIM president Eric Larson (1994-95) recalls: *"My connection to Shelly goes back to third-year medical school and house officer days. I met Shelly when he was Chief Resident at Beth Israel and one of my attendings. The young Shelly was infused with youthful idealism. He was very generous with his wise advice, ideas, and getting into details like sharing obscure papers and unique statistical approaches from journals I had never heard of! His wisdom, kindness, intelligence, and commitment to improvement, to helping others made a lasting impact on me."*

Former JGIM editor Rich Kravitz (2009-17) met Shelly in residency. He recounts: *"Shelly was already*

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a national figure in health services research, but to the residents he was someone who not only practiced evidence-based medicine before it was popular but approached patient care and teaching with effervescence and efficiency. This reminded us that medicine could not only be rewarding but also fun. Even then, I thought to myself, 'If I ever do academic medicine, I want to be like him.' Shelly was a wonderful research mentor: energetic, supportive, and generous with his time. Years later, he let it slip that he had some doubts about my early prospects, but he supported me anyway, and we got the work done. Shelly inspired me to take on important questions even if they're not immediately popular, to plan ahead, to take notice of the less well-off, and to try to remember that while it might not be our responsibility to finish the task of making the world better, neither are we free to avoid it. Shelly took a chance on me, supported me, challenged me, and inspired me to be a better clinician, researcher, and person."

Past SGIM president Lisa Rubenstein (2008-09), a resident and Clinical Scholar with Shelly, recalls: *"Shelly's stellar academic career might lead you to think of him as serious, stolid and difficult to talk to. Not so. Sitting down with Shelly meant having a chance to say what's on your mind and to hear what's on his. Communication was never a one-way street. He welcomed new ideas, however unusual or challenging, focusing on what could be accomplished rather than on what's wrong. And he defended his people like a lion. Conversations with Shelly and Sherrie were infused with humor that reflected appreciation for life, its vicissitudes, and the people around them. Given his understated brilliance, generosity and warmth, it is not surprising that Shelly was a mentor and teacher to multitudes of aspiring academics. He also remained a lifetime friend and role model to many, including myself."*

Past SGIM president Martin Shapiro (2002-03) discloses: *"Shelly was my secular savior. I came to UCLA from Canada in 1976. I was apprehensive about working in U.S. health care, which lacked universal health insurance. A first-day lecture by a health economist convinced me that I had made a terrible mistake. The country, the values, and the policy priorities were so conservative. I wanted to get out. When I spoke to Shelly about it, he validated my apprehensions but also said that I would find allies and be able to do things consistent with my values. He was right. Shelly was always someone I could talk to about my concerns, and he encouraged me to be fearless in my pursuits. He was one of the least pretentious people I have known. Research for Shelly always was about making things better for patients, not for gaining glory. He and Sherrie made many seminal contributions but never made a big deal about it. So many of us who trained at UCLA looked to him as a confidante and supporter who always was there for us. He consistently made me feel like part of his family. His heart, his arms, his house, and his table were always open to all of us who needed him."*

A graduate of Harvard University and University of Cincinnati School of Medicine, Shelly completed a residency and chief residency at Beth Israel Hospital, Boston, Massachusetts. He served as an Epidemic Intelligence Officer at the Centers for Disease Control and Prevention (CDC) before joining UCLA's new Division of GIM and Health Services Research at its inception in 1972. He later moved to Tufts/New England Medical Center, building another set of strong research, education, and clinical care initiatives. He spent his last decades at the University of California, Irvine—taking on the challenges of building a strong GIM research, education and clinical care enterprise along with Sherrie, who became a UC Irvine Vice Chancellor. At each stop, he combined clinical care and teaching with clinically focused health services research.

Those who knew Shelly understand that many of his wonderful attributes, and comments that documented them, didn't make it into this brief remembrance. Nonetheless, we hope that all SGIM members will recognize with gratitude one of the pioneering GIM leaders upon whose shoulders their current work stands.

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