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SGIM FORUM

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PERSPECTIVE: PART I

REVIEWING EXPECTATIONS: AN ATTENDING'S QUEST TO INSPIRE HIS TEAMS

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It's snowing in April in Pittsburgh, Pennsylvania, but I'm already planning for summer—the season of renewal for medical trainees and, so long as we can keep pace, for medical educators. In the spirit of renewal, I am reading an essay about baseball. Not one that glorifies the springtime of youth or the long summer of experience aspiring to mastery, but a meditation on the art of longevity, which is also the art of constancy—how to maintain a certain standard of performance well into the cooler days.

In the essay, John Updike writes, "Baseball is a game of the long season, of relentless averaging-out… [its relevance] can be maintained not by the occasional heroics that sportswriters feed upon but by players who always *care*." [1] Medicine is not a game. The stakes, at times, seem unimaginably high. And yet, its practitioners face the same risk as ball players of lapsing into an all too easy, potentially substandard routine.

Reflecting on standards, I finish the essay and begin sifting through a digital folder that contains a dozen years of "expectations" documents, signposts for travelers who briefly staff the inpatient teams on which I attend. The challenge facing the author, which his "expectations" are meant to address, is this: every thought, every action, every document, and conversation issued in the service of our shared patients is my responsibility. So, how should I inspire my team?

The utility of these documents depends on which traveler you ask. A medical student may attempt to extract from them a set of metrics, key to "winning" the finite game of their medicine clerkship. Interns—inveterate doers—want to know, often in detail, how the work should be done. Senior residents tend to ask clarifying questions that define the contours of our relationship: "Should I check with you before calling consultants?"

Being a parent, I recognize that I have little influ-

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ence beyond the example of my actions. Each new team will skim my papers and just as quickly discard them. Accepting this, while continuing to obsess over the content of these pages year after year begs this question: who is the intended audience? All fiction is auto-fiction. All writing is a gesture towards an idealized vision of oneself.

According to my records, in the beginning, I was a bit of a micromanager, appending a predictable list of rules for rounding and for staffing new admissions with presumptuous attachments like "The Model Discharge Summary" and "Suggested Format for Problem Lists." It took me about three years to calm down and adopt a less prescriptive approach. Inspired by Simon Sinek's *Start with Why*,[2] I started with "WHY?" ("To care for him who shall have born the battle") before moving onto "HOW?" ("Open communication… if you don't know, ask") and relegating the dull "WHAT?" ("4-day call cycle… daily bedside rounds") to the bottom of the page. The "start with why" era signaled an early attempt to influence not just how my learners behaved but also how they approached and perceived their work.

Out went rigid guidance with the next evolution; in came a new primer on James Carse's *Finite and Infinite Games*,[3] a philosophical framework I can't seem to avoid in my teaching or writing about teaching. I'd like to think that attempts to influence mindset, meaning, and purpose were a sign of a maturing educator, one more poised to address the deeper currents in clinical medicine than his younger self had been. But, skimming the Carse handout, I feel as I often do when reading just about anything I've ever published, some mixture of sympathy for and embarrassment over the poor fool who wrote it.

The structure of my expectations morphed as often as the content. At one point, I seem to have gotten bored with the lecture format, reframing a list of declarative sentences as questions and retitling the document, "Expectations—The Quiz." Right now, I'm feeling less sympathy, more embarrassment.

Other notable iterations include: a) a hybrid form that combined "golden rules" and "learning objectives;" b) a twist on the quiz in which I asked the team to rank certain attitudes and behaviors according to their own prioritization; and c) several versions presenting values-based acronyms, including VA's ICARE (Integrity, Commitment, Advocacy, Respect, Excellence) and my own invention, PANDO (Professionalism, Advocacy, iNquiry, Dignity, Openheartedness).

Through the late 2010s and the COVID-19 pandemic, the expectations gradually evolve as core principles permanently supplant specific instructions. Tracing this evolution, there seems a simultaneous desire to distill the guidance to its essence while at the same time making more space for improvisation and grace. More autobiography. The title shifts from "Expectations" to "Priorities and Aspirations," to "Intentions and Aspirations," and, finally, to the "Five Intentions" described below.

A nearly full-page spread is now devoted to the following "Five intentions (and one caveat):"

1. "Find out what your patients need and make sure they get it"*
2. Ask for help
3. Share information with the team, with patients and families
4. Be curious, not judgmental
5. Resolve confusion and conflict through conversation with other humans.

Caveat: You don't need to have the answer. You just need to have a plan.

By the time you read this, even that version will be out of date. I'm constantly revising both the document and my attitude towards it. The challenge facing the author is this: how to cultivate in each team member both a flexible mindset and an ethic of consistent effort and care?

It's that intention that that brings me back to the baseball essay, the one in which John Updike "bids adieu" to one of the greatest hitters of all time. To be a great hitter, like Ted Williams, requires remarkable eyesight, coordination, and reflexes; the ability to adapt, in a fraction of a second, to a curveball's mysterious physics. At age 42, Williams homered in his final at bat. His longevity and dedication to his quest for perfection required remarkable commitment to an ethic of consistent effort and care. As Updike put it, "For me, Williams is the classic ballplayer of the game on a hot August weekday, before a small crowd, when the only thing at stake is the tissue-thin difference between a thing done well and a thing done ill."[1]

Every medical student and resident I work with can "play ball" well enough. At age 42, I can play well enough, too. As for that tissue-thin difference? The relentless effort to do right by each patient, every day. I believe that's always worth chasing.

**The author wishes to credit Dr. Hasan Shanawani for his contribution "Find out what your patients need and make sure they get it."*

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SGIM

MARDI GRAS FOR THE MIND: FINDING HAPPINESS OUTSIDE OF MEDICINE

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John Grisham. Michael Lewis. Connie Chung. Bob Woodward. Doris Kearns Goodwin. Jeffrey Goldberg. Anne Appelbaum. Charles Duhigg. Maureen Dowd. Walter Isaacson. What a powerful list of respected authors! Bibliophiles and casual readers alike would welcome a chance to see one of these authors in an intimate setting. A chance to see all of them over a two-day period seems impossible. The attendees of the fourth annual New Orleans Book Festival hosted by Tulane University enjoyed this opportunity. My spring pilgrimage to this event helps me find happiness outside of medicine.

Everything is different in New Orleans. *"Mardi Gras for the Mind,"* the festival's slogan, celebrates books and established authors with interactive sessions and book signings under the guidance of co-chairs Walter Isaacson and Cheryl Landrieu. The New Orleans Book Festival supports the local and national literary community with renowned authors celebrating their creative efforts. My attendance at the Book Festival has become an annual tradition as I negotiate with colleagues to ensure my attendance.

This year's opening session featured an interview with Jeffrey Goldberg in one of his first non-news appearances after the infamous *Signalgate* scandal. The line for this session started early and wrapped through campus for nearly a mile. I knew that I could not make the evening session due to this crowd and my late work meetings. Good thing for me, all sessions from the Book Festival are recorded and available.[1]

As a physician, my festival attendance focused on three sessions I considered essential: 1. Dr. Anthony Fauci, Former Director of the National Institute of Allergy and Infectious Diseases (NIAID) before serving as Chief Medical Advisor to the President; 2. Dr. Jennifer Doudna, the 2020 recipient of the Nobel Prize in Chemistry for her pioneering work in CRISPR (Clustered Regulatory Interspaced Short Palindromic Repeats); and 3. Dr. Francis Collins, Former Director of the National Institute of Health (NIH) after serving as Director of the Human Genome Project.

First Session: Dr. Anthony Fauci

The doors of the auditorium opened an hour before Dr. Fauci took the stage. The auditorium quickly swelled to capacity long before the session commenced. Dr. Fauci entered to a 30-second standing ovation. Over the next hour, Dr. Fauci regaled the audience with stories starting with his Jesuit education in Brooklyn, New York, which led to his "service to others" philosophy founded on integrity and honesty. His approach as a scientist has been to always do what he could to preserve and protect the health of the American public. Next, he described his father's community pharmacy and the influence this community gathering spot had on him as he trained and learned to focus on people. He reflected on biomedical research and his time at the NIH where he learned he could impact the care of many as opposed to the patient in front of him. He lamented governmental funding cuts while discussing attacks on research and universities.

Walter Isaacson redirected the conversation to Dr. Fauci's observations of the early cases of AIDS patients in 1981 and how this discovery impacted his career trajectory. Dr. Fauci compared the personal attacks he received then versus the current attacks on science. The discussion next transitioned to COVID-19, the origins of the virus, lessons learned, initial management, and longer-term decisions (which he noted should be re-examined). Dr. Fauci reflected on his book chapter ("He Loves Me, He Loves Me Not") while discussing his disagreements with President Trump and describing his need to always tell the truth to the American public. Dr. Fauci recounted the conversations with the President surrounding booster vaccine recommendations when the President asked, "Why can't you be more positive?" and the colorful language that accompanied this question. He concluded with the comment that critical thinking is essential in society but is often missing today.

After 12 rounds of applause during his interview, the attendees recognized Dr. Fauci with a nearly five-minute standing ovation as the session concluded. His book *On Call: A Doctor's Journey in Public Service*[2] is a must read.

Second Session: Dr. Jennifer Doudna

Walter Isaacson chatted with Nobel-Prize winner Dr. Doudna as she told of her early foray into science after her guidance counselor told her that "girls don't do science." Early memories included a gift from her father-a book on the discovery of the double helix before she pursued a career in chemistry. Her partnership with Dr. Jillian Banfield led to CRISPR after the discovery that bacteria could develop immunity to viruses. This discovery showed that CRISPR sequences encode RNA molecules that provide zip codes that tell proteins where

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to go and what viral DNA to cut. This led to targeted gene editing to cut or repair DNA as directed to address diseases, such as sickle cell disease, by overriding genetic mutations. A discussion followed on the moral quandary of targeted gene editing for purposes other than disease treatment such as editing genes of future generations.

The second half of the discussion delved into the commercialization of products, such as CRISPR, via establishing programs like the Innovative Genomic Institute. Dr. Doudna stressed the need to train scientists in business models to move from academic research to the business of implementation science. Further discussion focused on research funding cuts with the subsequent loss of scientific talent from the United States. Her final comments focused on the importance of explaining what we do in science and why it matters. For more details, I suggest Walter's book *"The Code Breaker."*[3]

Third Session: Dr. Francis Collins

Don Lemon conversed with Dr. Francis Collins as they started with "what is wisdom"—a mixture of knowledge, common sense, experience, and moral compass. Our road to wisdom is filled with potholes, per Dr. Collins. We need truth, science, faith, and trust in today's divided society. Dr. Collins recounted his "COVID-19 errors" but reminded the audience that we have forgotten how bad things were in 2020, and he wished he had clarified more that his message was related to "science at that moment." When recommendations changed, people began to doubt the science and distrust arose. Competence, integrity, and humility are all keys to establishing trust, but these concepts have been pushed aside. Today, the focus is whether the message resonates with "my people" as politics have crept into this conversation.

He contrasted historical memories of being the bearer of unpopular news with resulting phone calls from the President regarding his messages with the successful vaccine development within 11 months. Per Dr. Collins, our culture wars unnecessarily killed 234,000 people who refused available COVID-19 vaccines due to mistrust and disinformation. Collins' book, *"The Road to Wisdom,"*[4] details his story during COVID-19, feelings of personal failure, and our path forward as he references his transformation from an atheist to an evangelical Christian. His stories offer powerful reminders that healthcare leaders did the best possible in an ever-changing COVID-19 environment.

As medicine is stressful with the current healthcare and political climate, this pressure can take an emotional and physical toll. It is important that we find activities outside of medicine that make us happy. For me, reading helps fill this need. In *The Catcher in the Rye*, J.D. Salinger's protagonist says, "What really knocks me out is a book that, when you're all done reading it, you wish the author that wrote it was a terrific friend of yours and you could call him up on the phone whenever you felt like it. That doesn't happen much, though."[5] During these three sessions, I got to "sit" with three amazing scientists who

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have changed the scientific community over the past few decades. For 60 minutes, each interview felt like a conversation between only us. My three "friends" enthralled me with their stories of service, dedication, and discovery, even though I had to share them with 150 other attendees. Mission accomplished as I attended three amazing scientific sessions and had the authors sign their respective books.

"*Mardi Gras for the Mind*" was an amazing success. The growth of the New Orleans Book Festival ensures its continued presence on Tulane's campus. As the crowds continue to increase (an estimated 18,000 attendees in 2025), more distinguished authors will attend. My admiration for their creativity will continue to grow. My "out of office" response is ready for March 12-14, 2026, as I will be at the 2026 New Orleans Book Fest.

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SGIM

PRESIDENT'S COLUMN

A NEW ACADEMIC YEAR: TAKE STOCK, PLAN AHEAD, CELEBRATE WINS, DREAM A BIT

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

"Just listen to one of the Presidential Podcasts. The stories told by past SGIM Presidents are inspiring. I have been in the organization long enough to recognize their voices, which bring an emotional connection."

Every July marks the beginning of a new academic year. Medical students prepare to transition into residency programs, graduating residents pursue fellowships or launch careers, and faculty feverishly prepare for a smooth transition. During this busy period, we should reflect, take stock of the past year, and celebrate our achievements. I find myself reflecting on the exciting yet demanding path we've chosen in academic medicine. It's a career woven from the threads of unique patient experiences, the passion for teaching, the pursuit of discovery, and the search for ways to continuously improve patient care. In this article, I share some thoughts, gleaned from my own journey and personal observations.

Reflecting on the Past Year: Lessons Learned

I imagine that the past year has been a whirlwind for you, much like it has been for me. We have navigated complex cases, stood at the bedside guiding trainees, completed a quality improvement or research project, or implemented a curriculum. What moments from the past year resonate with you? Perhaps it was a diagnostic challenge, the spark of understanding you witnessed in a learner's eyes, or the victory of a completed project.

I acknowledge the challenges. There were moments of feeling stretched thin, juggling the demands of clinical duties with teaching responsibilities and administrative tasks. Perhaps the research proposal didn't pan out as expected, or a teaching session fell flat. Consider the feedback you received—from students, residents, colleagues, and patients. What did you learn from these experiences?

These moments, while sometimes disheartening, are valuable learning opportunities. Constructive criticism, though sometimes difficult to hear, is a gift that allows us to see ourselves through the eyes of others and identify blind spots. Embrace these lessons as a candid reflection on both successes and setbacks to provide a compass for future direction.

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Celebrating Your Successes: Acknowledge Your Milestones

Amidst the daily work, pause and celebrate your accomplishments. Develop a habit of updating your curriculum vitae (CV) often; I feel small bursts of happiness when I see my accomplishments there. It is even more gratifying when my name gets buried in the list of presentations or publications, and my mentees or colleagues take center stage. In *Drive* (one of my favorite books), author Daniel Pink argues that intrinsic motivation, fueled by autonomy, mastery, and purpose, is far more effective than traditional extrinsic rewards for meaningful work.[1] For me, the success of my collaborators works as an intrinsic reward that fuels my commitment. Share your successes with colleagues and bosses in a way that is genuine, authentic, and … humble. GIMLearn has an excellent module on just how to do that.[2]

Dreaming a Bit: Envision Your Future

Reflect on your passions, interests, and, yes, even your pain points. Find what "bugs" you (as a former fellow always said), whether it is a problem you are trying to solve or something you are curious about. Do something to deepen your understanding about this issue. I often hear my colleague Dr. Bob Centor say *"I am obsessed with …,"* and it took me no time to understand the contagious curiosity that those words meant. You can dream alone or in a group. The SGIM community is an excellent place to dream together.

I often quote the *"Just Do It"* slogan of Nike. *Just* listen to one of the Presidential Podcasts.[3] The stories told by past SGIM Presidents are inspiring. I have been in the organization long enough to recognize their voices, which brings an emotional connection. For a more junior trainee or faculty, *just* attend a regional meeting, present something, and get engaged. SGIM meetings *will* have workshops, sessions, and interest groups that *will* match your interests—for example, the Student Residents and Fellows (SRF) track at the Annual Meeting is a compilation of presentations highlighted for this specific audience. Dreaming a bit will serve as a guiding star, helping you to navigate the inevitable challenges and stay focused on your long-term goals.

Planning for Scholarly Activities: Cultivate Your Academic Voice

In academic medicine, scholarly activity is paramount. It not only advances the field but also enhances your credibility. Take time to strategically plan your scholarly pursuits for the upcoming year. Identify potential mentors who can guide you. Seek out individuals with a strong track record in your field. Discuss your interests and explore potential projects. Most importantly, find someone who you will enjoy working with. Establishing strong relationships with those around you provides support and builds community. Set realistic and achievable goals for the year. Aim to submit one abstract to a conference, draft a manuscript, or develop a pilot study. Then, *Just do it*.

Mentoring: Investing in the Future

As a member of the academic community, mentorship is a reciprocal gift. You will have a unique opportunity to shape the careers of junior faculty, residents, and students. Everyone can be a mentor. Mentors are needed across all stages of our professional careers. Reflect on your own mentoring experiences—what qualities in your mentors have been most impactful? Offer guidance and support to junior colleagues, residents, and medical students who express interest in your field or in pursuing a career in academic medicine. Share your experiences, offer advice, and help them navigate the challenges and opportunities they encounter. In my experience, mentoring and advising is a personally fulfilling gift and our responsibility in academic medicine.

In closing, a practical approach is to use the annual faculty review process at your institution—if there is no process in place, launch one with your peers (another *Just Do It* moment). You could use this process to update your CV and organize documents for teaching, service, and research portfolios. The process and discussion will help share your successes with your boss, document progress towards promotion and/or tenure (as applicable), and define opportunities for professional development and advancement.

The path of an SGIM member in academic medicine is a challenging yet deeply rewarding one. By reflecting on our experiences, celebrating our successes, dreaming boldly, planning strategically, investing in mentorship, and prioritizing our well-being, SGIM members can succeed and flourish. Embrace the journey, cherish the moments of connection and discovery, and don't lose sight of the profound impact we have on the lives of our patients and the education of our future leaders.

Disclosures: A publicly available Artificial Intelligence (AI) was used for writing the first draft of this article (following International Committee of Medical Journal Editors' guidelines).[4]

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SGIM

FROM THE SOCIETY

Q & A WITH SGIM'S CEO AND PAST PRESIDENT ON THE SOCIETY'S ACHIEVEMENTS OF 2024-25

Eric B. Bass, MD, MPH; Jada Bussey-Jones, MD, MACP

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Bussey-Jones (jcbusse@emory.edu) was the President of SGIM, 2024-25.

Dr. Jada Bussey-Jones served as SGIM's 47th President in 2024-25, the 15th woman to serve as President and sixth in the last seven years. As a tumultuous academic year reaches an end, I asked Dr. Bussey-Jones to share her reflections on the challenges and achievements of the past year.

EB: Looking back on your year as SGIM's President, what was the biggest challenge?

JBJ: Obviously, the biggest challenge arose from the broad scope of the federal administration's executive orders that have implications for many of SGIM's priorities and core values. Recognizing that many SGIM members were distressed by how the orders could affect the patients they serve, we revised the Society's approach to health policy education and advocacy to facilitate more streamlined and effective responses to the unprecedented threats to our mission.

Working closely with leaders of our Health Policy Committee, we decided to focus the most attention on three issues of great importance to members that should have some traction in the current political climate: 1) support for primary care; 2) Medicaid funding; and 3) funding for medical research. To address other concerns of our members, we increased our collaborative efforts with other organizations, including the Primary Care Collaborative, Association of American Medical Colleges, American College of Physicians, Council of Medical Specialty Societies, AcademyHealth, and Research!America. We also reintroduced and activated the Health Policy Interest Group to encourage members to speak out about their concerns and to collect stories about how new policies are affecting their patients and colleagues.

EB: What stands out to you about the achievements of SGIM's committees and commissions during the last year?

JBJ: I am proud of all the work done by our committees, commissions, and interest groups at a time when people are stressed by changes affecting all aspects of the academic mission. As one of our four core mission committees, the Health Policy Committee sent or signed on to numerous letters or statements on issues of importance to members. The Clinical Practice Committee streamlined its structure, published Bottom Line Summaries on four topics, and contributed to a seminal position statement on the use of generative artificial intelligence in medicine.[1] The Education Committee developed a learning module on building an educational portfolio, and launched Bite-Sized Teaching Competitions at our regional meetings in partnership with the Board of Regional Leaders. They also published an outstanding paper presenting a strong rationale for medical schools to invest in having Master Adaptive Clinician-Educators,[2] in addition to submitting comments to national accrediting organizations on education-related policies. The Research Committee supported the GIM Fellows Task Force in organizing a special precourse for fellows at the Annual Meeting and released an updated directory on GIM-related fellowship programs.

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Our core operational committees were busy too. The Program Committee led a fantastic national meeting that brought about 2,700 people together in May, representing nearly 90% of our members and energizing people to rise to the challenges we face. The Ethics Committee continued the "Ask an Ethicist" initiative with an article in the SGIM Forum on whether a patient can refuse care when they lack capacity, and continued work on the ethics of centering primary care and patients in research allocation. The Membership Committee continued its competition for membership renewal by committee and commission members, launched the fourth iteration of its Frontliners member highlight section (focusing this year on pioneering applications of artificial intelligence), and collaborated with the Philanthropy Committee and social media team in running a Giving Tuesday campaign to increase donations for the National Young Scholars in GIM scholarship program. The Finance Committee worked to ensure that the Society has sufficient resources to sustain its ambitious scope of work, and the Philanthropy Committee secured more than $200,000 of donations while increasing the percentage of members who made donations.

SGIM's commissions continue to foster collaboration with core committees, interest groups, and other organizations on multiple aspects of our mission. The Academic Hospitalist Commission worked with the Society of Hospital Medicine to prepare new content for the Academic Hospitalist Academy (AHA) that will be held in September 2025 as the Launching Your Career program (formerly known as AHA Level 1) and the Advancing Your Career program (formerly known as AHA Level 2). The Geriatrics Commission worked with the SGIM Forum to publish a theme issue on geriatrics. The Health Equity Commission prepared outstanding equity-focused content for the Annual Meeting, specifically for the Student, Resident, and Fellows Track, and prepared a position statement on overcoming challenges to evaluating health equity curricula. The Women and Medicine Commission collaborated with the Obstetrics Interest Group and the Program Committee to create an emergency obstetric care toolkit for the Annual Meeting and published an article in the SGIM Forum about the history of the Women's Caucus in SGIM.[3]

I particularly appreciate the ongoing work of the Diversity, Equity, and Inclusion Task Force that was charged by Council to reassess SGIM's efforts to support all members. The task force has helped to determine how to promote inclusivity in SGIM's activities while adjusting to recent changes in federal policies.

I also appreciate the progress made by the new Leadership Pathway Project Workgroup in fostering leadership development within SGIM. The group has prepared recommendations for improving members' understanding of leadership pathways within SGIM while promoting inclusivity and preparedness for leadership opportunities throughout the organization.

EB: What did you enjoy most during your year as SGIM's President?

JBJ: I greatly enjoyed interviewing past presidents for the President's Podcast, a new series I launched to celebrate SGIM's rich history and forward-looking vision as we approach our 50th anniversary.[4] The conversations highlight diverse leaders across health care, public health, policy, and academia. I believe their reflections will benefit SGIM, its members, and health care as we grow, innovate, and meet the challenges of our evolving health care environment.

I hope members will read the posted summary that provides more details about the achievements in the last year.[5] I also want to thank leaders and members of the committees, commissions, and interest groups for their superb work that advances our mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone.

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SGIM

FIVE STEPS TO SUCCESSFULLY NAVIGATE CAREER TRANSITIONS

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Introduction

Transitions are an integral part of physicians' careers. Emotions surrounding transitions can include anticipation, positive outlook, anxiety, distress, or trepidation. Transitions are inevitable: they can occur within one's current situation or involve change in a different situation. Preparation can facilitate successful transitions and help manage emotions during the process. Preparation involves reflection on core values, professional purpose, the current state, past transitions, as well as opportunities and challenges of the impending transition. Some transitions represent goals not met, while others align with positive career growth.

In this article, we describe five core steps, during a career transition. Each author also shares personal experiences of career transitions. To classify and align transitions with the five steps, our examples include the following:

- **Expected** transitions occur between typical stages of a physician's career. Examples are ending training (e.g., residency or fellowship); finishing a work contract or time-specified position; retirement.
- **Unexpected** transitions frequently occur suddenly and are often difficult to plan for in advance. Examples are positions that are changed or eliminated; leadership changes; deciding to leave.
- **Expectedly unexpected** transitions generally occur along an unspecified timeline, which could be years. An example includes a change in a spouse's or partner's situation that will impact one's own position.

Five Steps to Prepare for a Career Transition

First Step: Define Your Core Values

The process of defining core values begins with reflections on pivotal life experiences. By examining the motivations underlying decisions and actions during these formative moments, individuals identify values that consistently inform their behavior. Individuals live their values long before they can name them, suggesting that values are more accurately observed in actions than in stated beliefs.[1] Similarly, identifying "coherent lives" involves examining the intersection of work, play, and meaning, with core values serving as a compass for aligning decisions with personal fulfillment.[2] Core values typically consist of three to five enduring principles that recur across significant life events and choices. Recognizing and naming these values can offer clarity and grounding.

Second Step: Clarify Personal Priorities

With core values identified, clarifying personal priorities starts with distinguishing between immediate needs and long-term goals. This enables individuals to rank competing priorities and determine which take precedence. For example, an individual facing potential relocation may need to balance the short-term desire to minimize disruption for school-aged children with the long-term goals of maximizing financial growth and moving closer to aging parents. Each priority reflects a distinct time horizon and value orientation—stability, financial security, and familial connection, respectively. This clarification can occur through multiple approaches, including self-reflection, structured discussions with a partner or trusted advisors, or using coaching services. By articulating and ranking priorities, individuals can make more intentional decisions that align with current circumstances and future aspirations.

Third Step: Assess Resources

Resources, or lack thereof, can support or constrain transitions. Resources can be tangible (such as financial assets, professional networks, child care, or geographic flexibility) or intangible (including emotional resilience, social support, and institutional goodwill). A realistic audit of available resources helps individuals identify opportunities and gaps, often identifying potentially required trade-offs. For instance, one may discover they have strong peer support and professional experience for career change but have limited savings or childcare coverage—factors that may shape the transition's pace or structure. Resource assessment is an iterative process, as access to support systems and constraints evolve

LEADERSHIP AND HEALTHCARE ADMINISTRATION *(continued from page 9)*

alongside life circumstances. Building this awareness enables individuals to leverage strengths and anticipate challenges, increasing the likelihood of a values-aligned transition.

Fourth Step: Embrace Strategic Flexibility

Embracing strategic flexibility is essential when navigating complex transitions. This involves preparing for the best-case, worst-case, and most likely scenarios, while maintaining adaptability to shift course as new information emerges. Rather than fixating on a single outcome, individuals may benefit from cultivating a mindset of responsive planning, allowing for intention and improvisation. Decision matrices are a useful tool in this process (see table). Listing potential options alongside key priorities, then assigning weights to each factor, can help in evaluating choices more objectively, visualizing trade-offs. Structured approaches support clarity under pressure and reduce decision fatigue, especially when stakes are high, or timelines are compressed. Strategic flexibility is an active, empowering stance for individuals to align evolving realities with enduring values.

Fifth Step: Execute with Confidence

The last step is to take decisive steps grounded in thoughtful preparation. Confidence here stems from trust in the process of clarifying values, assessing resources, and cultivating strategic flexibility, even if the outcome is uncertain. Effective communication with key parties involved, including partners, employers, family members, and close friends, aligns expectations and secures needed support for a smooth transition. After implementing changes, it is equally important to create space for reflection: celebrating progress, acknowledging challenges, and adjusting course as needed. Transitions are rarely seamless, but a proactive, values-driven approach enables individuals to adapt with resilience and purpose.

Dr. Sprott's Expectedly Unexpected Transition

As a military spouse, remaining flexible through training schedules and deployments became the norm. Working full-time, I managed a household with two small children and navigated constant uncertainty of how long we'd remain in any one location. My dilemma centered around a deep desire to grow in leadership within my career, while recognizing that my path would be neither traditional nor linear. Clarifying my personal priorities—balancing family and work, while positioning myself for leadership growth—helped me focus my energy. With no nearby family, I had to assess and build my own resources: structured child care, paid help for household tasks, and a mix of fast friends and chosen family who stepped in when I needed support. Embracing strategic flexibility meant planning to go and planning to stay—remaining open to opportunity, even in instability, and defining success on terms that honored both my ambition and my reality.

Dr. Babbott's Expected Transition

One of my priorities as I approached the end of my career of practice, teaching and leadership was to ensure that I was "leaving well." This goal included what I could do to leave the various aspects of my work 'better than I found them' and ensure those whom I served were in the best position to carry on their own and our collective work. I defined five questions to guide my two-year transition to

Sample Decision Matrix for Mid-Career Outpatient Physician with Two School-Aged Children Transitioning to Hospitalist Work

Criteria	Weight (1–5)	Outpatient (Score 1–5)	Hospitalist (Score 1–5)	Weighted Score: Outpatient	Weighted Score: Hospitalist
Work-Life Balance	5	3	4	15	20
Income Potential	4	2	5	8	20
Schedule Predictability	3	4	2	12	6
Career Growth Opportunities	4	3	4	12	16
Child Care Compatibility	5	4	2	20	10
Skill Development (Inpatient/Procedures)	3	2	5	6	15
Total Weighted Score				73	87

Weight: Reflects how important each factor is to the decision-maker (1 = least important, 5 = most important).

Score: Rates how well each job option meets that criterion (1 = poor match, 5 = excellent match).

Weighted Score: Calculated by multiplying the weight by the score for each option.

LEADERSHIP AND HEALTHCARE ADMINISTRATION (continued from page 10)

retirement: Are my patients/residents/faculty OK? Are the programs and collaborations in which I am involved OK? And, am I OK? These questions modeled the iterative process of reflection on core values, personal and professional purpose. Similarly, assessing resources, embracing strategic flexibility, and executing were all supported with the clarity which comes from collaboration, communication, and networking.

Dr. Leung's Unexpected Transition

Before becoming a full-time publisher and editor, I used several professional resources to help with my unexpected transition—even if I didn't know it at the time. While working on obtaining MD recognition in the Netherlands,[3] I stayed connected through professional societies. One part of maintaining connections included my terms as an Associate Editor and later Editor-in-Chief of SGIM Forum. Communication is among my professional values – when I was a general internist in primary care; when I studied health literacy during my MPH, and even when I cut and pasted printed layouts for my high school newspaper. Staying connected, I developed new skills through opportunities, sponsorship, and mentoring relationships, many that developed through professional society networking.

Final Considerations during Any Transition

Additional general principles also help along the way: (1) Bloom where you're planted. Do a good job in the job you're in, which will help you to be visible and seen as someone who meaningfully contributes to a program or project or at least knows what they're looking for. (2) Be mindful, open, and ready. Think about how much risk you're willing to take, from the perspective of your current situation. (3) Know yourself and where you are—your values and priorities are the truest compass in navigating your career and its transitions. We believe these five steps can help SGIM members prepare for key career transitions and alleviate anxiety or fear, while instilling a sense of confidence during a transformative time.

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SGIM

HEALTH POLICY CORNER

AFFORDABLE AND EQUITABLE TREATMENT OF OBESITY

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The advent of Glucagon-Like Peptide 1 receptor agonists (GLP-1RAs) has revolutionized the understanding and treatment of obesity. However, lower-income individuals are unlikely to have access to these medications due to their high cost and the lack of government-sponsored insurance coverage. This article addresses concerns about resultant inequities in obesity management and reviews possible solutions. GLP-1RAs would become more cost-effective and affordable if Medicare/Medicaid covered anti-obesity medications (AOMs) at negotiated prices and if our definition of obesity was refined. Individual clinicians can play important roles in advocating for better coverage and pricing of GLP-1RAs and utilizing other AOMs as explained below.

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GLP-1RAs for Obesity

GLP-1RAs promote weight loss through several pathways. They slow gastric emptying through receptor activity in smooth muscle of the gastrointestinal tract and vagal nerve activation. Retention of food in the stomach promotes satiety. GLP-1 also promotes satiety in the brain by activating receptors in the hypothalamus that regulate energy balance and food consumption. This results in remarkable decreases in hunger and "food noise." Given the neurohormonal mechanisms by which the body defends obesity—slowed metabolism, increased hunger hormones and decreased satiety hormones—it is clear why the GLP-1RAs are effective.

While AOMs have existed for decades, the introduction of the highly potent GLP-1RAs has changed the landscape of obesity management. Previously, the most effective AOM Qsymia led to an average of 11% body weight loss at one year (compared to 5% with intensive behavioral therapy). In contrast, subcutaneous semaglutide leads to 14-15% weight loss on average, while tirzepatide can surpass 20% weight loss. In addition to profound weight loss, they are indicated to reduce the risk of cardiac events in patients with pre-existing cardiovascular disease (semaglutide) and reduce sleep apnea events (tirzepatide). More metabolic benefits were identified thereby demonstrating that effective obesity treatment leads to improved health in numerous domains.

GLP-1RA Costs

These medications are expensive. Manufacturers claim this reflects research and development investment as well as intensive manufacturing processes of these peptides. The cash price of semaglutide is $1,349 for four weeks of therapy; tirzepatitide costs $1,060. Since these medications must be continued long-term for most patients to maintain weight loss, the lifetime cost is substantial—GLP-1RAs are most expensive in the United States yet cost 80% less in other countries, such as Japan.[1]
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 prohibits Part D plans from covering AOMs as part of the standard prescription drug benefit and private insurers have followed suit, forcing most patients to pay out of pocket for treatment.[2] Patients taking the same compounds for diabetes do not face the same financial burden.

Former President Biden had proposed that Medicare and Medicaid should begin to cover AOMs for all patients who qualify (BMI >30 or BMI >27 with a comorbidity). This proposal would have expanded access to 7% (3.4 million) of part D Medicare participants and 4 million Medicaid participants with no currently covered indications. CMS projected that total Medicaid spending would increase by $14.8 billion over a 10-year period; $11 billion of that cost would be shouldered by the federal government and $3.8 billion by the states.[2] Many policy makers voiced concerns about expanding GLP-1RA access when Medicare costs already increase annually. The Trump administration declined to finalize the Biden proposal, citing potential costs.

Improving Cost Effectiveness

The government could not historically negotiate drug prices due to the non-interference clause in the aforementioned Medicare Modernization Act. The Inflation Reduction Act (IRA) of 2022 allowed Medicare to negotiate for the first time. The Department of Health and Human Services selected 10 drugs (among 50 that CMS identified as particularly costly) and set a Maximum Fair Price at which drug companies would be reimbursed (effective in 2026).[3] CMS reported a theoretical $6 billion reduction in spending thanks to this program, which did not include any GLP-1RAs. Excitingly, semaglutide (for both diabetes and cardiovascular disease/obesity) was selected for the next phase of negotiations and the savings could be substantial. For now, covering GLP-1RAs for Medicare/Medicaid beneficiaries would be costly, especially considering that studies have shown that these drugs are not "cost-effective" at their current pricing.[3] While there were early indicators that the Trump administration might repeal the IRA, imperiling the negotiated drug price program, they later revealed plans to improve upon the IRA instead. On May 12, 2025, President Trump signed an executive order to develop a "most favored nation" drug pricing plan that would tie U.S. drug prices to those paid by other nations.[4] The legal mechanics by which this order could be enforced are unclear, however, and a similar proposal was struck down by the courts during President Trump's first term.

There are valid financial concerns in covering GLP-1RAs, particularly since such a huge proportion of the population would qualify for treatment (41.9% of the U.S. population is considered obese). However, using BMI >30 to define obesity has limitations. Excess weight can reflect increased muscle mass rather than body fat. Some individuals with elevated BMI have no adverse consequences for their weight. To distinguish between these

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phenotypes, adding waist circumference measurements can capture individuals who have increased visceral fat and are at higher risk of metabolic dysfunction. Still, defining obesity based on body measurements is often inadequate to determine whether someone's weight puts them at risk of illness.

The Lancet Commission on Obesity recently released guidelines that aimed to define the disease state of clinical obesity.[5] First, to be considered to have obesity, one must have evidence of excess adipose tissue, not just elevated BMI. Then, "clinical obesity denotes a condition in which the risk to health associated with excess adiposity has already materialised and can be objectively documented by specific signs and symptoms reflecting biological alterations of tissues and organs, which are consistent with extant illness."[5] Patients with clinical obesity are more likely to benefit from intensive management; as such, clinical obesity could serve as the basis of eligibility for more effective/expensive medications like GLP-1RAs. Currently, the few insurance companies who do cover GLP-1RAs have enacted arbitrary criteria for who gets them (BMI >40). A new standardized definition could be leveraged to pressure insurance companies to cover GLP-1RAs for patients with clinical obesity without compelling them to cover the larger percentage of their enrollees with BMI >30. This would improve the relative cost-effectiveness of these drugs and bring us closer to a goal of equitable care.

Thinking beyond GLP-1RAs

Obesity medicine physicians are experienced in using other medications (metformin, topiramate, phentermine, bupropion/naltrexone) to treat obesity; they are more affordable and have been shown to be cost-effective. Consider that a GLP-1RA might be inappropriate in a patient with elevated BMI but no evidence of adiposity or complications given the risk of accelerated sarcopenia. Thoughtful use of AOMs takes these individual patient factors into account. It behooves the clinician to promote high value care and consider other medications, particularly in patients with elevated BMI but no complications.

A Call to Action

Besides judicious use of GLP-1RAs in patients with obesity, what roles do SGIM members have as clinicians and educators in the obesity epidemic? Advocating for and achieving drug pricing reform would improve GLP-1RA cost effectiveness and thus make Medicare/Medicaid and private insurance coverage more appealing. Since reform takes time, it is important to advocate for GLP-1RA coverage for the highest risk patients now. While SGIM can still support public health interventions (or lifestyle measures, as stressed by the current administration), the evidence has shown that AOMs are necessary to reduce the burden and downstream consequences of clinical obesity in our patients.

Those who are less health-policy inclined still play a crucial role. SGIM members can be proactive in counseling patients on healthy lifestyles, helping to prevent clinical obesity. We can fight weight stigma by educating our patients and peers on obesity pathophysiology and by treating patients of all sizes with respect. We can educate ourselves on non-GLP1-RA options and share this knowledge with learners. Medicare Part D drug coverage reform will allow us to treat obesity more equitably, but until then, we should think beyond GLP-1RAs to find the best treatment for our patients with obesity.

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SEVEN TIPS FOR A SUCCESSFUL GIMLEARN SUBMISSION

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GIMLearn is an online learning platform composed of content authored by SGIM members for a global community of academic general internists.[1] This platform expands the accessibility of topics that might be delivered synchronously at an academic meeting but are challenging to capture in text otherwise. The submissions are peer reviewed, such as for a refereed journal, and are available for the audience to engage at the time of their choosing. As editors and curators of this online content, we recognize submitters' desire for greater guidance in preparing their ideas for this platform. This article provides authors with seven key tips to create a successful GIMLearn submission.

Keys Tips for Success

1. Review GIMLearn submission guidelines as well as other published content.

During a submission cycle, the GIMLearn website contains a portal that presents detailed instructions for the submission process.[2] Check the website periodically as things may change over time. Review the website carefully to ensure that your planned submission does not duplicate previously published work.

2. Pick a topic that highlights an area of interest for general internists.

GIMLearn encourages a broad range of submissions, including programs, curricula, and clinical toolkits that can be adapted by local users.[1] If you are looking for inspiration, consider SGIM's strategic priorities or Calls for Submissions (current or prior) from the GIMLearn editorial board. Topics should be one where: (1) the authors are subject matter experts; (2) there is expected interest in learning about this topic from others; (3) the subject is inadequately represented via other sources; and (4) the topic can be successfully adapted for an asynchronous setting.

3. Submit a Letter of Interest prior to creating production-ready content for submission.

While not obligatory, this process allows GIMLearn editors the opportunity to provide feedback on proposals before the authors have completed a final product. The Letter of Interest opens a discussion between the submitter and the editors to optimize submissions before considerable time and resources are dedicated to the project.

4. Keep the end user experience in mind.

Like submissions to a live conference, all GIMLearn submissions must demonstrate the ability to engage the audience while simultaneously educating them. Submitting your in-person workshop slides or curricular outline alone to GIMLearn would be insufficient. Collectively, our past experiences with on-line learning range from completely passive modalities (e.g., watching a recorded lecture) to more active formats that increase user activity (e.g., reading a journal article followed by online questions, taking an online "open book" test, such as an ABIM longitudinal MOC knowledge assessment, or clicking on the screen to respond to prompts in web-based programs). Active learning content is preferred, especially when the user is prompted to reflect on what is being taught and how to apply the learning. This can be accomplished by breaking didactic components into brief knowledge "bursts" followed by an activity to apply this new knowledge. This will keep the audience more engaged than longer didactic sessions. Be creative. You may recruit "actors" such as fellow colleagues to act as students and act out a scenario or demonstrate the use of a new tool/technique for your content.

5. Provide support.

If the module's intent is for teachable content, provide tools such as a step-by-step facilitator guide, a narrated PowerPoint with talking points, or a recorded video demonstrating how to teach the material. You may include a resource list with links to online examples or an annotated bibliography that can add value to the user experience. It is important to recognize that the user is experiencing the material asynchronously for the first time and is without the advantage of an experienced facilitator to answer questions. GIMLearn users may better appreciate the depth of the content with this supporting material.

FROM THE SOCIETY *(continued from page 14)*

6. Practice and review.

Practice makes perfect. It is worth practicing your content before you submit your final submission. It will make your submission feel and appear more natural to your audience. It can clarify parts of the submission that may not synchronize with what you are presenting visually. You can add further clarifications prior to your final editing.

7. Be sure your submission is high-quality for production-ready content.

Your final submission should be ready to be posted to the GIMLearn online portal when it is uploaded. SGIM does not have a production studio ready to transform your ideas into a learning product. When recording your material, your presentation and style impacts interest and engagement as much as what you say. Talk slowly, clearly, and confidently. Adjust your lighting, spruce up your outfit and appearance, and optimize your background. Slides should be visually interesting and as simple as possible. Make tables, figures, and graphs clear and self-explanatory. The submission should avoid copyrighted information and institutional logos. Remove data irrelevant to a worldwide audience (e.g., a phone number for a local resource). Attention to production value makes an enormous difference.

We are excited by the potential GIMLearn brings to SGIM members. The GIMLearn audience is interested in your topic and sought out your content. GIMLearn serves as a valuable platform to share your expertise, to elevate educational and clinical skills, and to provide a venue for scholarship and promotion. The GIMLearn editors hope that these seven tips improve your submissions to GIMLearn.

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PERSPECTIVE: PART II

PATIENTS, PHYSICIANS, AND POLICY: HOW IMMIGRATION UNCERTAINTY IS SHAPING U.S. HEALTH CARE

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Immigration policy has always been political, but its impact reaches far beyond legislative debates. These policies—a lived reality for many in medicine—shape career paths, workforce stability, and patient care. Many physicians navigate complex visa processes and regulatory hurdles to practice in the United States. Others train in a system molded by the contributions of generations of foreign and American-trained doctors. The direction of immigration regulations has never been more unpredictable. This uncertainty creates a landscape that may leave foreign-trained and foreign-born doctors questioning their future in the United States. The ripple effects have a significant impact on the broader healthcare system.

This article examines the effects of immigration policy on physician workforce dynamics, ethical challenges in care delivery, and healthcare access for vulnerable populations.

Foreign-Trained Physicians: An Essential Force for Care in Underserved Communities

Some of the most immediate ways that uncertainties around immigration policy will manifest in health care are through the impacts on the physician workforce. The United States is experiencing a physician shortage, and evolving immigration guidelines would make the situation worse. A quarter of all practicing physicians

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in the United States are international medical graduates (IMGs).[1] In many rural hospitals, foreign-trained physicians are not just one part of the workforce; they *are* the workforce! They are disproportionately present in counties with higher poverty rates, larger minority populations, and limited healthcare access—areas where the number of American-trained doctors is insufficient to meet patient needs.[2] Research shows that these foreign trained physicians are more likely than U.S. medical graduates to enter primary care and commit to rural practice.[3] If restrictive regulations discourage these doctors from immigrating, the effects will ripple through the entire healthcare system, contributing to widening health disparities, increased wait times, and fewer providers in the areas where they are needed most.

Beyond the specifics of policy changes, the issue of immigration uncertainty also focuses on whether foreign-trained physicians perceive the United States as a stable and welcoming destination. In recent years, travel restrictions, increased visa scrutiny, and changing discourse on immigration called into question the long-term prospects of immigrant physicians in America. From 2016-18, there was a significant decline in residency applicants from many international regions.[4] While there was no outright ban on foreign doctors immigrating, the broader instability around immigration created doubt about their acceptance. If these cultural and political debates persist, similar patterns of hesitation among foreign-trained physicians will continue. This hesitation will further reduce the number of providers in underserved areas, deepening existing healthcare disparities.

The Emotional and Ethical Toll on Physicians and Their Patients

In border regions and beyond, immigration policy shapes the experiences of both physicians and the patients that they care for, including the undocumented.

A recent study examined clinicians' experiences with immigration enforcement and found that the vast majority of those surveyed, most of whom provide care for immigrant patients, had witnessed the negative impact of enforcement actions on their patients' health and access to care.[5] More than 80% reported that their patients were delaying or avoiding care out of fear, and nearly half said that some patients worried about being reported to authorities by their own healthcare providers.[5]

Growing fears about how immigration status might intersect with medical care are placing doctors in an increasingly complex ethical position. Physicians are not immigration officers, yet for many patients, the fear of immigration action has turned medical visits into moments of anxiety rather than care. As a result, the trust that the patient-physician relationship relies on is being strained. When patients avoid follow-up visits or refuse to seek care for chronic conditions, their health outcomes inevitably suffer, and providers are unable to perform their jobs effectively.

For doctors, the emotional toll is real—many physicians have reported experiencing vicarious trauma, absorbing their patients' stress and fears[5] while others struggle with moral distress, feeling helpless when legal barriers prevent them from providing the best possible care.[5] Looking ahead, some physicians may feel uncertainty about how immigration policies could put them at odds with their commitment to patient care, particularly in relation to the Hippocratic principle of *"primum non nocere"* (first, do no harm).

The Path Forward: Advocating for Physicians, Patients, and the Future of Care

Immigration policy will continue to be a politically charged topic, and physicians cannot control the shifting legal environment. But as healthcare professionals and advocates, we can control how we respond.

The medical community can advocate for fair, transparent regulations that support foreign-trained physicians and ensure immigration laws do not create unnecessary barriers to weaken the healthcare infrastructure. Further, clearer legal protections for doctors treating undocumented patients would allow them to focus on patient care rather than navigating legal uncertainty. This advocacy must also extend to congressional and senatorial representatives, whose legislative decisions shape physician visa pathways, residency opportunities, and funding for programs that ensure healthcare access in underserved communities.

Medicine is built on problem-solving, but physicians' ability to provide care is also shaped by factors beyond their control. When policies remain unclear—for SGIM members or their patients—the result is the same: gaps in care, strained relationships, and worse health outcomes. Foreign-trained and foreign-born physicians as well as the patients they serve have a place in our healthcare system regardless of their immigration status. Today's immigration decisions will have lasting consequences for both the medical workforce and those who rely on them.

The views expressed in this piece are those of the authors and do not necessarily reflect the positions or policies of their institutions or SGIM.

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BREADTH

WHEN WE LOOK UP: THE INDIVIDUAL BEHIND THE PHOTOGRAPH

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In the electronic medical record Epic, there is often a small "profile picture" in the upper left corner of the chart. Originally designed as a safety measure to prevent errors in care, it inadvertently serves a more profound purpose by adding a human aspect to an otherwise sterile chart full of data. These snapshots are often taken when the patient is well—perhaps during a routine appointment, smiling and composed, free from the visible weight and burden of acute illness. I view this sort of picture as a north star, anchoring me to the person beyond the pathology, especially when the individual before me is critically ill. In these moments, the image becomes a quiet prompt: *Who were they before this?*

I found this mantra particularly true when caring for one patient in the medical intensive care unit (MICU) during my early months as a second-year resident. Our patient was transferred from an outside, rural hospital for a higher level of care and access to our specialists. Curious and preparing for her arrival, I opened her medical record. Her photo drew my attention first: a woman wearing an Oregon State Beavers sweatshirt, her makeup meticulously applied, nails freshly done, beaming with a full, confident smile. I paused, realizing I was studying the photo far longer than most might. She looked vibrant—someone who might love life and, in turn, was loved by others.

However, when she arrived, she was unrecognizable. Jaundiced and obtunded, she could only repeat her name. If the two images—the one from her chart and the one from her bed—had been placed side by side, I am not sure I would have believed they were the same person. That photo remained with me, quietly insisting: *She is more than this moment*.

This patient, as well as others like her, clarified my initial rationale for pursuing medicine. I was originally interested in science, not unlike many students considering a future in medicine. However, over time, I realized that what sustains me is the humanistic side of our work as physicians: piecing together the narrative of a person who may no longer be able to speak for themselves. As such, these Epic photos, small and easily overlooked, often offer the first thread in that story.

In the ICU, we often meet patients at some of their most vulnerable times – intubated, sedated, with tubes and lines emerging from every surface of their body. Their voices are sometimes silenced as the illness before us can feel all-encompassing. But these photos offer a glimpse into a life that existed before hospitalization, and these snapshots remind me to ask more questions: *What did they do for work? What did their day-to-day life look like? What brought them joy? Whom did they love?* These are questions often answered by family members during

BREADTH *(continued from page 17)*

hushed conversations in the hallway, and slowly, the fuller, and often brighter, picture of who they are emerges.

Sometimes, it is not the disease alone that brings these patients to needing our interventions—it can be the very tools of modern medicine: chemotherapy complications, surgical missteps, adverse drug reactions. Despite our best efforts, sometimes we cannot prevent the inevitable. But by witnessing their stories—in honoring the people they were and may still be—we preserve something sacred despite medicine's failures and our best intentions.

While I remain in medicine to evolve my passion for science, I discovered a deeper significance in uncovering these intricate narratives which inform not only pieces of the identity of the patient before me, but their overall health. As such, I came to discover the person behind the photo. Despite the bad days, the losses, and adversity I have faced as a young physician, I enjoy the reminder of my patients as they are in their Epic photos. These reminders serve as steadfast cues that their illness will not and should not define them. I've come to realize that this humanistic thread isn't just what sustains me—it's what gives my work meaning, and I hope it will do the same for others.

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