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SGIM FORUM

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FROM THE SOCIETY: PART I

SEEDS OF GROWTH: SGIM'S CAREER DEVELOPMENT PROGRAMS CULTIVATE LEADERS ACROSS GENERAL INTERNAL MEDICINE

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What is the next bold step in your career? If your passion is shaping policy, redesigning education, championing equity, or accelerating your scholarly trajectory, the Society of General Internal Medicine (SGIM) has a launchpad for you. Since its inception, SGIM has advanced its mission and empowered its members. Over the past few decades, SGIM's career development programs—LEAD, Career Advising Program (CAP), Teaching Educators Across the Continuum of Healthcare (TEACH), Unified Leadership Training for Diversity (UNLTD) and Leadership in Health Policy (LEAHP)—have empowered members ready to lead, teach, innovate, and advocate across GIM.

Grounded in mentorship, adult learning principles, and outcome-driven training, these programs have advanced the careers of more than 750 of your colleagues—one of these SGIM programs could be your next step! Alumni from these programs used the knowledge and skills they learned to advance themselves professionally and make a difference for SGIM. In this article, we highlight these SGIM programs and illustrate how selected participants promoted their career successes and leadership in SGIM through the programs.

LEAD

The LEAD Program, founded by Association of Chiefs and Leaders of General Internal Medicine (ACLGIM)

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in 2013, equips junior to mid-career faculty with leadership skills. Participants attend an immersive day at the ACLGIM Leon Hess Management Training and Leadership Institute and selected workshops at the SGIM Annual Meeting, participate in monthly online discussions, and receive personal mentoring from established GIM leaders. The program emphasizes reflective practice, project management, and networking. More than 150 scholars have completed the program, gained significant leadership self-efficacy, and built a national peer network.

- ***Neda Laiteerapong (LEAD 2014)*** is associate professor of medicine and Chief of the Section of General Internal Medicine at the University of Chicago, where she is the Medical Director for Primary Care Behavioral Health Integration. She received the 2016 Midwest Region Clinician Investigator Award and served as ACLGIM Leadership Forum Editor. She has been a member of SGIM's Annual Meeting Program Committee, Research Committee, and the Health Policy Clinical Practice Subcommittee.
- ***Lucille Torres-Deas (LEAD 2020)*** is an associate professor of medicine at Columbia University and the former Medical Director of the Ambulatory Care Network Internal Medicine Primary Care Sites and Community and Population Health. She feels "the LEAD Program strengthened my ability to lead teams, implement system-level improvements, and advance health equity." As past Chair of SGIM's Health Equity Commission and past President of the Mid-Atlantic Region, Dr. Torres-Deas used these skills to "drive strategic initiatives, foster collaboration, and promote inclusive leadership within SGIM."

Drs. Laiteerapong and Torres-Deas demonstrate the incredible leadership potential within SGIM and the impact of the LEAD program.

CAP (Career Advising Program)

Established in 2013 by SGIM's Women & Medicine Commission, CAP is a two-year sponsorship program which supports junior and mid-career faculty in successfully navigating academic advancement opportunities. By connecting participants with senior "Career Sponsors," the program focuses on key activities, such as curriculum vitae (CV) enhancement, strategic committee membership, and relationship-building strategies to accelerate career progression. Matches are based on application insights to ensure alignment. There were more than 250 participants who enjoyed enhanced confidence, accelerated promotions, and expanded leadership roles.

- ***Brita Roy (CAP 2013)*** is associate professor of population health and medicine at NYU and the Director of Community Health and Clinical Outcomes and Research Pillar Lead for the Institute for Excellence in Health Equity. She has been SGIM Annual Meeting Program Chair, Women and Medicine Commission Chair, CAP Program Chair, Health Equity Commission Co-Chair, and an SGIM Council Member. CAP provided Dr. Roy with "invaluable guidance, support, and mentorship over many years, long after the end of the two-year program itself. These relationships and support helped me determine the right career paths and positions over time, negotiating two rounds of job searches and leadership positions, as well as advice on prioritization to achieve the best ratio of work-life balance/integration."
- ***Lisa Rotenstein (CAP 2021)*** is assistant professor of medicine at UCSF, the Medical Director of Ambulatory Quality and Safety, and Director of the Center to Advance Digital Physician Practice Transformation. She serves on SGIM's Clinical Practice Committee, ACLGIM Hess Initiative Workgroup on Rebalancing Primary Care Compensation, and was awarded the 2025 SGIM Outstanding Junior Investigator of the Year. CAP provided Dr. Rotenstein with "invaluable sponsorship, mentoring, and connections within SGIM—enhancing my sense of community and providing a network of advisors I can rely on in the future."

Drs. Roy and Rotenstein continue to benefit from the impact of CAP and the support of their expanded networks.

TEACH (Teaching Educators Across the Continuum of Healthcare)

Established in 2013, TEACH is a year-long professional-development program for early-career clinician-educators. TEACH combines hands-on workshops, peer learning, and mentoring from local and national faculty to support growth in clinical teaching, curriculum design, feedback, and educational scholarship. Through workshops, peer learning, and mentoring from local and national faculty, scholars build a robust educator portfolio focused on clinical teaching, curriculum design, feedback, and educational scholarship.

- ***Danielle Jones (TEACH 2013)*** is professor of medicine, associate chief of the Department of GIM, and Associate Program Director of the Medicine Residency Program at Emory University School of Medicine. Within SGIM, she has pursued opportunities to lead, including serving on Council. She mentors junior colleagues now as TEACH program faculty. "The TEACH Program provided me with essential skills for academic medicine, a network of

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mentors and collaborators, and opportunities to lead, including serving on SGIM's Education Committee, Education Award Committee, and Council."

- ***Sreekala Raghavan (TEACH 2017)*** is associate professor of medicine and medical education at Icahn School of Medicine at Mount Sinai and Associate Program Director for the Internal Medicine Residency at Mount Sinai Morningside/West. "TEACH gave me the foundational curriculum development skills and mentorship that shaped my path as a clinician educator." She is now TEACH program faculty, Chair of the Workshop Committee for the SGIM Mid-Atlantic Region, and a member of the SGIM Education Committee.

Drs. Jones and Raghavan highlight the impact TEACH has had on so many early-career clinician educators in SGIM.

UNLTD (Unified Leadership Training for Diversity)

Established in 2013, UNLTD prepares current and aspiring academic leaders with essential skills to thrive and drive diversity in academic organizations. It pairs competitively selected fellows each year with established leaders for individualized mentorship. Fellows attend the ACLGIM Leon Hess Management Training and Leadership Institute at the SGIM Annual Meeting, ACLGIM Winter Summit, and regional meetings to gain theoretical and practical knowledge in management and leadership in academia. UNLTD provides mentorship, networking, a comprehensive curriculum, management training, hands-on fellowships, empowerment, and inclusive support.

- ***Utibe Essien (UNLTD 2020)*** is assistant professor of medicine and Associate Vice Chair of Community Engagement and Inclusive Excellence at UCLA. He received the 2024 SGIM Outstanding Junior Investigator of the Year, and has served on the Annual Meeting Program Committee, Research Committee, Nominations Committee, Membership Committee, and Health Equity Commission. He has been in New England Regional Leadership and an SGIM Forum Associate Editor. "The UNTLD Program provided me with critical skills for early career research success and a national network of mentors and collaborators, which I have been able to leverage towards publications and grant funding."
- ***Christopher Gonzalez (UNLTD 2022)*** is assistant professor of medicine at Weill Cornell Medical College. He was previously a LEAD program participant and served in leadership of SGIM's Mid-Atlantic Region and Health Equity Commission. The UNLTD Program provided Dr. Gonzalez with "a national network of engaged mentors and experts in GIM, which helped to enhance my career development as a clinician-investigator and my presence within SGIM."

Drs. Essien and Gonzalez display what UNLTD has meant to them and its impact on their growing careers.

LEAHP (Leadership in Health Policy)

Launched in 2017, LEAHP prepares SGIM members to become effective health-policy advocates, institutional policy experts, and policy educators. The year-long program combines in-person workshops, monthly virtual webinars, a structured reading list, and mentored capstone projects. Scholars are matched with experienced policy mentors, join active health policy subcommittees, and complete at least two capstone projects, contributing to SGIM's policy agenda. Since 2017, there have been more than 130 scholars who have graduated from the program, many serving on SGIM's Health Policy Committee, Council, and advocating for policies to promote SGIM's mission.

- ***Avik Chatterjee (LEAHP 2017)*** is assistant professor of medicine at Boston University School of Medicine, an Addiction Medicine researcher, and advocate. He has led regional and annual meeting workshops on policy and is the 2026 SGIM Annual Meeting Advocacy Co-Chair. "LEAHP confirmed the importance of local, state, and federal policy implications on my work." Since LEAHP, he "has focused on the impact of policies on patients," which led to a seat on the Massachusetts Attorney General's Council on Substance Misuse.
- ***Elizabeth Griffiths (LEAHP 2022)*** is associate professor of medicine at UCSF and the Co-Associate Director of Training and Policy Programs at the Philip R. Lee Institute for Health Policy Studies and Education Lead for the CTSI IMPACT Core. She is Director of Advocacy and Community Engagement for the GIM residency program's Health Equity and Advocacy Pathway and is the Community Engagement Liaison for the School of Medicine. She is now a LEAHP faculty mentor.

The impact of LEAHP in developing health policy knowledge and advocacy skills are evident in Drs. Chatterjee and Griffith's experience.

Ready to Take the Next Step?

Applications for the 2026 cohorts are open from August 2025 through April 2026. Visit the SGIM Career Development hub for eligibility criteria, tuition details, and application portals for each program. SGIM's mission is advanced by the leaders, educators, advocates, and

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sponsors who emerge from these programs.[6] Plant the seed of your next professional chapter—apply, grow, and give back.

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SGIM

MEANINGFUL COMMUNICATIONS: AN ESSENTIAL TOOL TO BRIDGE THE GREAT DIVIDE

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Editor in Chief, SGIM Forum

"Communication leads to community, that is, to understanding, intimacy and mutual valuing."[1]

The United States is a country divided—today, the red, white, and blue seem to be only the red and the blue. Political divisiveness drives discussions leading to confrontations on nearly every issue. The focus is no longer on *us* but instead on *you* and *me*. "If you do not espouse the same ideas that I do, you are against me" seems to be the mantra of many organizations and individuals. This divide has drifted into everyday societal interactions as political disagreements have morphed into personal disagreements. I would argue that the last time the United States was this divided was in the mid-1800s prior to and during the Civil War. The United States is no longer united.

"It is through communication and community building that we can work toward a better tomorrow. SGIM members are trained in good communication and listening. It is essential to what we do as physicians. We need to continue attempts to have respectful and meaningful conversations."

What is driving our division today? Communication! Former President Gerald Ford said, "Nothing in life is more important than the ability to communicate effectively."[2] In 2025, we struggle to communicate effectively. Communication is not just talking, as that is only half the conversation. Communication involves *listening*. Society has lost the art of listening. Author Roy Bennett says, "Listen with curiosity. Speak with honesty. Act with integrity. The greatest problem with communication is we don't listen to understand. We listen to reply. When we listen with curiosity, we don't listen with the intent to reply. We listen for what's behind the words."[3]

If communication is the key, how do we improve our communications? I had the pleasure of attending a session at the New Orleans Book Festival hosted by Pulitzer Prize-winning author Charles Duhigg. As a journalist for *The New Yorker* magazine and a noted podcaster, Duhigg has enthralled readers with his engaging stories around human interactions. He has authored three books and his most recent book, *Supercommunicators*, spent more than 40 weeks on the bestseller list.[4] In this article, I offer insights from his book to improve communication skills in both personal and professional conversations.

If we want to be effective communicators (i.e., supercommunicators), we must first recognize that communication is a bilateral exchange. We should remember to talk *with* someone, not *at* someone. Effective communication relies on delivering *and* receiving ideas from our conversational counterpart. Do you remember the comment from your parents as you were growing up: "you were given two ears and one mouth, so you should be listening twice as much as you are talking"? Why don't we listen more? And what happens when we do?

In his book, Duhigg starts us on this path when he points out that meaningful conversations are learning conversations. Supercommunicators will often follow four rules as they engage in their learning conversations:

1. Pay attention to what kind of conversation is occurring
2. Share your goals, and ask what others are thinking
3. Ask about others' feelings, and share your own
4. Explore if identities are important to this discussion.[4]

In reviewing Duhigg's rules, we should note the intentional actions that make these meaningful communications. There is work to be done. Awareness and respect for the other individual's feelings and goals in the conversation are required.

"The most effective communicators pause before they speak and ask themselves: Why am I opening my mouth?"[4] For the effective communicators, this momentary pause should be intentional if the goal and type of conversation is unclear as noted in rule #1. Duhigg

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defines three diverse types of conversations, where each has appropriate responses based upon the context of the conversation:

1. Practical/Decision-Making Conversations
2. Emotional Conversations
3. Social Conversations.

Aspects of these three different conversations will overlap during the conversations, but identifying the type of conversation can more often lead to the desired outcome as we listen and engage in the conversation.

As physicians, SGIM members often weave through these types of conversations multiple times each day with patients, trainees, and colleagues. We may go from a fact-based discussion with a patient about their hypertension and discussing which medications are most appropriate (decision making conversation) to sharing a new cancer diagnosis with the next patient and their family (emotional conversation). Then, we step to the workstation and engage a colleague in a social conversation about the past weekend's activities (social conversation). Each conversation has a different intent and outcome if we take the time to reflect on the type of each conversation. As Duhigg notes, we can consider these three conversations outcomes as:

1. Do you want to be helped (a practical "what's this really about" fact-based conversation)?
2. Do you want to be hugged (an emotional "how do you feel" conversation)?
3. Do you want to be heard (a social "who we are" conversation)?[4]

For a conversation to be meaningful, identifying the type of conversation can lead to an acceptable outcome for both parties. I remember one of the best life lessons I learned was "Men need to remember that when women seem upset and talk about problems is not the time to offer solutions; instead she needs to be heard, and gradually she will feel better on her own."[5] It was only in recognizing that this was an emotional conversation that I could stop trying to solve the problem (practical conversation) as men often do.

Meaningful conversation rules #2 and #3 require an investment on our part to make the conversation impactful. Both rules require an inquiry to the other party engaged in the conversation regarding their goals and feelings in addition to sharing our own. We must want to know what is important to them. We must respect their answers even when we disagree. Respect and trust are valued commodities in meaningful conversations.

In rule #4, we are confronted with the hardest task—the one of self-reflection. It is essential to recognize what is important to us, and what values or experiences guide our responses at baseline before engaging in a fast moving or emotional conversation. This self-reflection allows us to find common ground with similarities in experiences and values, while approaching differences with intellectual and emotional curiosity during the conversation. If we enter each conversation with respect and a desire to learn about the other individual, we can build community through communication.

Conclusion

The lack of meaningful communication in 2025 has created sharp demarcations in society. We are a divided nation separated primarily along political party lines. The Red party only supports red initiatives; the Blue party only supports blue initiatives. Gone are the days of collaboration and a fight for a common good. As a country, we have allowed these political sentiments to sew discord into non-political conversations and interactions. This is a path that cannot continue. Meaningful conversations must happen. Ineffective communications only strengthen the divisions. It is through communication and community building that we can work toward a better tomorrow. SGIM members are trained in effective communication and listening skills. It is essential to what we do as physicians. We need to continue attempts to have respectful and meaningful conversations.

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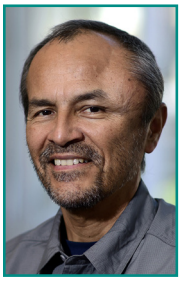
SGIM

HOW POSITIVE PSYCHOLOGY TRANSFORMS MEDICINE AND PROFESSIONAL PRACTICE

Carlos Estrada, MD, MS, FACP
President, SGIM

"Clinicians who received the 'positive affect' intervention showed more robust clinical decision-making, integrated information earlier, demonstrated less anchoring, and showed increased flexibility in their thinking."



In the late 1980s, I was about to start my GIM fellowship at Henry Ford Hospital under the mentorship of the late Dr. Mark Young. He said, "Carlos, I want you to meet Alice Isen when she comes for a visit." Little did I realize how significant the interaction with both individuals would be in my professional journey.

Professor Alice Isen, Ph.D. (1942-2012), was an expert on the influence of positive affect on cognition. She was aware of Mark's interest in clinical reasoning (how clinicians navigate the information in complex cases). During my fellowship, both guided me to conceptualize, design, implement, analyze, and publish our work.[1]

Professor Isen's research used subtle mood inductions (e.g., finding money, small gifts, comedy clips) to demonstrate that positive affect consistently enhances cognitive flexibility, creativity, prosocial behavior, and decision-making. Her rigorous experimental approach transformed positive emotion research from anecdotal to empirical science, with applications spanning organizational behavior, consumer psychology, and medical decision-making.

In our study,[1] we randomized clinicians into two groups to solve a clinical case of a patient with abnormal liver function tests. Like modern clinical problem-solving exercises, clinicians "thought out loud" as they worked through their decision-making process and the testing they would perform. Sessions were recorded, transcribed, and analyzed.

One group received a small bag of nicely wrapped chocolates just before starting to solve the exercise (which they were instructed to enjoy later) while the other group served as a control (they did not receive the chocolates). The blind analysis of the transcripts showed significant results. Clinicians who received the "positive affect" intervention showed more robust clinical decision-making, integrated information earlier, demonstrated less anchoring, and showed increased flexibility in their thinking.[1] Without funding and relying solely on sweat equity and effort, I am proud of this paper because all co-authors took the initial question of how positive affect induction influences clinical reasoning from conception to publication. This remains one of my most referenced publications.

I share this story for two reasons: first, to illustrate how a formative mentorship experience opened my mind to exploring territory completely foreign to my analytical, left-brain approach. Second, it sparked a lifelong curiosity about positive psychology that I have followed and practiced throughout my career.

I hope this story resonates with SGIM members who have had similar transformative encounters. In this article, I illustrate the influence of positive affect in medicine, beginning with applications outside of medicine.

Positive Psychology Applications

In the business world, positive psychology research demonstrates that happiness drives success, and positive mindsets enhance productivity, creativity, and problem-solving capabilities.[2] Martin Seligman, the father of positive psychology, shifted psychological research from mental illness to human flourishing. He developed the PERMA model (Positive Emotions, Engagement, Relationships, Meaning, Achievement).[3] Seligman demonstrated that happiness can be measured and cultivated through evidence-based interventions, transforming psychology and its practical applications.[3]

The business benefits include increased productivity when managers implement praise and recognition systems. Positive emotions enable better decision-making, faster problem solving, and greater intellectual flexibility. Organizations report enhanced resilience, stronger collaborations, and reduced turnover rates.[2] Practical implementation focuses on consistent positive behaviors, including gratitude practices, acts of kindness, mind-

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fulness exercises, and physical activity. Professional resources emphasize reframing stress, leveraging strengths, developing emotional intelligence, and connecting work to larger purposes.

These cognitive and organizational psychology findings have been extensively translated into medical practice under various frameworks. For patients, positive psychology interventions complement traditional treatments by enhancing psychological resources that support healing. Gratitude exercises and optimism training improve immune function and accelerate recovery, with cancer and cardiac patients showing enhanced quality of life and better treatment outcomes.[4]

Healthcare professionals benefit from positive psychology interventions addressing burnout and compassion fatigue. Resilience training and mindfulness practices create protective factors against occupational stress, with organizations reporting reduced turnover and improved patient care quality.[5]

When I attend SGIM meetings, I witness this "positive energy" firsthand—the enthusiasm is genuinely contagious. Much has been written in the SGIM Forum about the personal benefits of attending SGIM meetings and the deep satisfaction derived from brief encounters and established professional relationships.

Practical Steps to Cultivate Joy

Positive psychology works both as an external and internal motivator. A few years ago, a faculty member from another institution apologized when asking me to write an external reference letter, noting the considerable time commitment. It was an honor to be considered, and I learned about this person from a different perspective. This opportunity could have been viewed as just another task. However, it brought unexpected joy when I framed it as a positive interaction to learn more about the individual.

Creating sustainable joy at work requires intentional practices that celebrate progress and protect your well-being. Establish a "happy folder" in your e-mail (or physical folder) to save positive comments and thank you notes. Revisit these during tough times for an instant mood boost. Yes, I keep a "happy folder." Develop personal celebration rituals that mark achievements, like treating yourself to something special with each accomplishment. Early in my career, I bought a tie after every paper I published!

Identify what brings you joy—whether it's a morning coffee ritual or a walk between meetings—and build these habits into your routine. Most importantly, give yourself permission to disconnect, set boundaries around after-hours communication, take actual lunch breaks, and resist checking e-mails during personal time. These small acts of self-care are essential investments in your long-term productivity and happiness. I have learned to be intentional about defining time for my personal joys, and this shift has made a meaningful difference in my well-being.

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Conclusion

As we navigate the complexities of our profession, embracing positive psychology isn't just about personal well-being—it's about becoming better team members, clinicians, colleagues, and leaders. The science is clear: small acts of positivity create ripple effects that transform personal interactions, patient care, and organizational well-being. The SGIM community epitomizes the power of positive psychology. Educators highlight the significance of positive learning environments, both in class and during clinical encounters. Clinicians use appreciative inquiry and motivational interviewing to bring desired change in behaviors. SGIM members should recognize the positive psychology in these interactions and be intentional in including these positive interventions in their future efforts.

Disclosure: This article was written with assistance from a large language model, with the author taking full responsibility for the content presented.

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SGIM

FROM THE SOCIETY: PART II

COUNCIL'S RESPONSE TO THE SGIM25 COMMUNITY FORUM ON ENGAGING IN ADVOCACY

Eric B. Bass, MD, MPH; Jada Bussey-Jones, MD, MACP; Carlos Estrada, MD, MS, FACP

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At SGIM's Annual Meeting in May 2025, our Council hosted a community forum on SGIM's advocacy priorities and tactics in the current crisis. The forum had three main objectives: 1) explain how SGIM leadership revised advocacy priorities and tactics to address threats to our mission and core values, focusing on where our voice can have the greatest impact; 2) motivate and enable members to engage in advocacy in a rapidly changing political environment; and 3) solicit input on promoting advocacy at individual, institutional, and professional society levels while making the best use of our resources and expertise. In this article, we share what SGIM leaders heard from attendees and how we are responding to issues raised.

We were encouraged that more than 200 SGIM members attended and engaged in active discussions at topic-focused round tables. Topics included the following:

- Clinical care in safety net sites (including Medicaid access)
- Reproductive health care
- Preventive care (including vaccination policies)
- Health care for lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ+) patients
- Health care for immigrants and refugees
- Diversity, equity, and inclusion programs in universities

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- Veterans Affairs support for clinical, educational, and research missions
- International medical graduates
- Health services research (including primary care research)
- Translational research
- Research on disparities
- Censorship of science and educational activities
- Global health issues.

Participants selected table topics based on their greatest concerns.

Dr. Bussey-Jones and Dr. Bass opened the session with a brief review of threats to the educational, research, and clinical parts of our mission. They explained how SGIM recently revised its approach to advocacy by streamlining leadership of the Health Policy Committee, increasing participation in coalition advocacy, and focusing direct advocacy on priorities most likely to gain traction, such as Medicaid funding, medical research, and primary care. Then they asked each table to identify the most important priorities and strategies for action at individual, institutional, and professional society levels. Each discussion was moderated by a member of SGIM's Council or Health Policy Committee.

Members offered many suggestions for what SGIM's health policy team could do to advocate for the patients and members we serve, though in some instances these would be a continuation of SGIM's existing health policy work:

- Strengthen member engagement through toolkits, policy briefs, curated messaging, and peer storytelling[1]
- Continue to provide tools and mentorship for individual and local advocacy efforts, including at regional meetings
- Continue to partner with other professional societies on advocacy efforts
- Continue to support a strong commitment to diversity, equity, and inclusion
- Continue to advocate for support of primary care research
- Explore how to support members' interests in global health
- Name the threats from new federal policies and explicitly acknowledge the challenge in how we communicate about the threats
- Collect and analyze data about member characteristics that SGIM does not currently collect (e.g., international medical graduate or LGBTQ+ status). [Note: Council members expressed reservations about this suggestion because of the sensitive nature of such data.]

Members also made the following suggestions for what SGIM should do to support the advocacy efforts of individual members:

- Engage the Diversity, Equity, and Inclusion Taskforce to promote training that supports vulnerable learners and protects them in hiring and admissions
- Highlight personal stories to humanize policy impacts, especially in immigrant, LGBTQ+, and global healthcare contexts
- Explore bridge funding models in use at some institutions and gather best practices to inform others
- Consider SGIM's role as an educator or connector rather than a central driver of advocacy
- Investigate technology-enabled solutions (e.g., platforms for advocacy mentorship or matchmaking).

Finally, members suggested ways to stimulate advocacy by members' institutions:

- Support member outreach to leaders in their local institutions
- Identify and connect members experienced with state-level advocacy for peer mentorship.

We appreciated the constructive suggestions in each of the above-listed three categories.

At the Council's retreat in June, we reviewed this feedback from the community forum. Council reviewed what SGIM is already doing in response to community forum suggestions and identified actions that could be taken to expand efforts. Council broke into subgroups to prioritize actions, considering the level of effort required and limitations of our resources. The full Council then discussed the recommendations of each subgroup and identified two overarching priorities for this year: 1) develop and implement a comprehensive strategy for activating and engaging members in advocacy on issues of greatest concern to members; and 2) support the work and recommendations of the Diversity, Equity, and Inclusion Taskforce. Together, these priorities address many of the specific suggestions made by participants in the community forum. These top two priorities do not preclude other actions that may be taken by SGIM's committees, commissions, and interest groups.

SGIM's President-Elect Dr. Mark Schwartz volunteered to work with Dr. Bass and the Health Policy Committee on the strategy for increasing engagement of members in advocacy efforts. They have already had several meetings and initiated efforts to guide the work of the Health Policy Committee's subcommittees on research, education, and clinical practice while also activating more members in the Health Policy Interest Group.

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They are exploring how to engage Leadership in Health Policy (LEAHP) Scholars in developing advocacy-oriented educational sessions for regional and national meetings. In addition, the Health Policy Committee has been working with Cavarocchi-Ruscio-Dennis Associates, LLC, (CRD), to add more advocacy resources to SGIM's website, including a Grassroots Advocacy Toolkit with guidance for meeting with your member of Congress, attending Town Halls, and writing an op-ed or letter to the editor.[1]

Kay Ovington, Deputy CEO, is working with Dr. Monica Lypson, the Chair of the Diversity, Equity, and Inclusion Taskforce, and Dr. Elizabeth Dzeng, the Council liaison for the Taskforce, to continue guiding their work. Council asked the taskforce to submit a report before the Council's winter retreat, focusing on ways to incorporate diversity, equity, and inclusion principles within legal guidelines in our career development programs, and on developing fair and transparent rubrics to ensure inclusivity in SGIM's award decisions.

We urge all members to keep an eye out for communications about how SGIM is addressing these priorities. We may not be able to actively advocate for all the issues brought forward by our members, but we are committed to listening to your concerns and suggestions as we seek to engage as many people as possible in advocating for our stated mission. Please let us know if you would like to get more involved in any of this critically important work by joining one of our advocacy-related groups!

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SGIM

MEDICAL EDUCATION

CATALYZING CHANGE THROUGH EVIDENCE: HIGHLIGHTING INNOVATIONS FROM THE SGIM UPDATE IN MEDICAL EDUCATION

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Introduction

This update in Medical Education discusses five impactful studies presented at the 2025 Society of General Internal Medicine (SGIM) Annual Meeting. These studies examine key structural and cultural factors that shape learning environments, including preparation for transitions, recruitment practices, workload equity, mental health during training, and bias in communication. Together, they provide evidence to drive equity, well-being, and readiness for practice in academic internal medicine (IM).

Methods

A *PubMed* search was conducted to identify original medical education studies published in select high-impact medical education and general medical journals (see table). Eligible studies included U.S. or Canadian learners and excluded reviews and editorials. Abstracts were independently screened for eligibility by two reviewers, followed by two independent full-text reviews to assess IM relevance, medical education significance, generalizability, methodological rigor, innovativeness, and SGIM 2025 alignment to the meeting theme ("Catalyzing

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Change in Academic General Internal Medicine"). Articles with the greatest potential to impact educational theory or practice were prioritized through a consensus meeting.

Consensus-Derived Recommended Skills for Transition to Residency Courses

Transition to residency (TTR) courses are increasingly used by U.S. medical schools to help graduates transition from medical school to internship. Despite their growing prevalence, these courses lack standardized content. Rustici et al. aimed to establish a consensus-derived list of core skills and entrustment levels for graduating students completing a TTR course to support development of a national curriculum framework.[1]

Using a modified Delphi approach, the authors engaged nine TTR experts and a broader group of educators, program directors, and residents over three survey rounds from 2020-22. From an initial list of 102 skills, 54 reached the pre-set 75% consensus, which were consolidated into 37 final skills across clinical, communication, personal/professional, and procedural domains. Most skills were clinical or communication focused; only one procedural skill reached consensus. Entrustment ratings used a 6-point scale, with most skills rated at level 4 (independent performance with double-check).

Strengths include its multi-institutional, multi-specialty representation and rigorous consensus methodology. Limitations include declining response rates, procedural specialist underrepresentation, and local resource variability. This work offers a prioritized skillset and entrustment expectations to guide national TTR course design, resource allocation, and evaluation.

Comparing Perceptions of Virtual and In-Person Residency Interviews

During the COVID-19 pandemic, in-person residency interviews were replaced with a virtual format. Whether this shift preserved the effectiveness of the interview process for applicants is uncertain. Henschen et al. surveyed more than 23,000 U.S. internal medicine residents to compare perceptions of virtual (post-graduate year [PGY]-1 and PGY-2) versus in-person (PGY-3) residency interviews.[2] Using an optional questionnaire attached to the 2022 IM In-Training Examination, residents rated satisfaction, confidence in program choice, and program culture portrayal accuracy.

Overall satisfaction was high for both formats, though in-person interviewees reported slightly greater satisfaction (80.1% v. 76.6%, P<.001) and confidence in selecting a program (80.5% v. 75.5%, P<.001). Virtual interviewees more often felt their program's culture was accurately portrayed (83% v. 79.9%, P<.001). Across PGYs, sessions with residents and one-on-one interviews most influenced ranking. Female residents and international medical graduates reported higher satisfaction in both formats.

Although differences between formats were statistically significant, the authors note they were small, likely reflecting the large sample size. The study affirms that virtual interviews can provide applicants with useful, accurate information while offering logistical benefits, such as reduced cost and travel, thus promoting equity. Programs should weigh these advantages against the marginal satisfaction difference when deciding on future interview formats.

Gender Disparities in Electronic Health Record Usage and Inbasket Burden for Internal Medicine Residents

Increased administrative workload has been linked to clinician burnout, with prior studies suggesting female physicians spend more time in the electronic health record (EHR) than male counterparts. Liddell et al. conducted a single-site retrospective cohort study to characterize gender-based differences in EHR workload within the setting of IM training.[3] Monthly EHR activity for 156 residents was collected from Epic's Signal and Physician Efficiency Profile tools to measure documentation time, intervisit care, inbox activity, and appointment data.

While panel size, appointment volume, patient complexity, number of tests ordered, and response times for inbox messages were comparable, female residents received significantly more patient calls and medical advice requests and spent more EHR time on intervisit care. Multivariable regression modeling showed that female patients assigned to female residents generated an additional 1.9 messages per year compared to those assigned to male residents—a pattern not seen in female patients assigned to male residents.

Strengths include robust statistical analyses and balanced panel demographics. Limitations include binary gender categorization, potential EHR tracking inaccuracies, and lack of data on non-EHR work.

These findings underscore gender-based workload inequities and suggest that structural interventions, such as balancing patient panel assignments and enhancing training in agenda and boundary setting, may mitigate burnout risk.

Duration of New-Onset Depressive Symptoms During Medical Residency

It is unclear if depression during the intern year is a temporary response to training stress or has lasting implications for physician mental health. Kim et al. examined the association between and persistence of new-onset and long-term depressive symptoms among interns in a prospective cohort study from the Intern Health Study.[4]

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Complete List of Medical Education Journals Screened for the 2025 Update in Medical Education	
Academic Medicine	*New England Journal of Medicine*
Medical Education	*Journal of the American Medical Association*
Advances in Health Science Education	*JAMA Internal Medicine*
Journal of Graduate Medical Education	*JAMA Network Open*
BMC Medical Education	*Journal of General Internal Medicine*
Medical Teacher	*Annals of Internal Medicine*
Teaching and Learning in Medicine	*American Journal of Medicine*
Medical Science Educator	*Journal of Hospital Medicine*

The authors assessed depression trajectories over 10 years among physicians who did and did not develop depression during their intern year.

Of 858 participants with baseline Patient Health Questionnaire (PHQ)-9 <10 (where 53% self-identified as women, 36.6% as Asian, and 51.5% as surgical residents), 35.2% developed moderate-to-severe depression (PHQ-9 ≥10) during the intern year, with women physicians disproportionately affected (59.9% v. 40.1% men). Physicians with intern-year depression had persistently elevated depression rates: 21.9% remained depressed at 1-year post-internship compared with 6.6% of controls, 8.8% v. 2.4% at five years, and 8.9% v. 3.7% at eight years. Mean PHQ-9 scores remained significantly higher throughout all 10 years of follow-up and never returned to pre-internship baseline levels for either group.

Depression during the intern year may manifest as a marker for sustained mental health vulnerability rather than solely transient training stress. This persistent PHQ-9 elevation can add significant burden to practicing physicians, potentially affecting long-term career satisfaction, patient care quality, and contributing to physician suicide rates. These findings underscore the critical importance of early intervention during intern year (or earlier) to protect the long-term wellbeing of our physician workforce.

Biased Language in Simulated Handoffs and Clinician Recall and Attitudes

Wesevich and colleagues explored the impact of biased language in inpatient handoffs on the recall accuracy of clinical information and on clinician attitudes towards their patients.[5] Study handoffs were based on real handoffs about Black patients recorded for a prior project; each contained some element of bias (stereotype, blame, or doubt). Participants were randomized to the original biased version or a neutral version of three different handoffs. They were then surveyed about each handoff. The main outcomes were recall of the clinical information included in each handoff, clinician attitudes toward the patient, and identification of key takeaways from the handoff.

Participants who heard the biased version had lower information recall accuracy than those who heard a neutral version (88% v. 92%, p=0.12), most pronounced among participants hearing blame-based bias handoffs (77% v. 93%, p=0.005). Participants who heard a biased handoff had less positive regard for their patient (22.9% v. 25.2%, p<0.001). The more positive the overall attitude toward a patient, the higher the odds of accurately recalling clinical information from the handoff (AOR 1.16, 1.02-1.33).

The authors concluded that biased language in handoffs reduces clinicians' information recall and empathy. This poses a barrier to safe and effective transfer of information, potentially worsening healthcare-related disparities. They are advocating for standardized handoff structures to mitigate racial bias and improve patient safety.

Conclusion

These studies highlight diverse but interconnected aspects of the learning environment, from recruitment practices to workload and well-being. Collectively, they provide evidence to guide changes that foster equity, support trainee mental health, and enhance preparation for clinical practice.

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SGIM

HEALTH POLICY CORNER

FROM THE CLINIC TO THE CAPITOL: IN THE ROOM WHERE IT HAPPENS

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Introduction

Stepping into a completely different world, this article shares insight about the time I decided to pack up my white coat and trade in the clinic hallways for the marble corridors of Capitol Hill. Walking into the Capitol each day never got old. Passing statues of historical figures and navigating the underground tunnels connecting Senate offices never lost its flair. Chance hallway encounters with Senators like Ben Ray Luján (D-NM), Tim Scott (R-SC), and Jon Ossoff (D-GA), or exchanging pleasantries with the CMS Administrator, were constant reminders I was really "in the room where it happens." It was not lost on me that with this access came a clear responsibility: to bring the voices of my patients, learners, and community into spaces where their perspectives are often missing.

Navigating Policy in a Partisan Era

You cannot ignore the hyperpolarized political climate, declining public trust, and misinformation epidemic. At times, congressional hearings felt more like political theater than substantive debate. But behind closed doors, committed staffers from both parties worked together to improve the health of our nation.

Orientation: Drinking from the Fire Hose

My fellowship began with an intensive 3.5-month orientation which we often joked was like "drinking from a fire hose." It was an intensive crash course into all things health policy. We met with think tanks, advocacy groups, federal agencies, and legislative leaders. We learned how to write memos, craft policy arguments, and navigate the complex federal government.

However, my experience went beyond content. My co-fellows consisting of physicians, public health experts, researchers, and nurse executives brought an incredible diversity of thought and lived experience. We bonded over policy debates and even a Hamilton themed skit about being "in the room where it happens," where we each introduced ourselves to the RWJF Alumni with a unique verse about who we are.

Memorable moments included having "fireside chats" with former U.S. Surgeon General Dr. Jerome Adams on navigating politics and science during public health crises. Dr. Don Berwick shared insights on large-scale systems change and Dr. Karen DeSalvo offered reflections on her path from city health commissioner to national health Information Technology leader and Acting Assistant Secretary of Health. I appreciated how these leaders shared their wins and how they navigated challenges.

Beyond formal briefings, serendipitous hallway conversations with National Academy of Medicine members, and impromptu field trips to the Botanical Gardens enriched our experience. Another highlight was the annual RWJF Alumni retreat, where alumni candidly reflected on life after the fellowship, and how they leveraged their experiences to lead change and create impact.

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Placement: Working in the Minority

As health policy fellows, we had the option to work in the executive branch. Alternatively, we could work in a Member's office (Senator or Representative). I like to frame working for a Member's office as similar to being a generalist, where you tackle myriad policy issues depending on the focus of the Member. Additionally, we had the option to work on a committee of jurisdiction: Senate Finance, Senate HELP (Health, Education, Labor and Pensions), House Energy and Commerce, or House Ways and Means. Working in a committee is analogous to working in a specialized field, like cardiology or GI, where you work on specific policy issues in your jurisdiction (or scope of practice), such as Medicare, Medicaid, workforce, or education. I chose to work on a committee because I desired to sharpen my expertise in payment policy.

I was selected for the Senate Finance Committee during a time of Republican control across Congress and the White House. During my placement, I focused primarily on Medicare Part B issues: Medicare physician fee schedule (MPFS), behavioral health, end stage renal disease, durable medical equipment, home infusions, and emerging topics, such as artificial intelligence in health care. I was told in jest by a colleague that working in the minority would be like trying to play ball with two hands behind my back! Translation—we didn't have the formal power nor did we control the legislative agenda. However, I learned how even in the minority you could still influence policy through the art of bipartisan coalition building, the critical role in oversight, and being ready when a policy window opens.

Much like clinical training, the work was intense. I reviewed thousands of public comments, prepared various memos, reviewed, researched and drafted legislative text, and provided Member education. I took point on prepping nomination hearings for key Department of Health and Human Services officials and supported my Member in constituent meetings where I helped bridge the gap between community needs and federal policy.

The Six Ps of Capitol Hill

I distilled my time into six key principles:

1. **Policy Isn't Politics.** Evidence is essential, but the timing of the legislative calendar (e.g., passing a bill before recess begins or considering leadership priorities) also has merit.
2. **Power Is Different in D.C.** Power and influence sometimes come from outside elected officials. Senior staffers hold institutional memory, relationships, and procedural expertise.
3. **Process Is the Product.** Knowing the legislative mechanics is just as critical as having a good policy idea (e.g., understanding budget reconciliation rules is just as important as having the right policy idea).
4. **Position Shapes Perspective.** Being in the minority can facilitate creative problem solving and engaging unlikely allies.
5. **Preparation.** The Hill seems to move at two speeds: glacial and breakneck. When policy windows open, only those who have done the groundwork can act quickly.
6. **Project.** Having a project or a portfolio of policy issues is key to your professional fulfillment and identity on the Hill. This is like establishing your niche in academic medicine (essentially what you're known for).

Understanding the 6Ps increases your chance of success on Capitol Hill.

Medicare Physician Payment Reform

Inadequate and unpredictable payment updates have threatened access to care, driven physician burnout, and led to early attrition from medicine particularly in primary care. The Senate Finance Committee's 2024 bipartisan white paper, *Bolstering Chronic Care through Physician Payment,*[1] highlighted creating a more stable, predictable payment system, improving primary care, and promoting sustainability in chronic disease care. I was able to offer my perspective as a practicing physician.

Memorable Moments

I'll never forget my first Vote-a-rama—an overnight Senate voting marathon. I went down to the Senate Floor with other congressional fellows and watched the Senators as they came throughout the night to speak on various amendments. The Senate gallery was as grand as I remembered from TV but much smaller in person. I worked at my committee's office until 2:30 AM tracking hundreds of amendments, mostly designed for political messaging rather than policy change. It was an illustration of how legislative procedures can be used to advance or block ideas.

Another memorable moment was during the budget reconciliation process that overflowed into Senate recess. I contributed with an individual Byrd argument that helped keep a potential harmful provision out of a bill. Additionally, building trust and showing up prepared daily earned me a seat at the table for key conversations including supporting my Member on the dais during a Senate hearing.

Being on the committee afforded me certain privileges and insights. During my daily morning perusal of political news, I came across an article discussing a strategy about a policy issue that was already "Byrded out" or removed from the bill by our team. We were ahead of the news, and it was another one of those 'in the room where it happens' moments.

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New Skills and Advice

By the end of the year, I could read the *Federal Register* like a patient chart and devise legislative strategy with clarity like developing a treatment plan. I left with a stronger network of allies and mentors, sharper skills in policy analysis and strategy, and an appreciation for the role of relationships in getting anything done in D.C. or elsewhere. My advice to researchers, educators, and clinicians: pair data with compelling narratives, integrate policy and advocacy into clinical training, and remember that advocacy is a part of our chosen profession. We can advocate at the bedside, within our institutions, communities and even on Capitol Hill.

Conclusion

My RWJF Health Policy Fellowship year wasn't a detour from my clinical journey, it was an evolution. It taught me how to use my clinical experience to influence the policy solutions we urgently need. If there's one thing I'll carry forward with me after the fellowship, it's this: policy is being made whether we're in the room where it happens or not. We must make sure we're in the room.

Note: Deadline to apply for the next RWJF Health Policy cohort is November 3, 2025.

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SGIM

IMPROVING CARE

IMPROVING PATIENT COMFORT FOR IUD PLACEMENT: IMPORTANT UPDATES FOR SGIM CLINICIANS

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Introduction

Placement of intrauterine devices (IUDs) can range from uncomfortable to painful, which may deter some patients from choosing this effective form of contraception. Many patients also feel that they were inadequately counseled about pain management. Major media outlet coverage and social media posts highlight instances of inadequate analgesia for IUD placement and the lack of procedural pain management options.[1] In response to this, the American College of Gynecology (ACOG) and the *American Journal of Gynecology (AJOG)* published recommendations on pain management for IUD placement in May 2025.[2,3] While not all internal medicine (IM) physicians place IUDs, SGIM considers counseling patients about contraceptive options, including IUDs, a core competency in women's health.[4] This article reviews the latest guidelines for IUD pain control, evidence for available pain management options, and our own strategies to manage IUD placement pain as experienced IUD providers.

Essential Counseling for All Patients

As IM physicians, it is imperative that we counsel patients on anticipated risks, benefits, and preparation when we refer patients for procedures. This counseling should be part of routine IM practice when patients are referred for IUDs. For providers who place IUDs, it is also important to openly discuss the variable experiences patients may have with IUD placement, as well as a patient's specific goals and expectations for the procedure. This counseling

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should happen before patients undress for the procedure and should emphasize a trauma-informed approach to care. Patient autonomy should also be emphasized: this is an elective procedure that can be stopped at any time the patient desires.

In addition to pre-procedural counseling, there is also data to suggest that ongoing counseling during the procedure improves pain control, with one study showing "verbal anesthesia" to be as effective as oral tramadol in pain management for IUD placement.[5] Techniques for verbal anesthesia include using low voice volume, slow speech, and maintaining constant communication with the patient during the procedure.[5]

Ensuring a comfortable environment for patients should not be overlooked in reducing their anxiety and pain associated with IUD placement. Counseling patients about what to expect during the procedure, the various pain management strategies available to them, and using verbal anesthesia during the procedure are all emphasized as important elements of IUD placement in the recent AJOG expert review best practices.[3] Additional strategies we use in our own practices include encouraging patients to play music, permitting them to use their phones to read or play games, and allowing them to bring a support person into the room if preferred.

Pharmacologic Pain Management Strategies

There are a limited number of high-quality studies evaluating medications for pain management during IUD placement. This contributed to the previous lack of best practice guidelines for pain control with IUD placement. Commonly prescribed medications include non-steroidal anti-inflammatories (NSAIDs), opioids, benzodiazepines, synthetic prostaglandins, and lidocaine formulations. Here we briefly review each of these options and offer suggestions about how to counsel patients regarding their effectiveness for IUD placement.

There are few studies evaluating NSAID use (namely ibuprofen and naproxen) for pain control during IUD placement. Results of these studies have mixed results without evidence of consistent benefit for pain control during IUD placement. The recently published ACOG guidelines do not recommend NSAID use prior to IUD placement but do mention their potential benefit for post-procedural pain control.[2] The AJOG best practice guidelines recommend routine NSAID administration 1-2 hours prior to the procedure. Given the minimal financial cost to patients, low risk of harm, and potential benefits in managing post-procedural cramping, we believe it is reasonable to recommend NSAIDs prior to IUD placement.

Opioids and benzodiazepines are other medications sometimes prescribed for IUD placement, though studies do not demonstrate clear or consistent benefits for pain control during gynecologic procedures.[2] These medications impair patients' ability to provide consent and may necessitate two appointments. They also impair patients' ability to drive, resulting in possible financial and transportation barriers to IUD placement for some patients. The ACOG guidelines do not recommend opioids or benzodiazepines for IUD placement.[2] The AJOG guidelines suggest benzodiazepines for patients with significant anxiety about the procedure, but do not recommend opioids.[3] We suggest an individualized approach to the use of opioids and benzodiazepines. For select patients who have previously required these medications for successful IUD placement or who have high anxiety about the procedure, it may be reasonable to consider these medications on a case-by-case basis.

Synthetic prostaglandins (misoprostol or dinoprostone) have also been used for pain control in IUD placement but are not routinely recommended by ACOG.[2] The AJOG guidelines suggest their use in cases of prior failed IUD placement.[3] We do not routinely use or recommend synthetic prostaglandins for pain control during IUD placement but may consider it in cases of prior failed placement.

Numerous studies evaluate different formulations of lidocaine including lidocaine-prilocaine cream, lidocaine gel, and buffered lidocaine. There are also different techniques for application including cervical block, paracervical block, and topical administration. The May 2025 ACOG guidelines recommend lidocaine-prilocaine cream, lidocaine spray, or paracervical lidocaine block to manage pain during IUD placement.[2] The AJOG guidelines suggest an individualized approach: topical lidocaine formulations for patients at lower risk of IUD placement pain and cervical or paracervical block for those at higher risk of procedural pain.[3] In our own practices, we will likely begin to offer EMLA cream and/or topical lidocaine spray to most patients. We will suggest paracervical blocks to select patients who desire it, but counsel that the block itself can be painful.

Conclusion

In recent years, popular and social media discourse exposed a healthcare culture that dismisses women's pain, especially with gynecologic procedures.[1] As internists on the frontlines of health care, it remains important that SGIM members not only participate in the dialogue but also help advance the conversation to advocate for our patients. One way that SGIM members can do this as primary care IM physicians is by counseling our patients about their options for pain control when we refer them for gynecologic procedures, including IUDs.

After reviewing the literature and guidelines, we recommend offering a multimodal approach to procedural pain and anxiety management for IUD placement.

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We support pre-procedural counseling for all patients and believe this counseling should be done by primary care providers prior to referral, not just IUD proceduralists. We also encourage an open conversation with patients regarding their specific concerns with the procedure, and an individualized approach to pain control for IUD placement based on a patient's experience and goals. While some patients may choose some or none of these options for pain and anxiety management, SGIM members can help improve patients' overall experience by having candid conversations about the possibility of pain and the potential options for managing pain.

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