NOVEMBER 2025 V48, NO. 11

SGIM FORUM

IN THIS ISSUE:

SIGN OF THE TIMES

THE USE OF GENERATIVE ARTIFICIAL INTELLIGENCE ON INPATIENT MEDICINE SERVICES

Justin J. Choi, MD, MSc; Mona Krouss, MD; Daniel J. Morgan, MD; Luci K. Leykum, MD, MBA, MSc

Dr. Choi (juc9107@med.cornell.edu) is an assistant professor of Medicine at Weill Cornell Medicine in the Division of General Internal Medicine. Dr. Krouss (mona.krouss2@va.gov) is an adjunct associate professor in the Department of Medicine at the University of Maryland School of Medicine and the VA Maryland Healthcare System. Dr. Morgan (dmorgan@som.umaryland.edu) is a professor of Epidemiology and Medicine in the Department of Medicine and the Department of Epidemiology and Public Health at the University of Maryland School of Medicine, and the VA Maryland Healthcare System. Dr. Leykum (luci.leykum@austin.utexas.edu) is an affiliate professor in the Department of Medicine at The University of Texas at Austin, Dell Medical School, and the South Texas Veterans Health Care System.

Introduction

Large language models (LLMs), a type of generative artificial intelligence, have rapidly become part of the daily lives of many clinicians. Yet their current use in clinical practice has not been well characterized. Although these tools have shown potential to assist clinicians in core areas, such as clinical reasoning and patient communication,[1,2] they have not been implemented in a formalized manner. A significant gap exists between top-down institutional guidance on LLMs and their actual use on inpatient medicine services.

To address this gap, we explored the current use of LLMs on the inpatient wards. Based on informal observations across three different hospital systems in March and April 2025, we offer a perspective on the immediate implications of the "bottom-up" adoption of LLMs for clinical practice, medical education, and patient safety. During our observations, we asked medical trainees, advanced practice providers, and physicians on inpatient wards: "*Do you currently use artificial intelligence, and if so, for what purpose?*"

In the following sections, we share our experiences with the adoption of LLMs for inpatient care, the shift from traditional information sources to LLMs, and how users approach issues of trust regarding LLM outputs for clinical practice. Our purpose is to frame the real-world

SIGN OF THE TIMES *(continued from page 1)*

Current Uses of Large Language Models on Inpatient Medical Services

Type of Use	Examples
Clinical Information Lookup	Medication dosages, clinical guidelines, management options (e.g., oral antibiotic choices for pneumonia)
Documentation Assistance	Admission notes, progress notes, discharge summaries
Clinical Decision Support	Generating differential diagnoses, summarizing relevant evidence base
Patient Communication Guidance	Drafting patient instructions, explanations of conditions and treatments in patient-friendly language
Patient Letters and Documentation	Drafting letters for patients requesting work excuses, return-to-work clearances, travel clearances
Clarifying Terminology	Medical or surgical abbreviations, interpreting radiology or pathology reports

use of LLMs not only as a matter of new innovative technology but also as a critical challenge that already exists and demands a forward-looking strategy to ensure its appropriate use.

Variable Adoption and Uses

At the time of our inquiry, the hospitals we observed had not yet officially integrated LLMs into clinical workflows. Nonetheless, awareness of these tools was universal among those surveyed and informal use was common. The most prevalent LLMs used included OpenEvidence and ChatGPT, though other platforms were also mentioned, such as Claude, Perplexity, and Google's Gemini. Types of use varied from searching "one-off" clinical questions on medication dosing, management options, and clinical guidelines, to higher-order tasks, including formulating a differential diagnosis, outlining a management plan, and engaging in succinct case-based dialogues with LLMs (see table). Although use of LLMs was common, some clinical team members viewed the idea of asking clinical questions or "discussing a case" with LLMs as completely foreign.

The most cited reason for using LLMs was their efficiency. Nurse practitioners and physician assistants noted that asking clinical questions to LLMs was "easier and faster" than asking their supervising physician and waiting for their response. Interestingly, a team comprised of non-native English speakers reported lower usage, suggesting potential cultural or language factors influencing adoption patterns.

We observed that early adoption of LLMs demonstrated "bottom-up" implementation and "word-of-mouth" permeation across medical teams. Trainees and junior clinicians were more likely to be early adopters than senior clinicians. Some supervising clinicians learned about these tools from trainees, rather than through formalized institutional processes. Many users first learned about these tools through informal peer recommendations. For example, on one team we observed two residents sign up for OpenEvidence during a rotation after hearing their peers talk about it.

> **"This real-time, bottom-up implementation indicates that top-down formalized processes for integrating LLMs into clinical workflows must be swiftly developed to ensure that SGIM clinicians can safely and effectively leverage these tools for patient care."**

Transforming Information Retrieval

Clinicians have traditionally accessed information through resources, such as journal articles and online platforms, including UpToDate.[3] The growing use of LLMs marks a shift in how many clinicians retrieve information in real-time. We found that users appreciated the immediacy and specificity provided by LLMs compared to traditional resources. Because asking a specific question (e.g., "*What is the initial antibiotic choice for community-acquired pneumonia in a patient with a penicillin allergy?*") provides more targeted information than a general summary of a topic, clinicians perceived LLMs as more efficient for real-time information retrieval. Furthermore, LLMs that provided supporting citations were more appealing to users as they allowed users to verify the information provided.

Not everyone used LLMs for medical information. Many senior physicians, while aware of LLM tools, were reluctant to use them. If this is also true for leaders who are driving institutional policies, it could explain why top-down guidance remains constrained. Whether this reluctance reflects skepticism, generational difference in adopting new technologies, or mere preference, understanding barriers for formal integration of LLMs is essen-

SIGN OF THE TIMES (continued from page 2)

tial for developing top-down guidance. Access to medical information has shifted as technologies have evolved—from print to digital, from textbooks to UpToDate. Now we are seeing a transformation of clinicians seeking information through LLMs that are supplementing, and for some, replacing traditional resources.

Redefining "Trust" in the Age of Artificial Intelligence

A cornerstone of clinical practice is knowing whom and what to trust. Many clinicians now use LLMs in their clinical workflows, suggesting a baseline level of trust and confidence in their capabilities. However, many of those we spoke with remain cautious when applying LLMs to clinical practice. Lack of familiarity, training, or errors and omissions in LLMs might contribute to their caution.

A common barrier to clinicians using LLMs is hallucinations or confabulations—instances when LLMs generate responses that appear plausible but are factually incorrect.[4] LLMs typically present information with skilled writing that conveys confidence in their outputs. This contributes to automation bias, or overly accepting of the automated output of machines, that can exacerbate challenges in identifying hallucinations.[5] Some clinicians we spoke with cross-checked outputs with more traditional resources, like UpToDate, while some still avoided using LLMs.

While clinicians might begin trusting LLMs, they remain uneasy with legal and regulatory concerns around using LLMs for practice. There are also concerns around data security (e.g., protected health information entering LLMs). Again, absence of top-down guidance leaves many clinicians uncertain about how to use LLMs ethically and legally.

Recommendations

Based on our experience and observations, we propose the following recommendations for hospital leaders, educators, and researchers:

1. Institutions and hospital medicine leaders must develop clear institutional guidelines and create policies that address data privacy while outlining responsible use (and prohibited use cases).
2. Medical educators should integrate artificial intelligence (AI) literacy into curricula across the medical education continuum. Trainees will need instruction on how LLMs work, how to optimize prompting for specific use cases, understanding their limitations, and acknowledging the legal and ethical issues at stake.
3. Researchers should design rigorous studies using a range of approaches to characterize the prevalence of LLM use, assess its impact on patient safety, quality of care, and education, and develop innovative curricula and interventions that use LMs to improve learner, patient, and system outcomes.

These recommendations outline the need for clear institutional and hospital policies, comprehensive educational programs, and rigorous research to guide the responsible and effective use of LLMs for inpatient medicine.

Conclusion

Formal integration of LLMs into clinical practice will likely occur in the coming years. Our observations across diverse inpatient settings revealed that LLMs are already reshaping how clinicians access information. Adoption varied widely, and tensions around trust, accuracy, and regulatory uncertainty were common. As clinicians in the hospital, we have been struck by the extent to which colleagues, especially junior trainees, embraced LLMs for real-time guidance. Many frontline SGIM clinicians have already developed improvised methods to gauge LLM reliability and find practical uses for patient care. This real-time, bottom-up implementation indicates that top-down formalized processes for integrating LLMs into clinical workflows must be swiftly developed to ensure that SGIM clinicians can safely and effectively leverage these tools for patient care.

Acknowledgements: Drs. Krouss, Morgan, and Leykum receive salary support from the Department of Veterans Affairs. The views expressed in this manuscript are those of the authors and do not reflect an official position of the Department of Veterans Affairs or the authors' other affiliated institutions.

References

1. Ayers JW, Poliak A, Dredze M, et al. Comparing physician and artificial intelligence chatbot responses to patient questions posted to a public social media forum. *JAMA Intern Med*. 2023;183(6):589-596. doi:10.1001/jamainternmed.2023.1838.
2. Goh E, Gallo R, Hom J, et al. Large language model influence on diagnostic reasoning: A randomized clinical trial. *JAMA Netw Open*. 2024;7(10):e2440 969. doi:10.1001/jamanetworkopen.2024.40969.
3. Gabbay J, le May A. Mindlines: Making sense of evidence in practice. *Br J Gen Pract*. 2016 Aug; 66(649):402-3. doi:10.3399/bjgp16X686221.
4. Azamfirei R, Kudchadkar SR, Fackler J. Large language models and the perils of their hallucinations. *Crit Care*. 2023;27(1):120. doi:10.1186/s13054-023-04393-x.
5. Goodman KE, Yi PH, Morgan DJ. AI-generated clinical summaries require more than accuracy. *JAMA*. 2024;331(8):637-638. doi:10.1001/jama.2024.0555.

SGIM

GOOD TO GREAT: 16 TRANSFORMATIONAL CONCEPTS FOR LEADERS

Michael Landry, MD, MSc, FACP
Editor in Chief, SGIM Forum

"Good leaders build products. Great leaders build cultures. Good leaders deliver results. Great leaders develop people. Good leaders have vision. Great leaders have values. Good leaders are role models at work. Great leaders are role models in life."[1]

In his book *Good to Great*, author Jim Collins highlights the essential steps needed for businesses to transform from a good to a great company.[2] He describes the three essential elements to break through the "culture of good" to become a great company via his *Good to Great* flywheel model: disciplined people, disciplined thought, and disciplined actions. "Level 5 Leadership" (a component of the disciplined people element) is the foundation by which good companies become great.[2] To become great, the company will need a great leader to chart the course. In this article, we focus on leadership constructs that transform good leaders into great leaders (Level 5 Leaders) by focusing on 16 essential concepts.

What does Level 5 Leadership entail? According to Collins, there are five key characteristics that Level 5 Leaders possess:

1. ***Personal Humility***. The classic servant leader who is willing to serve others, gives credit to others and creates a supportive collaborative working environment.
2. ***Professional Will***. Determination to achieve long-term success and meet personal and professional goals.
3. ***Ambition for the Cause***. The Level 5 Leader places the company's success above their own.
4. ***Focus on People***. The Level 5 Leader ensures that they have the right people in place before embarking on their transformation of company culture. You cannot embark on a journey of change without having the right people in the right place who are willing to go on the transformation journey.
5. ***Self-Awareness***. The great leader is aware of their personal strengths and weaknesses that are contributing to the transformation.

Collins asserts that these characteristics are the prerequisites necessary for a company to transform from good to great.

Good to Great addresses the transformation of company culture—but how do leaders transform from good to great to achieve Level 5 status. Where is that manual? Better yet, are there *CliffsNotes* to offer quick answers in a succinct format? Unfortunately, there is no easy path to read your way to Level 5 Leadership. But there are lessons that I have learned through experiences and articles to help develop great leaders:

1. A good leader maintains operations and the status quo; a great leader improves or develops new operations and processes by challenging the status quo.
2. A good leader focuses on system/structures/operations while a great leader focuses on the people behind these systems and operations.
3. A good leader provides detailed instructions for completing tasks to ensure a successful outcome. A great leader provides the vision and resources and then allows the group to determine the best steps to achieve the desired outcome.
4. A good leader leads by control whereas a great leader develops trust with their team to accomplish the same results.
5. A good leader has a short-term view on managing operations (hours, days or weeks) while a great leader employs a long-term vision (months, years, or decades).
6. A good leader may accept errors and mistakes as a cost of doing business to accomplish the goal; a great leader drives improvement to create a system that eliminates errors and mistakes and still achieves the goal.
7. A good leader knows "their people" as a collective group; a great leader knows each person in the group and what is important to them.
8. A good leader performs operations the right way; a great leader will do the right thing even at a cost.
9. A good leader will successfully lead their group through emergencies. A great leader will not only lead the group through an emergency but also then use the emergency to reflect on what worked or did not work as they prepare for the next emergency. The great leader also checks on their group post emergency to ensure that they are physically, mentally, and emotionally well.

FROM THE EDITOR (continued from page 4)

10. A good leader evaluates their employees for the job they are currently performing; a great leader not only evaluates the employee but also enquires about "next steps" and develops plans with the employee for attaining new skills or preparing for promotional opportunities.
11. A good leader cares about being "liked" by those they lead; a great leader cares about being respected by their team.
12. A good leader tells their employees "thank you." A great leader says "we appreciate you and what you do."
13. A good leader will develop faithful followers. A great leader develops and promotes faithful leaders.
14. A good leader responds to issues and problems raised by their people. A great leader anticipates the problem by proactively learning the concerns of their team. "The day the soldiers stop bringing you their problems is the day you stopped leading them. They have either lost confidence that you can help them or concluded that you do not care. Either case is a failure of leadership."[3]
15. A good leader may use "I" when credit is offered and "We" when blame is raised; a great leader expresses "We" when credit is given and "I" when blame is directed at the team.
16. A good leader "eats first" according to the established hierarchy. A great leader "eats last" after everyone else eats.

Mastering these concepts will help good leaders begin their transition to great leaders and along the way achieve Level 5 Leadership status.

Noted author John Maxwell writes "The single biggest way to impact an organization is to focus on leadership development. There is almost no limit to the potential of an organization that recruits good people, raises them up as leaders and continually develops them."[4] But who is setting the great culture that supports leadership development? A Level 5 Leader is likely responsible for the culture that exists in developing future leaders. Author Roy Bennett captures this essence stating, "Great leaders create more leaders, not followers."[5]

SGIM is full of leaders. SGIM has many programs to develop good leaders into great leaders (ACLGIM, LEAD, CAP, TEACH, UNLTD, and LEAHP). Invest in yourself and apply to these programs. When you make the personal transition from a good to a great leader, your organization is one step closer to transforming from good to great as well.

References

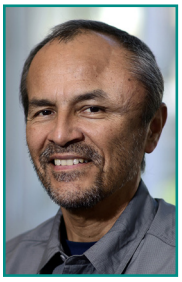
1. 10 leadership quotes on the qualities of a great leader: Adam Grant quote. *Qualtrics*. https://www.qualtrics.com/blog/50-powerful-leadership-quotes/. Accessed October 15, 2025.
2. Collins J. *Good to Great: Why Some Companies Make the Leap... and Others Don't*. New York: Harper Collins, 2001.
3. Colin Powell quotable quote. *Goodreads*. https://www.goodreads.com/quotes/113573-the-day-the-soldiers-stop-bringing-you-their-problems-is. Accessed October 15, 2025.
4. Maxwell JC. *QuoteFancy*. https://quotefancy.com/quote/841029/John-C-Maxwell-The-single-biggest-way-to-impact-an-organization-is-to-focus-on-leadership. Accessed October 15, 2025.
5. Roy T. Bennett quotable quote. *Goodreads*. https://www.goodreads.com/quotes/7987138-great-leaders-create-more-leaders-not-followers. Accessed October 15, 2025.

SGIM

SUPPORTING ACADEMIC HOSPITALISTS: THE ROLE OF PROFESSIONAL SOCIETIES

Carlos Estrada, MD, MS, FACP
President, SGIM

"Their article illuminates concerning patterns regarding institutional recognition of faculty value, equitable compensation, and academic support. These issues reflect broader systemic challenges that affect general internal medicine and hospital medicine faculty."



I was struck by Drs. Christopher Sankey and Sharon Ostfeld-Johns's article which states that academic hospitalists risk extinction due to undefined roles and poor compensation.[1] The authors opine that academic hospitalists would either formally redefine their identity with protected academic time or abandon the "academic" label entirely.[1] Their article illuminates concerning patterns regarding institutional recognition of faculty value, equitable compensation, and academic support.[1] These issues reflect broader systemic challenges that affect general internal medicine and hospital medicine faculty.

Both general internal medicine and hospital medicine have navigated similar challenges in establishing professional identity, securing institutional support, and creating career advancement pathways. For internists and hospitalists—groups with substantial overlap—having a "professional home" remains important. My article examines the historical evolution of academic general internal medicine and hospital medicine, explores current institutional barriers facing academic hospitalists, and outlines how professional societies like SGIM can better support hospitalists through strategic partnerships.

Academic General Internal Medicine

Academic general internal medicine divisions emerged in the 1970s, driven by graduate medical education mandates requiring meaningful outpatient learning experiences for residents. Prior to this, training focused primarily on inpatient care. Some past SGIM presidents served as founding leaders of these nascent GIM divisions.[2] Early years featured small faculty teams carrying educational innovation while facing skepticism from subspecialty-focused departments. One telling anecdote illustrates prevailing attitudes: a department chair at a prestigious institution told a newly recruited GIM faculty member, "*I don't believe in GIM–everyone should be a subspecialist working in basic science. But if I am going to form a new educational experience, it better be the best in the country.*" This sentiment captures the ambivalent relationship many academic medical centers had with general internists.

The promotion landscape for early academic generalists proved challenging. Traditional academic medicine prioritized research grants and publications as advancement metrics. Clinical educators focused on teaching faced uphill battles for academic recognition and promotion. The emphasis on funded research and subspecialty expertise created systemic barriers that persisted for decades, forcing talented generalists to navigate career paths with limited institutional support and unclear advancement criteria.

The Rise of Hospital Medicine

The hospital medicine movement introduced doctors who specialized exclusively in hospital care to manage increasingly complex inpatient medicine more efficiently. In 2016, Drs. Robert M. Wachter and Lee Goldman marked the 20th anniversary of the hospitalist concept.[3]

Wachter and Goldman eloquently summarized the trajectory and impact: "When we described the hospitalist concept 20 years ago, we argued that it would become an important part of the healthcare landscape. Yet we couldn't have predicted the growth and influence it has achieved. Today, hospital medicine is a respected field whose greatest legacies may be improvement of care and efficiency, injection of systems thinking into physician practice, and the vivid demonstration of our healthcare system's capacity for massive change under the right conditions."[3]

During the past 30 years, hospital medicine has experienced rapid growth in academic institutions and community practices, fundamentally reshaping inpatient care delivery. Academic hospitalist groups emerged with expectations to excel across multiple domains: clinical care, education, quality improvement, patient safety,

PRESIDENT'S COLUMN (continued from page 6)

research, and administration. This multi-faceted role created opportunities and challenges mirroring those faced by their academic GIM predecessors.

Contemporary Challenges and Institutional Barriers

Institutional support for strategic initiatives and professional development varies dramatically across different healthcare systems. This variation depends on factors such as available resources, governance structure, and institutional culture. The fundamental reality is that financial considerations often drive institutional priorities: "no margin, no mission." This oversimplified, yet pervasive, mindset fails to capture the complexity of running an academic institution while supporting diverse faculty career paths.

In research, the concept of Facilities and Administrative costs (F&A; also referred to as *indirect costs*) creates additional complexity. F&A costs are the shared operational expenses of an institution that support multiple activities and cannot be directly attributed to any single sponsored project. Support for F&A costs is under attack by the current administration.[4]

This reduction in F&A support limits the ability of academic center leaders to support their faculty. Academic departments operate under multi-tiered "taxation systems" to fund strategic initiatives: the institutional President taxes the Deans, the Deans tax the department chairs, and the process continues downward. With reduced F&A funding, there will be less money flowing through this system. External forces, like the reduction in F&A funding, will make it harder for universities to support increased salaries.

The Role of Professional Organizations

To support hospitalists' evolving professional development needs, SGIM has established partnerships with the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM), the Society of Hospital Medicine (SHM), and the American College of Physicians (ACP). Each organization has developed infrastructures and programming at national and regional meetings tailored to their members' needs. In a recent SGIM Forum article, Dr. Eric Bass, SGIM CEO, describes one example of joint programming: the Academic Hospitalist Academy.[5]

In SGIM, the Academic Hospitalist Commission (AHC) serves as the structural pillar for hospitalist members. Led by Drs. Attila Nemeth and Anne Smeraglio, the Commission will continue to develop and support submissions for workshops and distinguished professor programming at upcoming regional and national meetings. I am looking forward to seeing the product of a new initiative by the AHC—the creation of writing groups to increase scholarship opportunities for AHC members.

SGIM acknowledges the crucial role that academic general internists play in both inpatient and outpatient medicine. I believe they have a significant impact on the training of students and residents. SGIM members may have experiences like mine. I typically spend 3-4 months

PRESIDENT'S COLUMN *(continued from page 7)*

each year attending in the hospital, always with trainees, and have never practiced independently without them. Early in my career, I managed a panel of patients for approximately 10 years. Throughout my career, I have consistently supervised residents in clinics. I identify myself as an academic general internist who operates in both the inpatient and outpatient setting.

SGIM can do better to support our academic hospitalist members. The upcoming winter Council retreat will dedicate time for strategic discussions regarding how SGIM can better support hospitalists. This generative discussion will provide an opportunity for SGIM leadership to engage in thoughtful deliberation about future programming.

SGIM's leadership is committed to continuing collaboration with SHM on how to support academic hospitalists through the AHA in addition to exploring new opportunities to support SGIM members who remain engaged in hospital medicine. We recognize that strong inter-society partnerships require sustained engagement between senior leaders.

Just as academic general internal medicine evolved from small faculty teams facing skepticism to becoming established entities, academic hospital medicine *must* continue to navigate similar growing pains while defining its identity. The choice between redefining roles with protected academic time or abandoning the "academic" label—as highlighted by Sankey and Ostfeld-Johns—need not be binary. We can create sustainable pathways supporting diverse career trajectories through strategic partnerships between organizations such as SGIM, SHM, and ACP. SGIM's commitment to supporting hospitalists through enhanced collaborative programming reflects our understanding that academic hospitalists' success strengthens the entire general internal medicine community.

References

1. Sankey C, Ostfeld-Johns S. Academic hospitalists: Time to redefine or fade away. *ACP Hospitalist*. https://acphospitalist.acponline.org/archives/2025/08/13/free/academic-hospitalists-time-to-redefine-or-fade-away.htm. Posted August 13, 2025. Accessed October 15, 2025.
2. Inui T. How do stories inspire healthcare leaders? *SGIM*. https://www.sgim.org/about-sgim/leadership/presidents-podcast/. Accessed October 15, 2025.
3. Wachter RM, Goldman L. Zero to 50,000 - The 20th anniversary of the hospitalist. *N Engl J Med*. 2016 Sep 15;375(11):1009-11. doi:10.1056/NEJMp1607958. Epub 2016 Aug 10.
4. Snyder BR. Don't overlook the continued threat of cuts to universities' indirect research costs. *STAT*. https://www.statnews.com/2025/04/07/indirect-costs-facilitities-administration-nih-cuts-universities/. Published April 7, 2025. Accessed October 15, 2025.
5. Bass EB, Holmes-Maybank K, O'Dorisio N. What's new with the Academic Hospitalist Academy? SGIM Forum. https://www.sgim.org/forum-issue/sgim-forum-august-2025/. Published August 2025. Accessed October 15, 2025.

SGIM

Q & A WITH SGIM'S CEO AND INITIATORS OF AN INTERNATIONAL EFFORT TO ADDRESS ATTACKS ON HEALTH PROFESSIONALS

Eric B. Bass, MD, MPH; Leonard Rubenstein, JD, LLM; Martin Chalfie, PhD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Mr. Rubenstein (lrubenstein@jhu.edu) is a Distinguished Professor of the Practice at the Johns Hopkins University Bloomberg School of Public Health and previously served as Executive Director and then President of Physicians for Human Rights. Dr. Chalfie (mc21@columbia.edu) is the Chair of the Committee on Human Rights of the United States National Academy of Sciences, National Academy of Engineering, and National Academy of Medicine.

Many SGIM members have been leaders in advocating for human rights. In a previous column, I interviewed Michele Heisler and Monica Peek about what Physicians for Human Rights has been doing to address threats to the health of immigrants and refugees and to solicit advice on what SGIM members can do.[1] Last year, Editor in Chief Michael Landry devoted a column to the need for legislation to protect American healthcare workers from the increasing violence directed at them.[2] For this column, I decided to interview two of the initiators of an international effort to address attacks on health professionals about what needs to be done to address the growing threats to health professionals around the world.

EB: What is the mission of the Forum to Address Attacks on Health Professionals?

MC: The Forum, created in 2022, brings together leaders of healthcare and scientific associations to examine and address the problem of attacks on health professionals, both in the United States and around the world.[3] Such attacks range from threats, harassment, and silencing of researchers, clinicians, and other health professionals in connection with their work to physical attacks on healthcare providers in conflict zones.

LR: In the United States, for example, during the COVID-19 pandemic, public health professionals were threatened with violence for implementing policies that contributed to saving the lives of millions of people. Globally, combatants in conflicts throughout the world regularly, and, often relentlessly, attack hospitals and health providers, consequently depriving thousands, and sometimes millions, of people of access to health care in the fraught circumstances of war.

MC: The goal is to use the group's collective knowledge to help mitigate and prevent violence against health professionals wherever it occurs. Although many individuals and healthcare organizations have been concerned about aspects of this problem, the National Academies' Committee on Human Rights saw a need to share and expand these efforts and so created the Forum and serves as its convenor.

EB: What organizations are involved?

MC: The following 16 bodies now participate in the Forum's activities: World Medical Association, International Council of Nurses, European Federation of Nurses, American Academy of Pediatrics, American Association for the Advancement of Science, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Medical Student Association, American Nurses Association, American Psychological Association, American Public Health Association, Emergency Nurses Association, National League of Nursing, and Society of General Internal Medicine.

EB: How does the group seek to fulfill its mission?

MC: The group seeks to: 1) provide a platform for information-sharing among participants on different aspects of the problem of attacks against health professionals; 2) serve as a catalyst for raising public awareness about this problem through events and publications; and 3) undertake other individual and joint efforts to help protect health professionals from threats and violence. For instance, with input from Forum members, the Committee on Human Rights convened webinars on attacks against health professionals during the pandemic and a virtual event on attacks against health professionals who provide reproductive care. Several Forum participants and others, including the President of the National Academy of Medicine, co-authored an editorial in the *Lancet* on "Mobilising the Health Community to Protect Health Care from Attack."[4]

FROM THE SOCIETY *(continued from page 9)*

EB: What can professional societies and individuals do to address the issue at a national or international level?

LR: Organizations can start by highlighting the severity of the problem for members through their publications, sessions at annual meetings, webinars, and in-person events. As important, they should use their voices to speak up via resolutions, statements, press releases, social media, and other vehicles to condemn violence against health professionals both generally and in specific contexts, domestically and internationally. They should also advocate for protecting health professionals and demand accountability for perpetrators of violence, whether individuals, governments, or military organizations. Both individuals and organizations should offer support and solidarity to health professionals under threat. They should always emphasize that health researchers, clinicians, and other health professionals should never be targeted because of their work.

MC: The Committee on Human Rights maintains a large collection of resources on the problem, and we are happy to share these with interested organizations and individuals, together with providing advice on opportunities for action.

Finally, we encourage healthcare and scientific associations that aren't already part of the initiative to contact chr@nas.edu for more information about how to join our efforts.

References

1. Bass EB, Heisler M, Peek M. Q & A with SGIM's CEO and leaders of Physicians for Human Rights (PHR) on refugee and immigrant health. SGIM Forum. 2025;48 (6):7-9.
2. Landry M. Violence against healthcare workers: We need legislation to protect us. SGIM Forum. 2024;47(10):1-2.
3. The National Academies. Forum to Address Attacks on Health Professionals. *The Natl Academies*. https://www.nationalacademies.org/our-work/forum-to-address-attacks-on-health-professionals. Accessed October 15, 2025.
4. Chalfie M, Rubenstein L, Alqodmani L, et al. Mobilising the health community to protect health care from attack. *Lancet*. 2024 Dec 14;404(10470): 2399-2402. doi:10.1016/S0140-6736(24)02421-8. Epub 2024 Nov 11.

SGIM

PERSPECTIVE: ARTICLE I

IN A TIME OF SOCIETAL EMERGENCY, OUR SOCIETY MUST ADVOCATE DIFFERENTLY

Alexander Friedman, DO; Zackary Berger, MD, PhD

Dr. Friedman (AlexFriedmanDO@gmail.com) is an associate clinical professor at the University of California, Riverside, School of Medicine. Dr. Berger (zberger1@jhmi.edu) is an associate professor at the Johns Hopkins School of Medicine, Johns Hopkins Bloomberg School of Public Health, and core faculty at the Johns Hopkins Berman Institute of Bioethics, Baltimore, Maryland.

Introduction

The United States is at a dangerous juncture for the medical profession, patients, and the institutions that comprise our healthcare system. Our Society has previously lobbied elected officials, engaged in public advocacy on issues of interest, and issued statements of principle and policy with the endorsement of Council. However, times have changed.

In the current societal emergency, SGIM members must look beyond our immediate professional considerations and decide how our Society and general internal medicine (GIM) can contribute to the greater good. This reflection requires changing our understanding of how our political advocacy must manifest. Our article proposes a different approach, one that involves more direct collaboration with patient and community organizations.

Why This Moment Is Different

Unlike challenges encountered during previous administrations, the current issues in academic medicine are not merely funding cuts or the ebbs and flows of treatment options. Rather, the destruction of democratic institutions has undermined the bedrock of American medicine, creating an existential threat to research, public health, and the responsible transmission of medical knowledge.

PERSPECTIVE: ARTICLE I (continued from page 10)

It may appear that these pernicious developments have precedents:

- Medicaid cuts, or conversion of Medicaid funding to block grants, have been proposed and implemented before
- Affordable Care Act (ACA) repeal and cuts to premiums have long been on the conservative agenda
- Primary care has been endangered for years owing to workforce shortages and decreased primary care density
- Care for gender diverse people has been restricted in extent over the past few years, as has reproductive care
- Care of the undocumented has always been under considerable constraint.

Health care for the poor and marginalized has often been at the forefront of budget cuts in the name of "fiscal discipline."

But the current regime has been qualitatively different: its scorn for truth has led to the destruction of America's scientific crown jewels, obliterating the ability of agencies such as National Institutes of Health, National Science Foundation, and the Centers for Disease Control to perform core functions. Similar efforts at the Environmental Protection Agency and the Departments of Veterans Affairs and Defense impair public health and clinical care for millions, while Medicaid cuts (without precedent or public transparency) are far-reaching in their destruction.

SGIM Actions to Date

Previously, the advocacy response of SGIM would have been to engage elected officials directly or via lobbying firms, presenting arguments for policy changes. Unfortunately, legislators are extraordinarily limited in their power to effect change—not only because those who support President Trump are in power but also because the executive branch has arrogated to itself powers that the Constitution assigns to other branches of government. This unprecedented scenario demands a different strategy.

SGIM has certainly engaged in salutary efforts to protect patients, primary care, public health, medical education, and research. The lawsuit to counter the destruction of the Agency for Healthcare Research and Quality is notable,[1] as are the Society's other institutional actions and consistent requests to members to advocate with elected officials. However, proceeding through ordinary channels will achieve limited success because there is no longer a functioning system. Because the current federal regime has broken that system, all sections of society must collaborate to reconstitute democracy itself.

General internal medicine has always understood its roles in research, clinical care, education, and advocacy to be part and parcel of a functioning democracy. Our efforts as a Society to reduce disparities, collaborate with communities in participatory research, and equitably distribute research gains have been predicated on the notion of a United States that is structured for the benefit of all residents.

Unfortunately, individuals controlling the federal government are actively disassembling democratic institutions. This process, called *democratic backsliding*, renders the exercise of political power more arbitrary and authoritarian. This makes it more difficult—and in some cases impossible—to provide proper care to patients, engage in empirically based, ethical research, and teach trainees. Since it is those in power who are subverting democracy, lobbying them to reverse this process will be ineffective.

Recent Member Efforts

At the 2025 SGIM Annual Meeting, several members attempted to highlight opportunities for SGIM to recognize these issues through a "speak-out" near the convention hall. Many disseminated an open letter, which was signed by more than 60 SGIM members and served as a testament to the significance of these topics. We were honored to be joined by members from California, Colorado, Maryland, and Florida, but we know that they represent a fraction of the support these positions have within our organization.

Proposed Next Steps for SGIM

To meet this moment, SGIM needs to develop a multipronged approach:

- Forge more extensive relationships with community organizations. This means soliciting these organizations' input on SGIM policy initiatives and partnering with these organizations in their activism efforts. This could include attending protests and rallies, as well as engaging in acts of civil disobedience.
- Physicians have a sacred role in society that bestows privilege—and responsibility. Our authority should not be squandered on advocacy efforts that are confined to the generation of white papers. Showing up in white coats at rallies for immigrants, Medicaid recipients, and transgender persons provides marginalized groups with proof of our commitment to their well-being. It also demonstrates to those on the sidelines that the years we spent acquiring our knowledge and expertise were not only for the dispensation of clinical care but also the betterment of our entire society.
- SGIM must provide ethical guidance to its constituents. This should include the prioritization of migrant and transgender patients' clinical care and the opti-

PERSPECTIVE: ARTICLE I *(continued from page 11)*

mization of their social determinants of health by the medical facilities at which SGIM members practice. Clinicians could then use SGIM-provided tools to advocate for patients at their facilities. This might include:
  - o mandating that medical centers coordinate with their legal counsels to adopt sanctuary policies (limiting sharing of information with state agents to that specifically required by warrants)
  - o creating collaborations with legal aid and community organizations
  - o ensuring clear, multilingual, inclusive signage outlining facility policy to protect all patients' health privacy
  - o developing trauma informed care education for its staff.
- As a collective of academic physicians, SGIM should direct its members to instruct their trainees in methods of advocacy for patients and the ethical precepts that underpin such advocacy, including health equity and health care being a fundamental human right.
- Camaraderie has always been important to SGIM members. We guide one another through the exigencies of classroom design, research method development, and labyrinthine bureaucracies. In the same vein, SGIM should materially support physician colleagues who are experiencing hardship caused by ill-informed government policies, such as censorship, attempts at deportation, and defunding of research due to ideological opposition. This support may take various forms, including the establishment of grants for those in dire economic straits.

Such interventions can help mitigate the harm caused by state oppression.

Conclusion

SGIM has historically championed the interests of patients and members through lobbying and arms-length relationships with community organizations. In the current crisis of our democracy, SGIM must re-evaluate its strategies to adequately address the critical issues arising today. We believe that through the development of robust community partnerships, mutual aid programs, and reinforcement of ethical precepts, our Society can meet the needs of this historic moment.

By expanding its roles, we hope to help SGIM reach its full potential.

Note: The opinions in this article reflect those of the authors and do not purport to reflect the opinions, views, or positions of SGIM or any other entity or organization.

References

1. Society of General Internal Medicine, et al. v. Klein et al. Case No. 8:25-cv-02751-BAH. United States District Court, District of Maryland. *Public Citizen*. https://www.citizen.org/wp-content/uploads/1.-AHRQ-Complaint_FINAL.pdf. Complaint filed August 21, 2025. Accessed October 15, 2025.

SGIM

MEDICAL EDUCATION

TEACHING THE CONSULT CALL: A FELLOW-LED CURRICULUM TO IMPROVE BI-DIRECTIONAL COMMUNICATION

Shreya Narayanan, MD; Christopher D. Jackson, MD

Dr. Narayanan (snarayanan@usf.edu), an attending gastroenterologist, is the Associate Program Director for the Gastroenterology Fellowship program and an assistant professor of Medicine at the University of South Florida. Dr. Jackson (christopherjackson @usf.edu) is Associate Dean of Student Affairs and associate professor of Medicine at the University of South Florida.

Consider the first time you called a consultant. Do you remember the anxiety? Were you at a loss for words when the cardiology fellow asked about the EKG findings? Did the gastroenterology fellow sound frustrated when you couldn't quickly report the last hemoglobin, most recent vitals, or your rectal exam findings? Could you have been better prepared for that moment and for the many consult calls that followed—each one essential to ensure your patients receive timely and appropriate care? Although calling a consultant is a foundational skill in internal medicine, it remains one skill inconsistently taught during residency. Despite

MEDICAL EDUCATION *(continued from page 12)*

the ubiquity of this task, residents often receive little to no formal feedback on their consult communication. Additionally, the individuals best positioned to offer that feedback, the consultants, are rarely involved in teaching this skill. In this article, we present a novel consultant led workshop designed to enhance resident skill and comfort in communicating with consultants.

Background and Literature Review

The role of interdisciplinary work, including consultation, is essential to the delivery of comprehensive care. Effective communication is associated with enhanced interprofessional collaboration, fewer delays in diagnosis and treatment, and improved patient outcomes. Despite this knowledge, communication around consultations at the residency level has historically been taught informally.[1]

Studies have highlighted how trainees often feel underprepared to make consult calls and experience discomfort in interprofessional communication. Efforts to teach consultation skills have previously included frameworks, such as the CONSULT card, which we have utilized, as well as other communication tools and faculty-led workshops.[2] Few workshops or published studies incorporate the perspectives of the consulting specialists or utilize subspecialty fellows as near-peer teachers, despite evidence that this model can increase engagement, enhance the learning environment, improve retention, and facilitate long-term dialogue.[3]

Workshop Development and Structure

Reflecting on a particularly challenging call night, the then-chief GI fellow was left with the feeling that patient care was suffering not only because she was not getting called but also was not getting the *right* calls. She heard about the patient who wanted another dose of MiraLAX at midnight but had not been informed about the patient who, though hemodynamically stable, was having melena with a 4-gram hemoglobin drop. And thus, from a conversation between the then GI and cardiology chief fellows, a specialist-led workshop was born, designed to teach residents how to structure and deliver effective calls to consultants.

This one-hour workshop is delivered annually to our internal medicine trainees during their noon conference series early in the academic year. Internal medicine subspecialty fellows lead the program under the guidance of faculty consultants, and it includes a concise, interactive didactic session developed in collaboration with specialists across internal medicine, surgery, and radiology. The content focuses on structuring written and verbal consult requests, anticipating consultant questions, and delivering concise and pertinent information to the consultant using a simple algorithm: the CONSULT card.[2] Developed at the Icahn School of Medicine at Mount Sinai in New York City to aid their trainees in communicating with consultants, this tool provides a clear, structured, and reproducible framework for making the call to a consultant. Trainees are methodically prepared to courteously contact the consultant, orient them to the situation, provide focused clinical questions and pertinent clinical information, and develop a follow-up plan with the consultant.[2]

The second half of the workshop features structured role-play, in which trainees practice consult calls to medical and surgical subspecialists using the CONSULT card framework. Feedback is provided in real-time by fellows, faculty, and peers. This format brings the hidden curriculum to light, providing explicit instruction on a task that is often left to informal learning.

Highlights and Educational Impact

There are three features that distinguish this workshop. First, including subspecialty fellows—the usual audience for these consultations—enriches teaching by grounding it in real-world relevance. Their perspective enables residents to appreciate what information consultants value most and how to foster productive, respectful communication. This near-peer teaching model enhances psychological safety, encourages candid feedback, and supports the development of a professional identity among both fellows and residents. Dr. Francisco Pascual, a senior resident, shared that "*having direct access to and receiving feedback from a GI fellow and attending during this workshop helped me build a strong foundation in strategic case framing, enhanced my confidence, and empowered me to become a more collaborative, effective member of our healthcare team.*"

Second, the workshop emphasizes the bi-directional nature of consultation, modeling it not merely as a transaction, but as a collaborative conversation grounded in shared clinical reasoning. From the educator perspective, Dr. Matthew Heckroth, the senior fellow who ran this year's workshop, expressed that the fellow-run nature of this workshop helps to "*alleviate some of the stress felt when placing consults. We were in their position a couple of years ago and had the same fears and confusion, so this humanizes it a little bit. Fellows are also who the residents are speaking with when placing consults, so getting input directly from the source is helpful.*" The involvement of subspecialists in this capacity enhances communication across teams and fosters a culture of respect and understanding, with a shared goal of providing high-quality, evidence-based, patient-centered care.

Third, the structure of the session—part didactic, part simulation—encourages durable skill development. Dr. Heather Gosnell, a senior resident who attended the workshop during all three years of her residency train-

MEDICAL EDUCATION (continued from page 13)

ing, noted that "*this workshop equips residents with the language, structure, and confidence to navigate these conversations skillfully beginning in early residency training.*" The residents collectively refine their communication in practice with consultants while simultaneously gaining experience in giving and receiving feedback in a safe learning environment, thereby adding a second layer of skill development.

Conclusion

By making these implicit skills explicit and engaging learners at multiple levels of training, our fellow-led consult communication workshop fills an essential gap in residency education. This model utilizes near-peers to develop communication skills among internal residents—skills that they will use daily—and offers a sustainable and scalable approach for other programs seeking to build foundational consultation skills early into graduate medical education. This model offers a valuable framework that can be tailored and adopted by SGIM members and other training programs to strengthen consult communication skills among internal medicine residents.

References

1. Lee T, Pappius EM, Goldman L. Impact of inter-physician communication on the effectiveness of medical consultations. *Am J Med*. 1983 Jan;74(1):106-12. doi:10.1016/0002-9343(83)91126-9.
2. Podolsky A, Stern DT, Peccoralo L. The courteous consult: A CONSULT card and training to improve resident consults. *J Grad Med Educ*. 2015 Mar;7(1):113-7. doi:10.4300/JGME-D-14-00207.1.
3. Riddell N, King S. Near-peer teaching in medical education. *Med Teach*. 2016;38(3):317-8. doi:10.3109/0142159X.2015.1083964. Epub 2015 Oct 20.

SGIM

IMPROVING CARE

PRIMARY CARE FOR PEOPLE WITH HIV: WHY GENERAL INTERNISTS ARE KEY TO ENDING THE HIV EPIDEMIC

Jeremy W. Snyder, MD, FAAP, FACP, AAHIVS; Rebecca Glassman, MD, AAHIVS; Louise King, MD, AAHIVS; Chris Terndrup, MD, FACP; De-Vaughn Williams, MD

Dr. Snyder (jwsnyder@salud.unm.edu) is an associate professor of Internal Medicine and Pediatrics at the University of New Mexico. Dr. Glassman (rebecca.glassman@wmchealth.org) is the medical director of the Westchester Medical Center in Hawthorne, NY. Dr. King (louise_king@med.unc.edu) is an associate professor of Internal Medicine at the University of North Carolina. Dr. Terndrup (chris.terndrup@vumc.org) is an associate professor of Medicine at Vanderbilt University Medical Center. Dr. Williams (de-vaughn_williams@med.unc.edu) is an assistant professor of Medicine at the University of North Carolina.

At the height of the human immunodeficiency virus (HIV) epidemic, more than 108,000 people were diagnosed with HIV yearly in the United States. In 2022, that number dropped to nearly 38,000 new diagnoses.[1] While substantially lower than the early days of the epidemic, the United States remains far from the Center for Disease Control and Prevention (CDC) "Ending the HIV Epidemic" goals of 9,000 new infections yearly by 2025.[1] To reach this goal, and to effectively care for the millions living with HIV across the country, general internists are needed now more than ever to provide care for this special population. This article highlights recent advances in HIV treatment, unique challenges to care access, and helpful resources available to engage and encourage more internists to provide HIV care.

The medical advances since the early days of the HIV epidemic are myriad. Now, single-tablet antiretroviral therapy (ART) regimens have replaced complicated, multi-pill regimens that were rife with side effects. Newer, more effective medications have also led to the simplification of treatment guidance, including long-acting injectables. Now, all patients, regardless of CD4 count or HIV stage, are recommended to start and remain on ART. Most patients are eligible for these sim-

IMPROVING CARE *(continued from page 14)*

pler ART regimens that increase medication adherence and patient satisfaction while quickly suppressing HIV viral replication.

More evidence has also elucidated the importance of "treatment as prevention" among people with HIV (PWH). These studies have shown PWH who maintain an undetectable viral load and remain adherent to medications are unable to transmit the virus to their sexual partners.[2] This breakthrough, known as "undetectable=untransmittable," or "U=U," has revolutionarily changed the discussion surrounding HIV risk and medication use, serving to help decrease stigma, promote medication adherence, and encourage regular laboratory follow-up for patients.

Highly effective ART has also helped PWH to live longer lives. As HIV mortality has plummeted since its zenith in the early 1990s, HIV prevalence has increased insubstantially. There are now nearly two million PWH in the United States, 54% of whom are 50 years or older.[1,3] At the same time, Infectious Disease specialists who originally provided most of the care to PWH have decreased in number in recent years. Many of these seasoned practitioners are retiring or leaving the workforce while numbers of new fellowship applicants continue to decrease.[4]

While life expectancy for PWH has improved, it remains 7-9 years lower than that of the general population.[5] In addition, aging PWH are more likely to develop other chronic medical conditions, such as diabetes mellitus, hypertension, lung and liver disease, and certain kinds of cancers.[3] These chronic, noncommunicable diseases often occur earlier, up to 16 years earlier among PWH than the general population.[5] Rather than opportunistic infections, these noncommunicable diseases are the ones this population, and its healthcare practitioners, are now addressing. As specialists in these chronic diseases now affecting PWH, general internists are well positioned to lead the way in the care for PWH. Primary care providers can consolidate care for most PWH, decreasing appointment burden for patients, alleviating health system stress, and improving treatment adherence.

The simplification of ART has also lowered the entry point for internists who are less familiar or comfortable with older regimens. Education around and familiarity with HIV pre-exposure prophylaxis (PrEP), which includes components of ART used for HIV treatment, have increased in recent years. With the expansion of HIV PrEP recommendations from various professional societies, general internists are now well-suited to provide "status neutral" care for all patients.

Status neutral is a term that refers to HIV care and service delivery that is comprehensive, evidence-based, and person-focused, regardless of the HIV test result. Under this service delivery model, all patients are recommended to be screened for HIV. If screening tests are negative, patient-practitioner discussions center on risk reduction, including barrier protection, regular sexually transmitted infection screening, and, if applicable, HIV PrEP. If screening tests are positive, patient-practitioner discussions focus on starting ART, getting to "undetectable," and working toward overall health.

By developing relationships with and providing care to patients focused on the need of the moment, regardless of HIV-status, general internists can provide the care needed to stem the tide of new infections. By providing PrEP to people at risk of HIV acquisition and HIV suppressive ART to PWH, internists can significantly diminish new infection rates. This status neutral approach also allows patients to stay with practitioners that they know and trust, rather than seeking care from outside specialists that may be more difficult to access.

Internists are also recognizing the benefit of providing care to this special population. While some internal medicine trainees are now opting for HIV medicine care folded into their existing curriculum, internists already in practice who covet more HIV-specific knowledge also have access to many valuable and easily accessible resources. The National HIV Curriculum, created by the University of Washington and funded by the Health Resources and Services Administration (HRSA), provides multiple self-paced modules on topics including routine HIV screening, lab interpretation, opportunistic infection prophylaxis and treatment, and antiretroviral medication management. The American Academy of HIV Medicine provides a community forum for novice and experienced practitioners to share tips, engage in questions, and support the practice of HIV care. They also offer a specialist in HIV certification program. The National Clinician Consultation Center, a member of the HRSA AIDS Education and Training Center (AETC), provides consultative resources for practitioners with questions regarding HIV prevention and treatment. Regional AETCs also provide opportunities for training, conferences, and resources tailored to specific communities.

The 2025 SGIM Annual Meeting featured a workshop on HIV Medicine for General Internists that drew a large crowd of interested participants committed to learning the latest evidence-based practice in HIV primary care. The SGIM HIV/AIDS Interest Group attracts internists and learners from across the country in diverse practice settings and presents ongoing education and advocacy opportunities for members.

In this time of political and financial uncertainty, many resources for the prevention and treatment of HIV remain tenuous. The healthcare status gap between people with and without HIV has narrowed over the years, but it still exists and may be in danger of widening again. For this reason, now is the time for more partnership and

IMPROVING CARE *(continued from page 15)*

advocacy on behalf of patients. SGIM members who are considering more involvement in HIV care are encouraged to jump in, embracing their expertise in complex care and voice in patient advocacy.

References

1. HIV surveillance report: Diagnoses, deaths, and prevalence of HIV in the United States and 6 territories and freely associated states, 2022. *CDC Stacks*. https://stacks.cdc.gov/view/cdc/156509. Published May 21, 2024. Accessed October 15, 2025.
2. Rodger AJ, Cambiano V, Bruun T, et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): Final results of a multicentre, prospective, observational study. *Lancet*. 2019;393(10189):2428-2438. doi:10.1016/S0140-6736(19)30418-0.
3. Yang HY, Beymer MR, Suen S. Chronic disease onset among people living with HIV and AIDS in a large private insurance claims dataset. *Sci Rep*. 2019;9(1):18514. doi:10.1038/s41598-019-54969-3.
4. Nolan NS, Promer K, Tang M, et al. Training the next generation of the Human Immunodeficiency Virus workforce: Needs, challenges, and opportunities. *Infect Dis Clin North Am*. 2024;38(3):627-639. doi:10.1016/j.idc.2024.06.004.
5. Collins LF, Armstrong WS. What it means to age with HIV infection: Years gained are not comorbidity free. *JAMA Network Open*. 2020;3(6):e208023. doi:10.1001/jamanetworkopen.2020.8023.

SGIM

PERSPECTIVE: ARTICLE II

A REFLECTIVE FRAMEWORK FOR TRAINEES CONSIDERING DUAL DEGREES

Ruth Bishop, MD, MBA

Dr. Bishop (bishopru@musc.edu) is a fourth-year resident in the combined Internal Medicine and Psychiatry program at the Medical University of South Carolina in Charleston, SC.

Trainees in medicine increasingly encounter opportunities to pursue additional graduate-level degrees—such as a Master of Public Health (MPH), Master of Business Administration (MBA), Master of Public Policy (MPP), or Juris Doctor (JD)—during medical school or postgraduate training. According to data from the Association of American Medical Colleges (AAMC), approximately 9% of medical students pursue dual degrees.[1,2] That number is expected to rise, particularly among MD/MPH and MD/MBA programs, which continue to see increased enrollment.[3,4]

Despite this growing trend, many trainees face uncertainty as they consider pursuing an additional degree. Reflecting on my own path, I realized I would have benefitted from a clear framework to guide my decision. This article offers a structured approach based on personal experience using reflective questions. This framework will help trainees make their personal decisions regarding dual degrees while assisting SGIM members to better advise trainees during this process.

Question 1: What Is Your Personal Mission and Vision? Does This Additional Degree Align with It?

Before pursuing any additional degrees, the first question to ask is: Why? What is your long-term mission, and what kind of impact do you hope to make? Whether your goals involve clinical care, health policy, research, medical education, or leadership, being grounded with a clear vision helps ensure that every academic and professional decision moves you closer to that goal. Without this clarity, it is easy to be pulled in multiple directions or to pursue degrees that look impressive, but do not support your unique professional path.

When I completed college, I was offered a full scholarship to pursue an MBA. I intended to apply to medical

PERSPECTIVE: ARTICLE II *(continued from page 16)*

school but lacked clarity on what specialty I would pursue or the practice setting I would work in. At that time, I had a strong commitment to underserved communities and felt called to a career rooted in health equity. When the MBA opportunity arose, I thought, *"A little business knowledge couldn't hurt."*

Looking back, I now see that I skipped a vital step: clearly defining my mission and vision. I didn't fully consider what positions I wanted in the future—whether in academia, community practice, or health system leadership—and whether an MBA would give me the skills to succeed. I also didn't evaluate whether the potential benefits of the degree—expanded career options, intellectual fulfillment, or increased earnings—were worth the time, energy, and opportunity cost the degree required. Starting with your purpose helps ensure any additional training is not simply an impressive credential, but rather, a meaningful investment.

> **"While the decision to pursue a dual degree can feel overwhelming, a clear and reflective framework can transform ambiguity into direction. Asking three key questions—Does this align with my mission? Is this the right time and place? Do I have the right mentors?—can help trainees avoid decisions driven solely by prestige, fear of missing out, or vague aspirations."**

Question 2: Is This the Right Time and Place?

Once you have determined that a degree aligns with your goals, the next question is about timing and place. *When* and *where* should you pursue it? Dual degrees can be pursued at several points along the medical education pathway: before medical school, during medical school, between medical school and residency, or after residency. Each interval offers trade-offs related to cost, flexibility, clinical exposure, and clarity of purpose. Some degrees may help narrow career or specialty direction early on while others may be more impactful after you've gained more real-word clinical experience.

Equally important is choosing the right program at the right institution. Do the courses, mentorship, research opportunities, and alumni network align with your goals? Can you access healthcare-specific opportunities (e.g., health policy research, innovation fellowships, or partnerships with academic health centers)? Look at recent graduates and where they work—are they doing the type of work that you would also enjoy? If not, consider why and whether there are still opportunities to pursue the work that you desire.

If I had to do it again, I might have delayed my MBA until I had a better understanding of my career path. My MBA program, while excellent, lacked healthcare-specific research, mentorship, and alumni. I also did not have access to physician role models who had previously completed the program. Looking back, I believe that having more clinical experience would have helped me make more intentional choices—such as seeking out programs with stronger healthcare integration or deferring the degree until I had better defined my career vision. This doesn't mean my MBA wasn't valuable—but with greater foresight, I could have maximized its relevance and return on investment for my future.

Question 3: Who Are Your Mentors and Are They Right for You?

Strong mentorship is the cornerstone for making informed career decisions within medicine.[5] This is especially true when considering additional degrees. In college, I leaned on undergraduate and graduate school professors I admired, assuming their guidance would be sufficient. However, they weren't physicians who would be familiar with the intersection of medical training and business. As a result, they couldn't fully assess the relevance of the MBA to my long-term career aspirations. My mentors, while well-intentioned, were "not the right kind of mentors."

Physician mentors—especially those whose careers mirror the ones you envision—can provide critical insights as you explore alternative paths, evaluate the real-world utility of degrees and the ideal time to pursue them, and reflect on whether the degree would provide you with the skillsets needed for your ideal career. In some cases, they may help you realize that another degree isn't necessary at all. For SGIM members mentoring trainees, this is an opportunity to ask not only *"What are you interested in?"* but also *"What impact do you want to make"* and *"What's the most efficient and fulfilling way to get there?"*

Conclusion: A Framework for SGIM Mentors and Trainees

While the decision to pursue a dual degree can feel overwhelming, a clear and reflective framework can transform ambiguity into direction. Asking three key questions—*Does this degree align with my mission? Is this the right time and place? Do I have the right mentors?*—can help trainees avoid decisions driven solely by prestige, fear of missing out, or vague aspirations.

For SGIM members—many of whom serve as mentors, educators, and leaders—this framework offers more than personal reflection. It provides a structured

PERSPECTIVE: ARTICLE II *(continued from page 17)*

approach to coaching the next generation of internists, helping them think critically about how additional degrees may (or may not) serve their goals in academic medicine, policy, research, or community leadership. By supporting intentional, mission-aligned decisions, SGIM members can help trainees build professions marked by purpose, not just credentials. In a field increasingly shaped by complexity, interdisciplinary collaboration, and systems-level challenges, this kind of clarity is more valuable than ever.

References

1. AAMC. 2024 FACTS: Enrollment, graduates, and MD-PhD data. *AAMC*. https://www.aamc.org/data-reports/students-residents/data/facts-enrollment-graduates-and-md-phd. Accessed October 15, 2025.
2. AAMC. More medical students want more than an MD. *AAMC*. https://www.aamc.org/news/more-medical-students-want-more-md. Accessed October 15, 2025.
3. Larson DB, Chandler M, Forman HP. MD/MBA programs in the United States: Evidence of a change in health care leadership. *Acad Med*. 2003;78(3):335-341. doi:10.1097/00001888-200303000-00021.
4. Reilly JM, Plepys CM, Cousineau MR. Dual MD–MPH degree students in the United States: Moving the medical workforce toward population health. *Public Health Rep*. 2021;136(5):640-647. doi:10.1177/0033354920978422.
5. Choi AMK, Moon JE, Steinecke A, et al. Developing a culture of mentorship to strengthen academic medical centers. *Acad Med*. 2019;94(5):630-633. doi:10.1097/ACM.0000000000002498.

SGIM