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SGIM FORUM

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MEDICAL EDUCATION

THE 2025 SGIM BITE-SIZE TEACHING SYMPOSIUM: ELEVATING CLINICIAN EDUCATORS AND EVIDENCE-BASED TEACHING

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Introduction

In a room full of SGIM Annual Meeting attendees, six SGIM regional educators brought their teaching skills to the big stage. The SGIM Education Committee's national teaching competition recognizes teaching excellence in trainees and junior faculty as they share educational topics and showcase evidence-based pedagogical techniques.[1] The 2025 SGIM Annual Meeting Bite-Size Teaching (BST) symposium was the first time SGIM's six regional competition winners assembled to demonstrate their teaching live at the Annual Meeting (see table). During this symposium, Education Committee members provided commentary on three specific teaching strategies that these six educators used: active audience engagement, deliberately crafted visual aids, and mnemonics for rapid knowledge retrieval. In this article, we summarize these three strategies for SGIM members to incorporate into their educator playbook to spark creativity in learning and knowledge retention.

Audience Engagement

Audience engagement during educational presentations is grounded in adult learning theory, which emphasizes that active participation optimizes outcomes for mature, self-directed learners. Constructivist and cognitive perspectives further support this approach.[2]

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2024-25 Regional SGIM Bite-Size Teaching Competition Winners

Participant & Institution	SGIM Region	Presentation	Teaching Technique Highlighted
John "Clinton" Olivas, MD (PGY3, University) of Washington	Northwest	Triaging the acutely agitated hospitalized patient	Audience Engagement
Kristina Collins, MBBS (PGY3, University of Texas Southwestern)	Southern	PFTs for the general internist	Audience Engagement
Harith Ghnaima, MD (PGY3, University of Michigan Health—Sparrow)	Midwest	Point-of-care ultrasound for pericardial effusion/tamponade	Visual Aids
Setze Bush, MD Candidate (Tufts School of Medicine)	Northeast	How providers can advocate for older adults with hearing loss	Visual Aids
George Tran, MD (Hospitalist, West LA Veterans Affairs Medical Center)	Southwest	Facilitating effective code status discussions	Mnemonics
Zamina Mithani, MD, MBE (PGY1, Lenox Hill)	Mid-Atlantic	Informed refusal—the NOPE approach	Mnemonics

Dr. Olivas used a simple but effective "thumbs up/down/to the side" polling method during his session on assessing and responding to patients at risk of aggression. His method required participants to commit to management decisions in real time. This technique reflects constructivist learning theory, in which learners integrate new information with prior knowledge through active engagement.[2] Real-time polling offered immediate feedback to both instructor and audience, allowing Dr. Olivas to tailor his teaching to learners' understanding.

In her presentation on pulmonary function tests (PFTs), Dr. Collins engaged the audience in shared breathing exercises to demonstrate lung volumes and prompted them to repeat key phrases aloud. These activities align with cognitive learning theory by supporting the construction of mental schemas through multimodal inputs—kinesthetic, visual, and verbal—and reinforcing them through repetition and active processing.[2,3] Per Dr. Collins, "Reflection questions were used to maintain audience attention and reduce cognitive load by actively linking prior knowledge to new pulmonary function test concepts."

Together, these practices demonstrate how interactive learning environments foster comprehension and knowledge organization and allow educators to adapt teaching content in real time. As a final pearl, Dr. Olivas advises that, "Effective audience engagement requires intentional learning goals, creative methods, and mindful use of time and effort."

Visual Aids

Classroom teaching often relies on slides or whiteboards that are frequently used in ways misaligned with effective learning principles. Given the ubiquity of visual aids in medical education, it is essential to understand how they best support learning.

Mayer's cognitive theory of multimedia learning states that humans process information through separate visual and auditory channels, each with limited working memory capacity.[4] When visuals complement narration, learners integrate information more efficiently, enhancing knowledge retention.[4] Cognitive load theory expands on this by distinguishing intrinsic load (content complexity), extraneous load (distractions), and germane load (mental effort for learning). Effective visual aids minimize extraneous load (e.g., excess animations, dense text) while structuring and simplifying complex content to manage intrinsic and germane load. Examples include comparison tables, flow charts, and stepwise diagram reveals.[4]

Dr. Ghnaima's cardiac point-of-care ultrasound presentation exemplified these principles. His slides used videos of real echocardiogram findings directly alongside labeled anatomic drawings. The juxtaposed images reduced intrinsic and germane load. Audience members could use familiar anatomy diagrams to orient themselves to previously unfamiliar echocardiogram windows and findings. When describing his slide design, Dr. Ghnaima explains, "I selected visual imagery as an introductory tool, as evidence suggests that [it] plays a pivotal role in the processing and retention of radiology-related information."

Student Doctor Bush effectively combined visual aids with active engagement. Her presentation included an artificial intelligence-generated image of a patient with hearing impairment inside a hospital room full of distractions. She asked the audience to "search and find"

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items in the image that they would adjust to improve the patient's hospital experience. Per Presenter Bush, "I figured utilizing a playful, familiar activity for summarizing teaching points would help keep the audience engaged."

Well-designed visual aids are not only decorative but also shape comprehension and memory. Both presenters demonstrated that thoughtful visual design reduces cognitive barriers, supports comprehension, and creates memorable, effective learning experiences.

Mnemonics

Used frequently in medical education, mnemonic devices are mental tools generally used to reduce germane load. Mnemonics help learners organize large volumes of material in memory, where it is primed for ready recall. Mnemonics can take many forms, including acronyms, acrostics, songs, rhymes, maps, visualization, and storytelling. Despite the diversity of form, mnemonics have a common structure that serves "as handy mental pockets for filing what (we've) learned and linking the main ideas in each pocket to vivid memory cues so that (we) can readily bring them to mind and retrieve the associated concepts and details, in depth, at the unexpected moments that the need arises."[5]

> **"It was an incredible opportunity to learn firsthand from so many talented educators, and I am taking away many new strategies and skills that I plan to use to enhance my own teaching."**

Two regional winners effectively used the acronym style of mnemonics to crystallize learning opportunities. Dr. Tran created the "CLEAR" (Curiosity, Language, Empathy, Assurance, Recommendation) Communication mnemonic. CLEAR is a flexible framework that supports a clinician through important communication principles to guide complex code status conversations. Similarly, Dr. Mithani created the "NOPE" (Never assume, Options, Perceive, Educate) approach for patients declining recommended care plans. Per Dr. Mithani, she hoped her "NOPE" mnemonic would "teach a communication concept in a way that can be remembered, applied, and even written into a note to document why a patient might decline a certain intervention." Both the CLEAR and NOPE mnemonics were particularly effective in that they were short, avoided repeating letters, and spelled out words directly related to the teaching topics.

The myriad ways and content areas where mnemonics can be used in medical education make them a familiar and ideal strategy for medical educators and trainees alike.

Conclusion

The 2025 National SGIM BST Symposium highlighted several high-yield teaching techniques in action. Engaging the room, utilizing visual scaffolds, and compressing ideas into mnemonics requires intention and rehearsal to perform effectively. National spotlights, such as the BST Symposium, galvanize promising junior educators to action, providing them well-deserved recognition while also sharing valuable knowledge to SGIM members. By continuing to showcase "the how," SGIM raises the floor for everyday teaching and widens the circle of educators who shine. One symposium presenter, Dr. Tran, put it best: "It was an incredible opportunity to learn firsthand from so many talented educators, and I am taking away many new strategies and skills that I plan to use to enhance my own teaching."

Catch the action as SGIM highlights new teaching strategies and the 2025-26 regional BST winners at the upcoming Bite Size Teaching Symposium during SGIM's May 2026 Annual Meeting (#SGIM26)!

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SGIM

ADDRESSING HEALTHCARE CONCERNS IN 2026: MOVING PAST THE ATTACKS OF 2025

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

What is the definition of insanity?
"Insanity is doing the same thing over and over again and expecting different results."[1]

As 2025 ends and we move towards a bright new year, SGIM members should reflect on the state of medicine in the United States—it is at a crossroads. Health care in the United States is a rudderless ship drifting without guidance on a sea of uncertainty. There are forces that are plundering the system for their benefit and agenda. Do nothing and we will surely sink. Do something and we can bail enough water to stay afloat for another few years. Do everything possible and there is time to fill the holes and right the listing ship of medicine. Or do we scuttle the antiquated ship called *USS Medicine* and build a new modern ship to sail today's treacherous seas? In this article, I reflect on our recent journey and our future destination.

The healthcare system has been a centerpiece of countless political discussions in 2025. Where does the system stand as we enter 2026?

1. "Poor systems design has led to errors, poor quality of care, and dissatisfaction among patients and health professionals.
2. The needs of the chronically ill are not being adequately met. Addressing those needs requires the reform of systems of care and greater coordination and collaboration among health professionals, as well as more attention to prevention and the behavioral determinants of health.
3. Technological advances in information technology and an expanded evidence base gained from research on clinical practice have the potential to transform health care, but such advances have not been adequately harnessed.
4. Patients and consumers are now increasingly informed about their health. As a result, there is a need for a new relationship of shared decision making between patients and healthcare providers. Providers also need to be more attentive to patient values, preferences, and cultural backgrounds.
5. Workforce issues related to shortages and effective deployment of existing professionals need to be addressed before quality of care is further compromised.
6. Healthcare employers and recent graduates cite gaps between the way health professionals are prepared and what they are called upon to do in practice, gaps that are attributable to many factors, including a lack of funding to revamp curricula and a limited focus on teaching in academic health centers."[2]

"SGIM members are many of the brightest leaders in health care. We need to carry the mantle of healthcare reform. As general internists, who is in a better position than SGIM members to diagnose and treat the system as a whole? We do it with our patients daily."

These issues are but a subset of the problems that are well known to physicians practicing in 2025.

Would it surprise you to learn that these six issues were summarized by Greiner and Kneble from the 2003 Institute of Medicine (U.S.) Committee on the Health Professions Education Summit?[2] Would it also surprise you that as I write this article in October 2025, the National Institute of Health website (where this reference is found) features a banner proclaiming "Because of a lapse in government funding, the information on this website may not be up to date, transactions submitted via the website may not be processed, and the agency may not be able to respond to inquiries until appropriations are enacted."[2] The irony cannot go unnoticed.

Medicine remains mired in the quicksand of mediocracy—both internal and external forces prevent medicine from advancing past the problems SGIM members experience today. Yet, these six items were identified at a medical education summit—medical education is the first step in educating and empowering tomorrow's healthcare leaders. Many of today's leaders would have been impacted by changes enacted in 2003.

FROM THE EDITOR (continued from page 4)

In the past 22 years, how has Medicine addressed these six issues? Our healthcare system remains broken. The United States has one of the highest healthcare expenditures per capita with worse healthcare outcomes than other developed nations. We would be hard pressed to find many patients and providers who are satisfied with the current healthcare system. The needs of the chronically ill remain unmet. The behavioral and social determinants of health have been identified in part but rarely addressed in ways that would affect real change in health outcomes. Technological advances and research have expanded the evidence base, but many of these advances are being undone if they do not meet the agenda of the day (e.g., vaccines). With the advancement of artificial intelligence (AI) based on large language models learning from existing and added data sets, what future will AI hold if the data it learns from is wrong or compromised?

Patients have become more informed about their health care (sometimes in ways that endanger their health aka Dr. Google). Physicians have made greater efforts to incorporate shared decision making in healthcare decisions as we learn what is most important to our patients. But have we done enough? If we do not recruit a diverse workforce, where are the physicians to provide race and culture concordant health care. Workplace shortages continue to exist and are worsening. There are some who tout increased applicants to medical schools; but applicant decisions including their eventual practice location and choice of specialty are often driven by medical school debt. The role of advanced practice professionals remains ill-defined in the greater structure of increasing medical knowledge requirements and treatment options within shortened educational timelines. Gaps remain in education versus actual clinical practice while technologic advances like AI will slowly be incorporated into medical education. Medical education remains hampered by a lack of funding even as advancements in adult learning methods improve the quality of education.

Over the past year, we have seen a plan unfold that attacks the underbelly of our healthcare system. But the reality is that the system was limping along over the past 22+ years while under attack by other entities.

How can SGIM members set our course for Medicine in 2026 and beyond? A new year brings new opportunities and new hopes. We make resolutions to improve. How do we assemble our crew to staff our ship of reform or even design a new ship? Recent SGIM Forum articles highlight opportunities that can be undertaken by SGIM and its members.[3, 4]

My editorial does not offer an easy answer to transform today's healthcare system into the optimized healthcare system of tomorrow. Our future system *must* meet the needs of patients, physicians, and trainees. But we must do something different. SGIM members are the brightest leaders in health care. We need to carry the mantle of healthcare reform. As general internists, who is in a better position than SGIM members to diagnose and treat the diseased healthcare system? We do it with our patients daily. Should we allow specialists, policy makers, and insurance companies decide how we practice medicine? Do we allow those who wish to remove evidence-based treatment options design the system in which we work and deliver care?

How can SGIM members make a difference in 2026?

1. Advocate for what we know is just and right.
2. Protect and speak for those who have no seat at the table.
3. Generate and protect the science and data of medicine that is being revised and removed.
4. Educate the doctors of tomorrow to be on the right side of justice.
5. Design systems that provide care for those in need.

These are just a handful of resolutions we can make to get 2026 off to a great start.

Noted author and motivational speaker Denis Waitley states "There are two primary choices in life: to accept conditions as they exist or accept the responsibility for changing them."[5] SGIM members must be on the side of change to make a difference in 2026!

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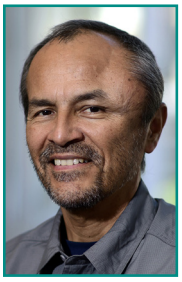
SGIM

PROFESSIONAL HOME, FAMILY BONDS: CELEBRATING SGIM'S MEDICAL FAMILIES

Carlos Estrada, MD, MS, FACP
President, SGIM

"This society has been my professional home—I have been exposed to many different career paths within internal medicine, and I loved being part of such a diverse and mission-driven academic community. A fun fact is that my dad and I presented a poster together at SGIM, which we later published as a case report—my sister is also a co-author!"



I am the first in my family to become a doctor (as is my wife, whom I met in medical school). Since my father was in the military, I initially wanted to join the Air Force or Navy like many of my classmates at a school for military families. After being hospitalized with acute hepatitis A and later with a broken arm requiring surgery, I was interested instead in pursuing a career in surgery. As a foreign medical graduate, securing a surgical position was impossible at that time. During medical school, exceptional mentors helped me discover other fulfilling careers in medicine; inspired by my mentors trained abroad, I applied to United States residency programs. I secured an internal medicine position at Henry Ford Hospital in Detroit, Michigan, where a Chief Medical Resident introduced me to General Internal Medicine (GIM). This led me to pursue a GIM fellowship with a focus on research and medical education. My fellowship director, the late Mark Young, MD, invited me to the SGIM Midwest regional meeting—I was hooked.

In addition to my entire family supporting me going to medical school, I found a supportive environment during residency and fellowship—both professional and personal. At one point, there were more than two dozen Peruvian medical families living in the Detroit area. Similarly, at SGIM, I noticed families with a shared interest in academic medicine. This article celebrates the family connections that enrich SGIM. Their experiences illuminate the role that family and professional community play in shaping careers in academic general internal medicine. Here are their stories.

Danielle Fine, MD, MSc; Michael J. Fine, MD, MSc (Daughter, Father)

DF: I am a third-generation general internist. Some of my earliest memories are of Sunday night dinners listening to my dad and grandfather work through challenging diagnostic cases. Though my mother and grandmother often shook their heads at their endless conversations, their deep love of medicine—and the way they were able to balance it with making family a priority—made the choice to follow in their footsteps a natural one.

When I attended my first SGIM meeting 10 years ago, it felt like an extension of those dinner table conversations: a community that shared the same curiosity, passion, and values I grew up around. SGIM has become my academic home, offering mentorship, inspiration, and a professional community. Most meaningfully, it has allowed me to share general medicine with my dad as a colleague, strengthening a bond that has always been so important to my life.

Aditya K. Ghosh, MD; Karthik Ghosh, MD; Amit Ghosh, MD, MBA (Son, Parents)

AKG: My journey to medicine started early, shaped by dinner table conversations and long drives that turned into mini medical seminars with my internist parents. By college, I noticed many premedical students lacked a deeper understanding of medicine as a field. This sparked *The Medical Decoder*—a publication I launched with friends to bridge the gap between interest and insight, demystifying medicine for aspiring physicians.

One constant thread has been the Society of General Internal Medicine. My earliest SGIM memory dates to Chicago in 2004—I was just a kid, but I sensed my parents' excitement connecting with colleagues nationwide. Over the years, SGIM helped me see general internal medicine beyond my parents' lens, as a vast community of enthusiastic clinicians, educators, and researchers, shaping my career in ways I'm still discovering.

While medicine is serious and we stay locked in throughout the week, my family keeps things light with movie night—watching beloved films repeatedly, adding fresh "Director's Commentary" each time. It's our quirky way to connect and laugh.

From decoding medicine to decoding movie plots, my journey has been one of curiosity, connection, and community. I wouldn't have it any other way.

PRESIDENT'S COLUMN (continued from page 6)

Kaleb Keyserling, MD; Thomas Keyserling, MD; Alice Ammerman, DrPH (Son, Parents)

KK: I have SGIM in my blood. My dad attended his first SGIM meeting the year I was born. Growing up with a general internist as a father, I saw first-hand the joys and challenges of medicine—celebrating holidays without him or waiting for him to come home late but also hearing how appreciative his patients were. After a foray into plant ecology, my inkling for applying science to help people drew me to medicine. I went to medical school at the University of North Carolina (UNC) and journeyed to Oregon Health & Science University (OHSU) for residency, where I fell in love with primary care.

As junior faculty at OHSU, I've become involved in SGIM, presenting at regional and national meetings, co-chairing the Northwest (NW) regional meeting, and now serving as NW president-elect. In 2024, 20+ years since his last SGIM meeting, I convinced my dad to join me in Boston to celebrate my section chief's (Martha Gerrity) presidency. It was incredible catching up with him about medicine and life. The following year he joined me again in Florida along with my mom, a nutrition professor, who coauthored a plenary session abstract.

I'm hopeful to continue making SGIM a family affair—what could be better than shaping the future of general medicine while collaborating with your parents!

Karthik Rohatgi, MD; Anuradha Paranjape, MD (Nephew, Aunt)

KR: I knew that I wanted to focus my career on health equity and public health. Over time, I realized I loved individual patient interactions as well. My aunt, Dr. Anuradha Paranjape, was a huge inspiration and helped me realize that I didn't necessarily have to choose between the two. She had done a GIM fellowship at Boston University. As a general internist, I saw that I could work towards health equity on multiple levels.

During residency, I attended the SGIM Annual Meeting in Boston and immediately realized this was my professional home. I met various researchers and health systems leaders working on interventions, the care of patients with complex needs, and other topics I care deeply about. I also received invaluable advice as I considered my options for fellowship. The people I met there played a key role in helping me decide to apply to the National Clinician Scholars Program, where I am now a first-year fellow. Most of our family have pursued careers in science, including public health, engineering, physics, and statistics.

Mark Schwartz, MD; Adina Kalet, MD, MPH (Husband, Wife)

MS: We met on July 1, 1984, as the intern team on 16 East of Bellevue Hospital in New York City (NYC). We were half of the first four residents in Mack Lipkin's new Primary Care Internal Medicine Residency Program.

As residency partners and fast friends, we saw the best and worst of each other, trading nights on call during that summer of the early acquired immunodeficiency syndrome (AIDS) epidemic. Adina (UNC) and

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

Mark (Duke) trained in North Carolina before becoming the first academic general internists as New York University (NYU) faculty at Gouverneur Hospital. We established Gouverneur, a community clinic in NYC's Chinatown, as a site for student and resident primary care training and research.

We built personal and professional families at NYU and at SGIM and have remained long-term SGIM members, mentors, and leaders. After 38 years, two wonderful kids, and many trainees, mentees, and colleagues, we still love SGIM as our national, professional home where we nourish our academic souls.

Rebecca Tsevat, MD, MS; Joel Tsevat, MD (Daughter, Father)

RT: My family played a significant role in my path to medicine. I grew up surrounded by physicians, nurses, physical and occupational therapists and have always been inspired by their dedication to their patients and their passion for improving health care. Ever since I attended my first SGIM conference as a medical student with my dad, this society has been my professional home—I have been exposed to many different career paths within internal medicine, and I loved being part of such a diverse and mission-driven academic community. A fun fact is that my dad and I presented a poster together at SGIM, which we later published as a case report—my sister is also a co-author!

Conclusion

SGIM members describe how SGIM has become a "professional home" nurturing both career development and family bonds. These stories reveal how relatives influence career paths and remind us that our society's greatest assets are its people: the mentors, colleagues, and loved ones who share our passion for academic general internal medicine and help shape our journeys. These stories highlight family connections as sources of guidance and inspiration.

I, too, consider SGIM my professional home—a place where I find inspiration and personal fulfillment. Whether seeking collaborators for workshops, external reviewers, letters of recommendation, or even a job, I find SGIM colleagues invaluable. The organization fosters meaningful connections among members. You can build your own family community within SGIM. SGIM

SGIM families (clockwise from top left): Joel and Rebecca Tsevat. Danielle and Michael Fine. Aditya, Karthik, and Amit Ghosh. Thomas Keyserling, Alice Ammerman, and Kaleb Keyserling. Mark Schwartz and Adina Kalet.

Q & A ON USING GIM SUPERPOWERS: KEYNOTE SPEECH AT ACLGIM'S WINTER SUMMIT

Eric B. Bass, MD, MPH; L. Ebony Boulware, MD, MPH

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Boulware (EbonyBoulware@Advocatehealth.org) is the Dean of Wake Forest University School of Medicine and Chief Science Officer and Vice Chief Academic Officer of Advocate Health (and will become the Chief Academic Officer in January 2026).

The theme of ACLGIM's 2025 Winter Summit is "Unlocking Your GIM Superpowers."[1] The Summit is timely because leaders in general internal medicine (GIM) are facing enormous threats to the academic mission while transformative forces are creating new opportunities to improve clinical practice, medical education, and healthcare research. I was delighted to hear that Dr. Ebony Boulware had agreed to give the keynote speech at the Summit and share how she has used her "GIM superpowers" to thrive in her career and leadership positions. By interviewing Ebony for this column, I share her insights with the entire SGIM membership.

EBB: One of the most rewarding aspects of my career is the opportunity to follow the success of the amazingly talented people who were fellows when I was the director of the Johns Hopkins GIM Fellowship Program. I remember being tremendously impressed by your performance as a fellow. Looking back on your training, what would you identify as the key skills and traits that laid the foundation for the "GIM superpowers" you have used throughout your career?
LEB: First, I want to say how grateful I am for the mentorship and training I received while I was a GIM fellow at Hopkins working with you, Eric! That was a truly transformational period in my development that opened me up to the breadth of opportunities available to general internists who want to have an impact in academic medicine, policy, and other arenas. One reason I gravitated to GIM is my interest in engaging with a variety of content areas both within and outside of clinical practice; and my ability to integrate information across disciplines and scenarios. I think all generalists have this basic grounding—an interest in multiple facets of health coupled with a desire to apply and integrate those interests in practice. I believe GIM as a discipline supports these values in a way that honors what I think of as "holistic excellence." Many healthcare professionals go deep in a single area. What distinguishes GIM professionals is that we are excellent at going deep and broad simultaneously which allows us to bridge gaps in ways that others may not. I have found this to be evident in clinical care, research, education, and administrative arenas. I leveraged my own training and practice in GIM in many ways—to deepen my passion for clinical care, develop a vibrant research career, and develop institutional leadership skills. I think it was my curiosity as a generalist that helped me thrive as a leader in progressively influential ways across multiple institutions and settings.

EBB: What do you see as the most important "GIM superpowers" in your current leadership position?
LEB: I think some of the core GIM values I have learned over time are critical to my current leadership roles. These include listening carefully, bringing humanism and empathy into interaction with others, and integrating multiple points of view to achieve desirable outcomes. I believe my generalist mindset has facilitated my ability to see the 'big picture' as it relates to my work as an institutional leader. I also think generalists have translation skills. For instance, we frequently "translate" information from multiple sources for patients and families in ways they can understand and act on. That translation skill helps me a lot when I am working with different groups, particularly as a leader.

EBB: Could you give some examples of how you have used your "GIM superpowers" in the various leadership positions you have held?
LEB: There are so many examples. For instance, as Dean of the Wake Forest University School of Medicine, I lead Chairs and Vice Deans across the School of Medicine in every discipline and administrative area. My ability to understand and translate priorities across all these different arenas– including various medical and scientific disciplines, different teaching and training programs,

FROM THE SOCIETY (continued from page 9)

and even different institutional campuses and university spaces– is greatly facilitated by my generalist disposition and willingness to learn. As the Chief Science Officer and soon-to-be Chief Academic Officer across Advocate Health, I am a strategic leader overseeing all research and academic aspects of a multi-state health system. My ability to translate academic priorities into a large corporate health system is allowing us to create transformational platforms to conduct clinical trials and coordinated training and innovation at a national scale.

EBB: What is the most important advice you wish to give to SGIM members about identifying and nurturing their "GIM superpowers"?
LEB: My advice is to leverage your superpowers to be bold and visionary. See your generalist skillset as an asset that enables you to influence and traverse many initiatives and communities. As a generalist who can see and make sense of the "big picture" in ways that others may not, you are uniquely poised to elevate capabilities of our entire health care ecosystem to improve the health of our patients and communities everywhere.

EBB: Knowing how busy you are in leading a large health system, I greatly appreciate your willingness to share these insights with members attending this year's ACLGIM Summit. The annual Summit is a great venue for GIM leaders to nurture their superpowers!

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SGIM

COMMISSION/COMMITTEE/INTEREST GROUP UPDATE

MEMBERSHIP HAS ITS PRIVILEGES: RENEW YOUR SGIM MEMBERSHIP TODAY!

Amar Kohli, MD, MS; Edward H. Wu, MD, MS

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Echoing the spirit of that familiar advertising line, membership in SGIM undoubtedly carries its privileges, ones that continue to inspire SGIM members to renew their commitment year after year. Members enjoy access to the *Journal of General Internal Medicine (JGIM),* SGIM Forum, and archives of the *ACLGIM Leadership Forum*, as well as the ever-expanding catalog of amazing online courses through *GIMLearn*. They also receive substantial discounts on registration fees for both regional meetings and the Annual Meeting.

Beyond these tangible benefits, SGIM membership offers a wealth of opportunities to engage in committees, commissions, and workgroups—each offering a chance to deepen clinical, educational, research, and policy expertise. *GIMConnect* offers members access to a vibrant community of more than 3,300 academic generalists and trainees, fostering collaboration, networking, and lifelong professional connections. Many members have benefited from SGIM's robust mentoring program, finding guidance that has shaped their careers and, in turn, becoming mentors themselves to the next generation of academic generalists.

SGIM membership also provides outstanding opportunities for career development for members without having to pause clinical responsibilities. Taught by estab-

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lished faculty and fellow SGIM members, there are five year-long programs:

1. **LEAD:** a program to cultivate leadership skills of junior and mid-career faculty.
2. **Teaching Educators Across the Continuum of Healthcare-TEACH:** an education led program to develop junior clinician educators' teaching skills.
3. **Leadership in Health Policy-LEAHP:** a program dedicated to learning about federal health policy and advocacy skills.
4. **Unified Leadership Training for Diversity-UNLTD:** a program designed to equip current and aspiring academic leaders with the essential skills to thrive and drive diversity in academic organizations.
5. **MedEd Scholarship:** a program for enhancing scholarship skills of clinician educators.

There is also a longer program: the Women & Medicine Commission's **Career Advising Program-CAP**, a two-year longitudinal sponsorship program to support junior and mid-career faculty in successfully navigating academic advancement opportunities.

Perhaps the value of SGIM membership is best captured in the words of Dr. Wu, Membership Committee Co-Chair, who often shares with colleagues and prospective members why he has renewed his membership every year since 2003: *"SGIM is my professional home, and it's always been there for me, even in the years when I was not involved in academic medicine. Being an SGIM member has connected me with a diverse group of colleagues who have helped me grow as a generalist. It has provided new leadership opportunities that I had never considered and facilitated and reassured me about changes in my career path. Most of all, it is the community of members whose kinship I value the most—I can reach out to any fellow member for advice, support, and fellowship. No matter where my career takes me, I know I always have a home at SGIM."*

Stay connected to the programs, networking, and opportunities that make SGIM special. Visit the SGIM website to renew your membership today.[1] Remember, membership has its privileges!

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LESSONS IN INTERNAL MEDICINE-EMERGENCY MEDICINE COLLABORATION: BUILDING BRIDGES BEFORE THE HOSPITAL BREAKS

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In this article, I share something I have come to realize about internal medicine. One of our most important skills isn't clinical; it is building genuine partnerships with our emergency medicine colleagues, especially before our system is on the verge of collapse.

"We discussed the weight of uncertainty, the fear of missing something important, and how system pressures can cloud clinical judgment. That conversation didn't solve any systemic problems, but it reminded us that we're human beings trying to do impossible work under impossible circumstances."

It was early morning when my phone buzzed with a call from Dr. T in the emergency department (ED). *"We have six patients waiting for admission, three of them here since yesterday afternoon,"* she said, her voice tight with exhaustion. *"Can you help us figure out what's going on upstairs?"*

My first instinct? Defensiveness. We'd been slammed on the general medicine service—maximum census, two new strokes, and a complex heart failure patient who'd been touch-and-go all evening. Didn't she understand we were drowning too? *"Dr. T, we're doing everything we can,"* I replied, more curtly than I intended. *"Medicine can only move so fast."*

I hung up feeling frustrated, but something about that conversation stuck with me. Over the next few weeks, I started paying closer attention to the tension between departments, especially in the age of ED overcrowding and boarding patients. ED physicians seemed increasingly irritated during patient handoffs. Our medicine residents were grumbling about "inappropriate" admissions. The charge nurses from both sides were barely speaking to each other. We were supposed to be caring for the same patients, but it felt like we were working on different planets.

The Anatomy of a Broken System

The numbers tell part of the story. Patients boarding in the ED, waiting for inpatient beds, have increased dramatically.[1] However, behind every statistic is a human story: Dr. T trying to provide quality emergency care in hallway beds, while I'm upstairs managing a census that feels unsafe and unsustainable. Or is it?

What I didn't understand during that phone call was that Dr. T wasn't calling to blame me or my team. She was calling because she was scared for her patients stuck in limbo, about missing something important in the chaos, and that our communication breakdown was putting patients at risk. I was scared, too, but instead of acknowledging our shared fear, I'd retreated into cross-departmental defensiveness.

The breakthrough came six months later during a particularly brutal weekend. We had three patients boarding in the ED for more than 24 hours. *"I know you're swamped,"* she said. *"What if I helped with some of the admission orders while we wait for beds?"* That simple human gesture, crossing the invisible boundary between emergency and inpatient medicine, changed everything.

Small Changes, Big Impact

What followed was not a dramatic overhaul of hospital policy, but a series of small, human-centered changes that transformed how we worked together. First, we started talking to each other—not just during formal handoffs, but real conversations about what was happening in our respective worlds. I learned that ED physicians feel like they're sending patients into a black box, as they rarely hear how their patients are doing once admitted. Meanwhile, Dr. T discovered that medicine teams struggle with incomplete information during handoffs, especially for complex patients admitted at night.

We implemented "bridge rounds," informal 15-minute check-ins between ED and medicine attendings

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during particularly busy periods. These check-ins were not "official meetings" or "quality improvement initiatives." These bridge rounds were just two physicians talking about shared challenges and brainstorming solutions. Sometimes Dr. T would give me a heads-up about a complicated patient coming upstairs. At other times, I would reach out to clarify a patient's presentation or provide updates on their progress.

The impact was immediate and measurable. Patient satisfaction scores for transitions of care improved over a six-month period. More importantly, the tone of our interactions shifted from adversarial to collaborative. Residents from both departments started eating lunch together. The charge nurses developed their own informal communication system. What had felt like a turf war began to feel like teamwork.[2]

The Human Element

Research on interprofessional collaboration consistently emphasizes the importance of shared mental models and common goals.[3] What the literature often misses is how much this work depends on basic human connections. I remember the afternoon Dr. T came to thank our team for the excellent care we'd provided to her neighbor, who'd been admitted through the ED the previous week. That five-minute conversation did more to build trust than any formal collaboration protocol could have achieved.

We learned to normalize the vulnerability that comes with working in broken systems. During one devastating shift, we lost a young patient to sepsis, and there were questions about whether earlier recognition might have changed the outcome. Dr. T and I debriefed together. We discussed the weight of uncertainty, the fear of missing something important, and how system pressures can cloud clinical judgment. That conversation didn't solve any systemic problems, but it reminded us that we're human beings trying to do impossible work under impossible circumstances.

When Crisis Becomes Connection

The real test of our partnership came during the early days of COVID-19. Suddenly, everything we thought we knew about patient flow, staffing, and resource allocation was obsolete. The ED was overwhelmed with respiratory illness. Medicine units were rapidly converting to COVID care. Communication, always challenging, became critical.

Because Dr. T and I had spent two years building trust and developing informal communication patterns, we were ready. We started having twice-daily calls to discuss capacity, staffing, and clinical concerns. We developed joint protocols for COVID-19 admissions that streamlined handoffs while ensuring nothing fell through the cracks. Most importantly, we supported each other through the emotional toll of caring for critically ill patients while worrying about our own families.

Our partnership became a model for other departments. Surgery started joining our calls. The ICU began participating when ventilator allocation became a daily discussion. What had started as a friendship between two attendings evolved into a hospital-wide approach to crisis management that prioritized communication and mutual support.[4]

Lessons for the Long Game

Looking back, I realize that building effective ED-medicine collaboration isn't about protocols or procedures; it's about remembering that we are caring for the same patients. It requires acknowledging that when hospitals are overwhelmed, everyone feels intense pressure differently. It means choosing curiosity over judgment when things go wrong and choosing connection over competition when resources are scarce.

The most practical advice is surprisingly simple: pick up the phone. Not only when there's a problem but also when something is going well. Call to clarify information, say thank you, or offer help. These small gestures of professional respect and personal connection create the collaborative foundation to withstand inevitable crises.

I also learned that effective collaboration requires organizational support. While Dr. T and I could build a personal working relationship, sustainable change required leadership engagement, dedicated time for communication, and recognition that interprofessional collaboration is legitimate work worthy of institutional investment.[5]

Building Bridges Together

That phone call from Dr. T feels like a lifetime ago, but the lessons from our partnership continue to shape my approach to collaborative care. We are both attending physicians at different hospitals now, but we still text each other occasionally when we read about innovative approaches to patient flow or emergency medicine collaboration. More importantly, we've both tried to recreate those collaborative relationships in our new environments.

The hospital systems we work in will continue to face capacity challenges, staffing shortages, and resource constraints. But I have learned that how we respond to these pressures—whether we retreat into departmental silos or reach across them—determines not only our professional satisfaction but also the quality of care we provide to patients.

Dr. T and colleagues taught me the most important bridge we build is not between departments or services—it is between human beings who share a commitment to caring for people during their most vulnerable moments.

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When the hospital is breaking, that human connection might be the strongest thing holding it together. For SGIM members navigating these same pressures, my advice remains simple: *pick up the phone*. Not just when there's a crisis, but especially when there isn't.

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TECHNOLOGY UPDATE

PROVIDING PRIMARY CARE IN A VIRTUAL CRITICAL ACCESS CLINIC

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Introduction

Preparing for primary care clinical sessions often begins by reviewing a list of scheduled patients for the day. In many clinical roles, this is a straightforward process. The clinician may log into the Electronic Health Record (EHR) and glance at the schedule, noting the reason for each visit and reviewing recent lab results, imaging studies, and clinical notes. In our current clinical roles as telehealth primary care physicians for the Veterans Health Administration (VHA) in the VISN 21 Clinical Resource Hub (CRH) Daily Open Access Resource (DOAR) clinic, preparing for a clinical session is more complicated. Patients are in different cities, states, and time zones throughout a large catchment area that includes Northern and Central California, Nevada, Hawaii, Guam, and Saipan. Depending on where they live, the patients are scheduled in one of seven different healthcare systems-each with their own separate version of the EHR.

The thought of this may seem overwhelming, but these clinical roles quickly evolved into the most interesting and rewarding experiences of our careers. More importantly, we can serve a group of patients who otherwise may not have access to care. In this article, we review the challenges and joys we experience when providing care in this regional telehealth model of care.

Rationale for a Regional Telehealth Model

There is a significant disparity in access to healthcare services in rural communities.[1] Lack of healthcare access causes patients to utilize emergency departments more frequently for primary care concerns[2] and has been associated with poor health outcomes and increased mortality compared with patients who live in urban centers.[1] Telehealth is a potential option to address some of these barriers.[3] Infrastructure investment to make this possible on a large scale is challenging. However, the creation of a virtual clinic that allows us to see patients from different communities and across state lines in the same clinic day has been an effective, sustainable way to address healthcare barriers for rural Veteran patients.

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Overcoming the Challenges

There are many challenges when providing telehealth care to patients from different states, time zones, communities, and cultures. We often know *what* to recommend to our patients after our telemedicine assessment, but it may be less clear about *how* to accomplish our plan given our lack of local resource knowledge. Many patients live in sparsely populated areas with transportation limitations; asking them to travel to a hospital or clinic for in-person care, including labs and x-rays, requires substantial effort and care coordination with local care teams. Given that we work with patients in several different healthcare systems (each with a unique version of the VA's EHR), ordering menus, policies, and consultation requirements to see specialists may be different for each patient we see during a single clinic day. We overcome these challenges by relying on an incredible team of scheduling staff, nurses, and providers in our telemedicine group, (the VISN 21 CRH), who support one another in navigating systems-level questions. The CRH staff also develop close relationships with clinic-based nursing staff and providers to collaborate on the care of our patients. Regularly scheduled in-service meetings with local clinic staff help improve our knowledge of their local resources and provide updates on the evolving needs of the clinics. Finally, we created a centralized resource folder that enables nurses and providers to share knowledge, such as important phone numbers, contacts, laboratory hours, and other key information, about the unique aspects of each healthcare system.

There is an understandable level of discomfort in caring for complex patients via video technology, which limits a clinician's ability to perform a traditional physical exam. We experienced many of these fears when we began these virtual clinical roles, but we acquired skills that improved our evaluation and management of patients via telemedicine. Some of these skills developed with time and experience, and others through intentional faculty development.

Faculty training in virtual exam skills was rushed and haphazard during the COVID-19 pandemic given the urgent need for widespread telehealth implementation.[4] To address this training gap, our group invested in monthly educational conferences to bolster both virtual examination and systems-based practice skills for telemedicine. Additionally, many providers attended formal VA courses that teach telemedicine skills and are grounded in national telehealth competencies.[5] Through intentional practice, we gained greater confidence diagnosing conditions ranging from fluid overload to full-thickness rotator cuff tears based on our virtual assessments alone. Given the ongoing use of telemedicine in United States health care, we believe that virtual physical examination skills should now be formally taught in pre-clinical health professions coursework, alongside traditional physical examination skills.

Finally, we are reminded of a common adage in our clinical practice: 80% of diagnoses can be ascertained with a good medical history. By building a thorough history, performing comprehensive chart reviews, and exercising sound clinical reasoning, we have diagnosed conditions as complex as rheumatoid arthritis and nephrotic syndrome through telephone visits alone. We believe that clinical reasoning curricula and clinical problem-solving cases published in the literature should intentionally include telemedicine cases, and expert discussion of how clinicians might reason through cases evaluated by telemedicine.

Reflecting on the Joys and Successes

There are many challenges working as a telehealth physician in this clinical setting. However, the joy that stems from helping underserved patients navigate a complex system and connect with resources is profound. We supported countless patients with new cancer diagnoses in navigating the workup and referral process, assisted patients who were recently hospitalized to ensure critical medications were ordered and available to them, and helped patients new to the VHA navigate the system and establish with a primary care doctor in their local community.

The ability to provide this level of access to patients is in large part attributed to our positioning within a regional telehealth hub, the CRH. Serving patients from a large catchment area, while challenging, allows us to see patients with the highest needs from different clinics and communities.

Conclusion

Being able to diagnose and manage complex medical conditions while maintaining humanistic connections with patients creates sustainable joy in primary care. Initially, we had fears that telehealth would detract from these joys and have pleasantly found this to be untrue. On the contrary, the ability to connect with, treat, and advocate for rural patients with limited local primary care access imbues our telemedicine work with more meaning.

We believe our clinical experience highlights a promising way to provide care to rural and underserved communities. While not all internal medicine physicians will practice in a primary telehealth clinic, we believe SGIM clinical educators and leaders should advocate for improved telehealth education for trainees and faculty. Additionally, SGIM members should advocate for ongoing telehealth access and reimbursement to ensure that patients from rural communities and those with transportation challenges can receive care through telemedicine.

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SIGN OF THE TIMES

WHERE DID EVERYBODY GO? ADDRESSING RESIDENT ENGAGEMENT IN CONFERENCE CULTURE

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At the start of a didactics session last fall, our faculty speaker was ready, the slides were prepared, and the room was set—yet only a few residents arrived to participate. In a program with more than 200 trainees, this was not an isolated occurrence. Many institutions are facing a notable decline in resident attendance at structured educational sessions. The pandemic transitioned many conferences to remote, and in-person learning has failed to recover to pre-pandemic levels.[1] As resident attendance at didactics decreased in our training program, our approach to conference culture required a review. This article shares our efforts at UT Southwestern to understand and address conference attendance in a large, urban academic setting.

Why This Matters

Educational conferences serve multiple essential functions in graduate medical education. They provide structured opportunities to cover content not always encountered in clinical work and allow faculty to model clinical reasoning. They also create protected spaces for reflection and developing professional identity formation. In large residency programs where residents are often geographically separated, conferences represent a rare, shared experience—a venue for reinforcing a unified program culture and encouraging community.

Post-pandemic shifts in conference culture have also impacted faculty, as evidenced by the widespread decline of in-person grand rounds that once facilitated direct face-to-face interaction among department members.[2] With the rise of podcasts and artificial intelligence, adapting to evolving learner preferences raises the bar on effective teaching; however, it does not render conferences obsolete. Trainees cannot master clinical reasoning skills through podcasts alone; they still benefit from collaborative learning amongst peers.

Although the Accreditation Council for Graduate Medical Education (ACGME) outlines expectations for

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structured learning, the responsibility lies with individual residency programs to create robust educational opportunities and actively encourage attendance by their house staff. When residents do not attend, it signals a deeper issue of disconnection from the educational community.[3] These behaviors intersect directly with ACGME milestones for Professionalism and Practice-Based Learning and Improvement,[3] raising concerns about how well trainees are sustaining core commitments to shared learning. Additionally, studies have demonstrated that attendance in core curriculum conferences has a positive impact on in-training examination scores, a magnitude of improvement comparable to an additional year of residency training.[4,5]

Identifying the Barriers

The decline in resident attendance at structured didactics has been a widely discussed topic in residency programs across the country. Although this shift in conference attendance coincides with the COVID-19 pandemic, there are several additional contributing factors to consider. Competing clinical demands often make it difficult for residents to attend, particularly on inpatient rotations with high clinical volumes. Residents express waning engagement with traditional lecture-based formats, describing them as misaligned with their evolving learning styles.[1]

Furthermore, poor resident attendance negatively affects faculty participation in didactics. Since faculty often rearrange clinical responsibilities to facilitate these sessions, poor trainee engagement can discourage faculty participation. Further studies are needed to determine whether these nationwide trends reflect changing resident attitudes around professionalism and self-directed learning. In the meantime, improving conference attendance demands a shift in how conferences are perceived, structured, and prioritized.

Institutional Experience and Interventions: Structural Adjustments

Recognizing that clinical obligations are a barrier for conference attendance during inpatient rotations, the UT Southwestern Internal Medicine Residency Program (which operates on a 4+1 model) designed the ambulatory clinic weeks to include a half-day of protected didactic time. Although this structure has been in place for at least 10 years, attendance at ambulatory didactics has waned over the past five years and reached a new low last year, as observed by several faculty educators.

To better understand the magnitude of declining attendance, we implemented sign-in procedures with advanced notice of attendance tracking, aiming to quantify the average participation of residents based on post-graduate year (PGY) level and curricular block. Interestingly, after initiating sign-in sheets in early 2025 simply to further study attendance trends, we noted a significant increase in resident attendance to ambulatory week didactics. We conclude that simple tracking of attendance helps reinforce the expectation that educational sessions are a core component of residency training. In addition, monitoring attendance trends offers an early warning for programs to address cultural and structural barriers before professionalism lapses become entrenched.

Curriculum Design

Educators must demand a shift in how conferences are perceived and prioritized by the house staff. Our General Internal Medicine faculty have long been committed to enhancing resident engagement in their structured learning activities. Over the years, our clinic week didactics have continued to undergo curriculum re-design to promote active learning. Innovations include gamification for our Cardiovascular Risk Reduction block (designed as a team-based Jeopardy competition), as well as resident-led sessions called *Reflection Rounds* to combat burnout and moral distress related to challenging patient outcomes. In response to resident requests for professional development topics, the "Life Hacks 101" lecture series was created for graduating residents to meet with faculty in small groups to practice billing and coding and learning about hospital reimbursement and physician payments. This past year, we employed panels of junior faculty to help residents prepare for job interviews and fellowship applications. Ambulatory skills training blocks are also included to prepare residents for outpatient clinical medicine for whichever specialty they choose. These collaborative approaches not only enhance content relevance but also increase resident ownership of the educational environment.

Outcomes, Reflections, and Future Directions

While formal evaluation is ongoing, early indicators suggest that these interventions have had a positive impact. Attendance at our ambulatory didactics improved over the last academic year in sessions where early interventions, such as attendance tracking and curriculum innovations, were implemented. Resident surveys have noted appreciation for the improvements, particularly for the fun and interactive learning environment of our Jeopardy game blocks and the practical utility of our professional development topics. Our faculty have similarly noted increased resident engagement and more robust discussions during these interactive sessions, creating a more positive and impactful experience for our educators—further encouraging future faculty involvement in resident teaching.

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More broadly, the initiative reinvigorated conversations in our program about what constitutes meaningful education and how residency programs can better align their formal curricula with resident values and lived experiences. Engagement can be earned through relevance and trust, with residents responding to transparency and a sense of shared ownership. Even small cultural shifts—such as attendance tracking—can significantly influence participation. We propose that key principles for improvement should include the following:

- Engaging learners in the design of the curriculum, ensuring content aligns with their needs and preferences
- Protecting educational time and clearly communicating the program's expectations for attendance
- Investing in the culture of conference as an integral part of lifelong learning helps ensure it becomes a valued part of the resident experience, not a task to be avoided
- Viewing recurrent conference absenteeism by the program's clinical competency committee as a potential soft marker of professionalism deficiencies.

Effective engagement in required didactics stems from shared ownership of learning, a culture that elevates conference beyond obligation, and accountability for participation.

Programs of all sizes face challenges with conference attendance in the wake of changing expectations around flexibility, virtual learning, and work-life integration. Our experience suggests that improving attendance is not only about enforcing policies and expectations but also rebuilding the perceived value of shared educational time. Educational conferences remain a cornerstone of internal medicine training—but only if they are designed and delivered in ways that resonate with today's learners. In large, complex training environments, conference culture can be both a challenge and an opportunity. By listening closely to residents, partnering with faculty, and reimagining traditional structures, we were able to revitalize an essential part of our educational mission. Ultimately, improving conference attendance is not an end in itself—SGIM members should reflect on the deeper goal: creating a connected, inclusive, and learner-centered residency experience.

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