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SGIM FORUM

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INCREASING TRAINEE ENGAGEMENT: INVESTING IN THE FUTURE OF SGIM

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The Society of General Internal Medicine (SGIM) serves as the professional home for generalist physicians across the spectrum, including numerous practice types and career focuses. Career hospitalists attend SGIM meetings alongside lifetime primary care physicians, while clinician-educators develop conference programming alongside primary researchers. In this article, we focus on the SGIM engagement programs that benefit students, residents, and fellows (SRFs) and highlight the return on investment from supporting these future members.

The breadth and depth of SGIM programming allows SRFs to explore career pathways and opportunities. Crafting posters, delivering oral presentations, and participating in workshops improve trainees' public speaking and information delivery skills. SGIM's strong focus on networking and mentorship provides trainees with ready connections to compatible members who assist in their growth and development as physicians, educators, and researchers.

Trainee engagement is critical to the successful development of future generalist leaders. Medical student and resident exposure to a particular career path is influential in choosing that specialty for training. Student membership in a specialty's professional society and conference attendance is positively correlated with selecting residency training in that specialty.[1,2] In addition, having mentors in a particular field increases the likelihood that SRFs will choose that career path.[3,4]

To recruit and retain generalists, SGIM is committed to providing ongoing opportunities for mentorship, specialty exposure, and conference attendance for SRFs.

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While medical schools and residency programs may provide conference funding for trainees, funds are often limited and unlikely to cover the full cost of national conference attendance.[5] To bridge this gap, SGIM has developed engagement programs to increase trainee membership and Annual Meeting attendance. Current programs include the National Young Scholars program for medical students and residents, and the Investing in General Internal Medicine (GIM) program for fellows.

National Young Scholars in General Internal Medicine (NYSGIM)

The National Young Scholars in General Internal Medicine (NYSGIM) award provides medical student and resident SGIM members with the opportunity to attend the Annual Meeting by covering registration fees. Launched in 2016, NYSGIM has been offered annually, except in 2020 due to the COVID-19 pandemic. The number of awards has increased over the past 10 years, reaching a record 69 awards distributed in 2025. This award is made possible through the generosity of SGIM members via the Future Leaders in GIM fund and the SGIM annual budget.

Award Outcomes

Applicants need not be presenters at the Annual Meeting to apply, but they must have an active SGIM membership. Each year, SGIM memberships increase among students and residents after the NYSGIM award application is announced. This requirement encourages applicants to explore the benefits of SGIM membership, particularly for those pursuing a career in GIM.

The outcomes from this award program illustrate the significant benefits of supporting Annual Meeting attendance for SRFs. Approximately 25% of award recipients maintain their membership for at least one additional year after receiving the award. Since 2016, more than one in five award recipients maintained active memberships in 2025 (with 5% of these active members receiving their award in 2016). This data excludes 2025 award recipients and repeat award recipients. Among past participants, 6% of current active member awardees have gone on to win one or more awards through SGIM while 21% currently serve on one or more SGIM committees.

Investing in GIM

The Investing in GIM program was established in 2012 to provide a free year of SGIM membership to first-year fellows in GIM-related programs. These programs include general medicine, hospital medicine, geriatrics, hospice and palliative care, health services research, health policy, obesity medicine, HIV medicine, addiction medicine, and LGBTQ+ health among others. Since its inception, 525 first-year fellows have received the award. In 2024-25, 50 awards were provided to recipients from all six SGIM regions. Investing in GIM is sponsored through the generous donations of SGIM members through the Future Leaders of GIM fund.

Award Outcomes

The Investing in GIM program provides first-year fellows with one year of membership funding, but the impact of this engagement is a notable return on investment as 85% of awardees continue their membership for at least one year after program completion. Investing in GIM recipients have gone on to hold many leadership positions at SGIM and their local institutions. Former awardees include SGIM Council members, committee and conference chairs, mentorship and career development program leaders, ACLGIM (Association of Chiefs and Leaders in GIM) members, and division chiefs at institutions nationwide. Among 2018-2025 award recipients, one in four hold a leadership position within SGIM.

Future Directions

SGIM aims to expand the reach of the NYSGIM and Investing in GIM award programs to a broader range of trainees across varied institutions, regions, and fellowship programs. SGIM encourages institutions without prior awardees to motivate SRFs interested in GIM to apply for the awards to reap the considerable benefits of an SGIM membership. Joining SGIM and attending the Annual Meeting at an early stage can increase the likelihood of choosing a generalist career, developing lifelong mentorship relationships, and improving the potential for future academic success. SGIM members are encouraged to invest in our trainees through the Future Leaders in GIM fund to ensure a strong and vibrant SGIM community for years to come. While donations to the fund are accepted at any time, membership renewal is an ideal time to invest in trainee engagement programs.

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SGIM

FROM THE EDITOR

THE BEST OF TIMES, THE WORST OF TIMES: CMS PAYMENT REVISIONS DURING A CRISIS

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"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us."[1]

For more than 30 years, the Specialty Society Relative Value Scale Update Committee (RUC) has wielded considerable influence over physician payment schedules. Influenced by the American Medical Association (AMA), the RUC makes annual recommendations to the Center for Medicare and Medicaid Services (CMS) for the Physician Fee Schedule (PFS). Medicaid and private insurance companies then adopt these relative value units (RVUs) and associated reimbursements. Under the AMA's influence, the RVU reimbursement set by the RUC has long favored operative and procedural based specialty care. SGIM members and other primary care specialties have long advocated for changes to the CMS's physician fee structure. In this article, I review changes to the 2026 PFS.

During President Trump's first term, the AMA resisted changes to the RUC's RVU setting and successfully argued for maintaining the *status quo* with higher reimbursement for operative and procedural specialties and lower payments for primary care. Many policy makers advocated for changes to the RUC. In 2018, authors from the Center for American Progress, Maura Calsyn (managing director of Health Policy) and Madeline Twomey (special assistant for Health Policy), argued, "The RUC process is broken, and the AMA has no interest in even minor changes. And given the Trump administration's extreme deference to the RUC, and the unlikelihood that there is sufficient congressional support to overcome that position, reform will have to wait. But the importance of reform is growing, and it is essential that policymakers and stakeholders outline what changes must be made to Medicare's current system."[2]

On October 31, 2025, CMS issued a press release that many SGIM members had long advocated for—"Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F)."[3] CMS Director Chris Klomp reflected the first significant change in healthcare reimbursement since the RUC was instituted in 1992 stating "CMS is reinforcing primary care as the foundation of a better healthcare system while ensuring Medicare dollars support real value for patients, and not the kind of waste or abuse that erodes trust in the system."[4] Health and Human Services (HHS) Secretary Robert F. Kennedy Jr. double downed on this radical departure from prior reimbursement models stating that this new PFS "realigns doctor incentives and helps move our country from a sick-care system to a true healthcare system."[4] (This might be the one situation where I agree with HHS leadership.)

What can we expect from the new CMS PFS Payment Revision? The components for 2026 include the following:

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1. **PFS Rate Setting and Conversion Factors:** To calculate physician fee payments, RVUs are multiplied by a conversion factor. In 2026, two conversion factors will be employed. The first will be set at +0.75% for qualifying alternative payment model (APM) participants who meet certain thresholds for participation in an advanced APM with accountability for quality of care and cost adjustments. The second factor of +0.25% is for non-qualifying APM participants. "The final CY 2026 qualifying APM conversion factor of $33.57 represents a projected increase of $1.22 (+3.77%) from the current conversion factor of $32.35. Similarly, the final CY 2026 nonqualifying APM conversion factor of $33.40 represents a projected increase of $1.05 (+3.26%) from the current conversion factor of $32.35."[3] CMS is putting money behind quality and cost containment.
2. **Efficiency Adjustment:** Efficiency adjustment has generated the greatest controversy with the 2026 PFS release. Long guided by the AMA RUC, "this process relies primarily on subjective information from surveys that have low response rates, with respondents who may have inherent conflicts of interest (since their responses are used in setting their payment rates)."[3] CMS proposed a Medicare Economic Index (MEI) productivity adjustment percentage at -2.5% for 2026. This proposal reflects concerns that RUC surveys contain inflated time assumptions for surgical and operative procedures and that changes in medical practice have resulted in greater efficiencies over time. CMS anticipates moving from survey-based results driven payment models to different future payment models.
3. **Practice Expense:** Practice expenses (PE) have been calculated utilizing similar AMA survey models dating to 2008 with an update in 2024. Due to concerns over survey data, CMS did not implement aspects from the AMA surveys but chose to significantly update PE methodologies to reflect higher practice expense costs for physicians working in office-based settings as opposed to facility-based physicians. This efficiency adjustment reflects perception that facility-based practices gain greater efficiencies in PE compared to practices in office-based settings.
4. **Telehealth Adjustment:** CMS adjusted the process of adding services under telehealth for reimbursement, removed distinctions between permanent and provisional services and identified services requiring direct physician supervision. For many SGIM members, CMS is not allowing the extension of the "current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings."[3] Since this has been integrated into many clinical practices, CMS is "allowing teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service was furnished virtually, on a permanent basis."[3]
5. **Strategies for Improving Global Surgery Payment Accuracy:** little direct relevance to SGIM members.
6. **Chronic Illness and Behavioral Healthcare Needs:** As part of the "Make America Healthy Again" initiative, "the Administration is directing our focus towards understanding and drastically lowering chronic disease rates, including thinking on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. As such, focusing on the prevention and management of chronic disease is a top priority for us."[3] CMS plans to incorporate "optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM) services. We are finalizing the establishment of three new G-codes to be billed as add-on services when the APCM base code is reported by the same practitioner in the same month."[3]
7. **Skin Substitutes:** Skin substitution payments have shown significant increases in cost ($252 million in 2019 to greater than $10 billion in 2024). CMS is changing reimbursement rates from "biologicals" to a "supplies" based reimbursement as part of a larger procedure-based payment. This includes streamlining categories for skin substitutes from three groups to one.
8. **Drugs and Biological Products Paid Under Medicare Part B:** little direct relevance to SGIM members.
9. **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs):** CMS would allow "optional add-on codes finalized under the PFS for … billing for BHI and CoCM services when RHCs and FQHCs are providing advanced primary care."[3]
10. **Medicare Prescription Drug Inflation Rebate Program:** little direct relevance to SGIM members.

The 2026 PFS recognizes that primary care plays a vital role in national health care. CMS has increased payment for foundational services to improve quality care.

Conclusion

As Dickens notes, "we have everything before us, we have nothing before us."[1] CMS has finally recognized the value of primary care, and this victory should be celebrated as the foundation of a better health care system. But we must recognize that the battle is not over. The AMA and specialty societies are protesting the CMS decision vowing to overturn or modify the new PFS ruling.

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Even for internal medicine physicians, there is work to be done. On the SGIM Advocacy and Policy webpage, SGIM policy leaders note "The impact of the rule's new policies will be mixed for general internal medicine physicians. CMS estimates an overall Medicare payment reduction of 1% for internal medicine physicians with those in the facility setting seeing an 8% decrease and those in office settings seeing a 6% increase."[5] One recognition of primary care contributions should only make SGIM members work harder to accomplish more. We still have goals to achieve.

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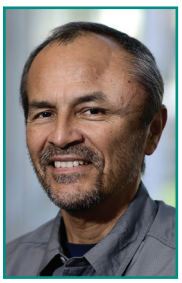
PRESIDENT'S COLUMN

SGIM 2026 ANNUAL MEETING PREVIEW: RECORD SUBMISSIONS, DISTINGUISHED SPEAKERS, AND THE BENEFITS OF ATTENDANCE

Carlos Estrada, MD, MS, FACP
President, SGIM

"The Annual Meeting offers value for everyone—from state-of-the-art innovations in health information technology to core values in medical education, practical skills development, and career advancement opportunities."



SGIM returns to Washington, DC, for the 2026 Annual Meeting! In the June 2025 issue of SGIM Forum, I introduced the Annual Meeting Chairs, Dr. Amanda Mixon and Dr. Eric Yudelevich.[1] Since they will serve as masters of ceremony for the 2026 Annual Meeting Program Committee, I want to expand on their credentials. As a Clinician-Investigator, Dr. Mixon focuses on improving care transitions by addressing social determinants that affect hospital readmissions as well as medication management, with an emphasis on medication reconciliation and deprescribing in patients with polypharmacy. Her federally funded work has positioned her as a leader in patient safety and deprescribing research. As a Clinician-Educator, Dr. Yudelevich's interests span medical education, clinical practice, and innovation. His work focuses on patient-clinician communication and the use of digital health tools (such as patient portals) in primary care settings.

In that same June issue, I described the process of crafting the 2026 SGIM Annual Meeting theme: "Individual Voices, Collective Impact: Advocating for Excellence in Academic Medicine."[1] In this article, I introduce the plenary speakers, share results from the

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initial wave of submissions, and highlight the benefits of attending the 2026 Annual Meeting (#SGIM26).

Plenary Speakers

The Annual Meeting Program Committee is thrilled to announce three distinguished plenary speakers whose expertise aligns perfectly with our meeting theme of excellence in academic medicine, innovation, and advocacy.

Dr. Sondra Zabar is a Professor of Medicine and Director of the Division of General Internal Medicine and Clinical Innovation at New York University Grossman School of Medicine (NYUGSOM). A nationally recognized leader in medical education innovation, she directs the Program for Medical Education Innovations and Research (PrMEIR) and the NYUGSOM Standardized Patient Program. Her work focuses on performance-based assessment through standardized patient simulations, including pioneering unannounced standardized patients in clinical environments. Dr. Zabar has also developed immersive simulation experiences to train and evaluate clinicians, teams, and health systems.

Dr. Kevin B. Johnson is the David L. Cohen University Professor at the University of Pennsylvania. He has developed innovative technological solutions to healthcare challenges, in particular leveraging artificial intelligence to transform clinical documentation and reduce clinician burnout. A physician, informatician, and internationally recognized science communicator, he is known for making complex topics, such as artificial intelligence and digital health, accessible and inspiring. He was inducted into the National Academy of Medicine, one of the highest professional honors in the field of health and medicine.

Dr. John Balbus leads Climate Care Consulting, LLC. Trained as a physician in Internal Medicine as well as Occupational and Environmental Medicine, he has devoted his career to understanding the health implications of climate change. He served as a Senior Advisor for Public Health at the National Institute for Environmental Health Sciences (2009-20). He established and directed the United States Department of Health and Human Services (HHS) Office of Climate Change and Health Equity (2021-25). He was also inducted into the National Academy of Medicine.

The meeting chairs and I sought advice from the 2026 Annual Meeting Program Committee regarding potential speakers. Together, we carefully selected experts in medical education, health information technology with an emphasis on artificial intelligence, and the health impact of climate change.

A Record-Breaking Initial Wave of Submissions

The initial wave of submissions included workshops, interest groups, and updates submitted by SGIM members as well as invited Special Symposia from SGIM's core committees and commissions. A revised set of 16 submission categories addressed members' evolving needs with categories spanning a full range of interests from ambulatory medicine and clinical skills to healthcare policy. Venue constraints prevented the program committee from offering additional pre-courses this year (another large meeting ends late in the day immediately before our meeting begins).

This year, the 2026 Annual Meeting program committee received a record number of workshop submissions (350!)—accepting approximately one-third. In addition, there were 27 updates (60% acceptance rate), 24 special symposia (50% acceptance rate), and all 65 interest group submissions were accepted. The process was highly competitive, and the blinded review process ensured fairness and balance. The members of the planning committee crafted the schedule to minimize conflicts between similar sessions. This careful planning ensures balanced content throughout the meeting while preventing session presentations on related topics during conflicting time slots.

I personally know the excitement when a submission is accepted as well as the disappointment of a rejected submission. After reviewing 20 submissions across several categories, it was clear to me that each submission was driven by focused passion and expertise. I thank the many SGIM member reviewers who completed this important task of reviewing submissions. This was no small task as reviewers entered more than 10,000 data points (estimated for 400 submissions, at five reviewers per submission, and an evaluation rubric consisting of five domains). By the time this article is published in January 2026, submissions for the remaining categories—abstracts, vignettes, and innovations—will be under review.

The meeting could not occur without a devoted and knowledgeable SGIM staff[2] working tirelessly behind the scenes while simultaneously managing regional meetings and other SGIM duties. As I know SGIM staff better, they epitomize the concepts of high performing teams. Kay Ovington, CAE, SGIM Deputy Chief Executive Officer (CEO), tells me of a deliberate effort to cross train the staff to support members and each other.

Why You Should Attend the Meeting

Attending the 2026 SGIM Annual Meeting provides excellent opportunities for professional growth. From my perspective, the following are the top six benefits of attending:

1. **Engage as a Leader and Contributor:** Take on meaningful roles, such as judging posters, moderating sessions, or participating in mentoring programs, to give back to the community while developing your skills.

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2. **Stay Current. Attend Special Symposia, Updates, and Workshops:** Craft your personal adventure and learn about the latest clinical guidelines, educational innovations, and practical uses of artificial intelligence that you can apply in your practice.
3. **Expand Your Professional Network:** Re-connect with peers from your region or connect with colleagues across other regions. Leverage your interests and seek future collaboration- a deliberate approach may lead to a joint workshop submission for the next regional/annual meeting or an invitation to be a Grand Rounds speaker.
4. **Advance Your Skills through SGIM Programs:** Participate in one of the many professional development programs including Leadership in Health Policy (LEAHP), Association of Chiefs and Leaders in Academic General Internal Medicine (ACLGIM) LEAD (for junior or mid-career faculty), or Teaching Educators Across the Continuum of Healthcare (TEACH).
5. **Present and Share Your Expertise:** You will gain valuable exposure and feedback from peers and leaders. Elevate your profile, inspire your colleagues, and play a key role in shaping the future of General Internal Medicine.
6. **Learn about Healthcare Policy and Advocacy:** Engage with healthcare leaders to influence the direction of primary care, address health disparities, and advocate for issues affecting general internists and our patients. In a future Forum issue, the Meeting Chairs will expand on innovations and advocacy efforts.

The Annual Meeting offers value for everyone—from state-of-the-art innovations in health information technology to core values in medical education, practical skills development, and career advancement opportunities.

The 2026 Annual Program Committee looks forward to welcoming you to Washington, DC, (#SGIM26). Whether you are presenting, attending sessions, or reconnecting with colleagues, your presence matters. Your individual voice makes a collective impact. I hope to see SGIM members in Washington, DC, as we work together to advocate for excellence in academic general internal medicine.

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Q & A ON WHAT SGIM MEMBERS SHOULD KNOW ABOUT THE 2025 LEARN, SERVE, LEAD MEETING OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC)

Elisha Lynn Brownfield, MD; Eric B. Bass, MD, MPH

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The Association of American Medical Colleges (AAMC) is dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations.[1] Thus, the AAMC's mission overlaps substantially with SGIM's mission to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way toward better health for all. With the entire field of academic medicine facing so many challenges, SGIM's relationship with the AAMC is more important than ever. To help nurture that relationship as much as possible, Dr. Elisha Brownfield has agreed to serve as SGIM's representative on the AAMC's Council of Faculty and Academic Societies. We both attended the AAMC's most recent Learn, Serve, Lead Meeting in San Antonio, Texas, and afterward I asked Elisha to share her thoughts on what was most relevant to SGIM's members.

EBB: SGIM recently created a task force to develop recommendations about the types of educational programming, resources, and guidelines that would help members navigate the impact of artificial intelligence (AI) on clinical practice, education, and research while using AI tools responsibly. What did you learn at the AAMC meeting that's relevant to the charge given to our AI task force?
ELB: Many of the sessions at the AAMC meeting focused on the use of AI, with representatives of multiple institutions sharing lessons learned from their AI initiatives. One of the most important lessons was to start with governance and ethics, not the AI tools. It's important to decide what you want to do, who will make decisions, and what will be the guiding principles. Other recommendations included: 1) design for data use from day one; 2) assess readiness; 3) start small and build for scalability; 4) build the necessary supporting workforce and cross-functional teams; 5) be intentional but adaptive; 6) be transparent; and 7) close the feedback loop.

EBB: SGIM has a long-standing commitment to advocating for our vision of a just system of care in which all people can achieve optimal health. What did you hear about what the AAMC is doing to advocate for improving the health of people everywhere?
ELB: Throughout the Learn, Serve, Lead Meeting, I heard a lot about the critically important role of storytelling in advocacy work. We all must get better at capturing and sharing the stories of our patients, trainees, and colleagues who are affected by policies that threaten their health and well-being.

I also learned that the AAMC is launching a new initiative designed to provide members with better support for advocacy efforts at the state and local levels. Even though the AAMC is much larger than SGIM, the AAMC does not have enough resources to support direct advocacy at the state and local levels. So, the AAMC is developing resources and tool kits that members can use in their own local efforts. They also have been convening virtual meetings of government relations officers from member institutions to facilitate better communication between institutions that are wrestling with similar threats and challenges.

Furthermore, the AAMC is investing resources in promoting greater community engagement. The AAMC's leaders assert that academic medical centers have a responsibility to get into the communities they serve to educate and to listen.

EBB: What seemed to be the AAMC's highest priorities for its direct advocacy efforts on Capitol Hill?
ELB: The AAMC's leaders emphasized their commitment to advocating for policies that strengthen academic health systems and teaching hospitals, and that strengthen the academic medicine workforce by supporting training of physicians and researchers. They also are committed to fighting for access to care by trying to restore Medicaid funding, preserve insurance subsidies from the Affordable Care Act, and protect safety net providers. They will con-

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tinue to advocate for maternal and mental health care. They also will continue to advocate for student financial aid while pushing for physicians to receive an exemption from the new $100,000 H-1B visa fee.

EBB: What else did you hear that would be of interest to SGIM members?
ELB: I was pleased to hear that the AAMC revised its physician workforce projections to account for feedback their workforce modeling team received from leaders of SGIM, the American College of Physicians (ACP), and the American Association of Family Physicians (AAFP).[2] As you recall, the AAMC announced a year ago that the rapidly increasing supply of Nurse Practitioners (NPs) and Physician Assistants (PAs) can meet the nation's demand for primary care within the next decade if the nation continues to increase the number of primary care physicians it trains. Thankfully, the AAMC team listened to concerns raised by SGIM, ACP, and AAFP about some assumptions in their modeling (e.g., they were counting hospitalists as primary care clinicians). The revised model now indicates that a serious shortage of primary care physicians will persist despite the increasing numbers of NPs and PAs. These projections have important ramifications for physician workforce policy.

EBB: I want to close by thanking you, Elisha, for volunteering to represent SGIM at the AAMC meetings. Your leadership will help to continue strengthening our partnership with the AAMC on issues critical to the mission of both organizations.

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FINDING BALANCE WHEN PRESSURE MOUNTS: A TEACHABLE MOMENT ON DISCHARGE PLANNING

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This article talks about developing pressure-resistant discharge planning frameworks, navigating honest conversations with patients and families about competing risks, and learning from readmissions that have deepened my understanding of balancing patient safety with operational demands.

Mrs. P was ready to go home. At least, that is what I told myself at 2:00 pm on a Thursday afternoon when the bed manager asked to discuss our discharge goals and three new admissions waiting in the emergency department. Mrs. P had been stable for 18 hours, her pneumonia was responding to oral antibiotics, and her oxygen saturation was fine on room air. The textbook said discharge. The quality metrics said discharge. The pressure in my chest said something different.

I sent her home….

Two days later, Mrs. P was back. She was hypotensive, confused, and significantly sicker than when she left. As I stood in her room listening to her daughter ask what had gone wrong, I engaged in a conversation that would reverberate in my head over the subsequent months. The textbooks said discharge. The quality metrics said discharge. But I had felt an unease I couldn't quite name, a clinical intuition whispering that something wasn't right. The pressure to keep beds moving hadn't allowed me the time to investigate that feeling, to sit with the uncertainty long enough to understand what that whisper was trying to tell me. That readmission taught me something painful but essential about hospital medicine: the art of safe discharge isn't just clinical; it's about navigating competing pressures.

The Pressure Cooker: When System Demands Meet Clinical Decision-Making

Let's be honest about the pressure physicians face when making discharge decisions. The morning huddle starts with census numbers and discharge targets. Somewhere during this system noise, the hospital team is trying to determine when it is safe for Mrs. P to leave the hospital.

The pressure is real and relentless. Research shows that hospitals with high occupancy rates have increased mortality, higher readmission rates, and longer emergency department boarding times.[1] But the solution isn't just moving patients out faster—it's learning to balance safety with flow in ways that serve both our patients and our healthcare systems.

What makes this balance difficult is that the stakes feel impossibly high on both sides. Keeping someone too long, and you're potentially exposing them to hospital-acquired infections, delirium, or unnecessary procedures while preventing someone else from accessing needed care. Discharging the patient too early risks readmission, complications, or worse.

The Ghost of Discharges Past

Mrs. P wasn't my first readmitted discharge, and she will not be my last. Each readmission has taught me something different about the complex calculus of hospital discharge decisions. There was a heart failure patient I sent home without adequate diuretic optimization because his insurance wouldn't cover an extra day. He was back within the week. Or, the stroke patient I discharged to rehabilitation because the family was anxious to start therapy, only to discover she wasn't medically stable enough for the intensity of rehab programming.

What haunts me most isn't the clinical complexity—it's the recognition that system pressures influenced decisions that should have been purely medical. The afternoon I discharged Mrs. P, I was thinking about throughput metrics as much as I was about clinical indicators. That realization forced me to develop strategies for protecting clinical decision-making from administrative pressures.[2]

Building a Framework for Safe Discharge

Over time, I developed a "pressure-resistant discharge planning" approach that acknowledges system constraints while prioritizing patient safety. This approach starts with an honest assessment of my decision-making process. When I feel rushed or pressured, I take a step back and ask myself: "If this were my family member, would I feel comfortable with this discharge plan?"

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The framework has three components:

1. Clinical readiness extends beyond vital signs and lab values to encompass functional status, social support, and patient confidence in self-management.
2. System readiness must ensure appropriate follow-up, medication access, and home support services are in place.
3. Shared decision-making that includes honest conversations with patients and families about the risks and benefits of discharge timing.[3]

Together, these three components create a buffer between system pressures and clinical judgment, enabling me to discharge patients confidently while maintaining safety as my top priority.

Learning from Readmissions

Every readmission within 30 days is reviewed, but I have also started my own informal analysis of my discharge decisions. This self-reflection has revealed patterns in my decision-making that I wouldn't have otherwise noticed. I discovered that I am more likely to discharge prematurely on busy weekdays when system pressure is highest and to keep patients unnecessarily during quiet weekends when there's less administrative oversight. I also learned that my discharge threshold changes based on my relationship with individual patients.

These insights led me to develop personal safeguards: always sleeping on discharge decisions that feel rushed, consulting colleagues when I'm feeling pressured, and maintaining a running list of patients I'm concerned about even after discharge. It is not foolproof, but it has helped me separate clinical judgment from system noise.[4]

Teaching the Next Generation

Residents and medical students observe how attending physicians make discharge decisions under pressure and learn lessons that may not be intended to be taught. When I discharge someone quickly because of bed availability without acknowledging the complexity, I was teaching that system efficiency trumps clinical judgment. Teaching moments also arise from readmissions. When Mrs. P returned, I used her case as a teaching example for a conference on discharge decision-making under pressure. Rather than focusing on the clinical details of her readmission, we discussed the system factors that influenced my original discharge decision and strategies for protecting clinical judgment from administrative pressures.

The Long Game

Sustainable discharge planning requires acknowledging that we can't eliminate all readmissions without keeping everyone in the hospital indefinitely.[5] The goal isn't perfection, but a consistent application of clinical judgment that prioritizes patient safety while acknowledging system realities.

Mrs. P recovered fully from her readmission, and when she needed hospitalization six months later for a different issue, she asked to work with me again. During her discharge planning, she expressed appreciation for my honesty about the competing pressures and trusted I was making decisions with her safety as my top priority. That conversation reminded me why this work matters, especially when it's difficult.

Finding Peace with Imperfection

I still think about Mrs. P's first readmission, but the guilt has evolved into a kind of wisdom. Every discharge decision involves uncertainty and competing risks. Our job isn't to eliminate that uncertainty but to navigate it thoughtfully, with patient safety as our North Star and honest communication as our guide.

The art of safe discharge isn't about getting every decision right—it's about approaching each decision with intentionality, honesty, and humility. Sometimes, we err on the side of caution and face criticism for being overly cautious. Sometimes, we'll discharge patients who aren't quite ready and deal with the consequences. Both outcomes, whether keeping patients too long or sending them home too soon, teach us something about the delicate balance we're trying to maintain. Both outcomes teach us something about the delicate balance we're trying to maintain.

The pressure to move patients through the system efficiently isn't going away. If anything, it's likely to intensify as healthcare costs continue rising and capacity constraints worsen. But SGIM members can develop frameworks for discharge planning that acknowledge these pressures while protecting our clinical judgment and patients' safety.

What matters most is that we continue to strive for accuracy, learn from our mistakes, and support one another through the challenging decisions that define modern hospital medicine. Because, in the end, that is what our patients need from us: not perfection, but a commitment to keep striving for it, despite all the pressures working against us.

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SGIM

MEDICAL EDUCATION

LEAVE IT BETTER THAN YOU FOUND IT: AN ANTIDOTE TO "BACK IN MY DAY" CALL COVERAGE

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Introduction

Today's resident physicians are enthusiastic about championing personal well-being and work life balance. Doing things "the old way" to maintain the *status quo* is no longer passively accepted in Graduate Medical Education (GME). For more than a decade, a 24-hour in-hospital call has been a hot button issue in GME nationally. Debate around this issue sparked in 2011, when the Accreditation Council for Graduate Medical Education (ACGME) prohibited PGY-1 residents from working longer than 16 hours continuously. In the wake of this change, residents who are not protected by the policy voiced concern as to the benefit of protecting PGY-1 residents from these long shifts if they will have to still endure them as a PGY-2.[1] Despite increased duty hour restrictions from the ACGME and growing demand for work-life balance from residents, the 24-hour call system persists, upheld by a "we've always done it this way" mindset to justify outdated practices that compromise patient and physician well-being.[2] In other high-stakes fields, such as aeronautics, nuclear energy, and long-haul trucking, prolonged work hours without rest are considered unsafe.[3] Why should medicine be different? Major overhauls in medical training are especially challenging due to the pervasive belief that, "I had to do it so you should, too," or the classic "back in my day" mentality. Both mindsets fuel friction among different generations of physicians. In this article, we offer an example of residents overcoming the "back in my day" mindset.

In recent years, our internal medicine residency program at Wake Forest University (WFU) received increasing feedback from residents calling for the elimination of our 24- and 28-hour in-hospital call shifts for upper-level residents. Trainees emphasized that most post-residency hospitalist jobs do not involve 24-hour in-house calls. While residency leadership was open to considering proposals redistributing 24-hour duties into separate shifts, there were hesitations about the acceptance of increased workload (more 12-hour shifts vs fewer 24-hour shifts). Many proposals would increase the workload of residents during rotations perceived as lighter, and leadership doubted residents would accept such changes.

The commonly known "*Boy Scout Rule*" refers to leaving things better than you found them (for Scouts, this can refer to camping, hiking, or other activities). Beyond youth scouting and environmental programs, other industries, such as software development, have

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adopted this motto as a framework for personal accountability and continuous improvement.[3] By adopting the Boy Scout's philosophy, WFU residents chose to lighten a workload for future residents, ultimately making residency better for all.

Eliminating 24+-Hour Shifts

WFU is a large academic program with 34 categorical internal medicine (IM) residents per year. The resident inpatient ward services included four General Medicine teams and five specialty teams. Pre-intervention, upper-level residents provided night coverage for inpatient specialty services by a combination of those residents on night float rotations and those on the daytime inpatient specialty services. Upper-level residents on inpatient specialty services who were already working six days a week were completing extra 24- and 28-hour shifts during their inpatient month to allow night float residents their nights off. Although these schedules complied with duty hour requirements, these inpatient specialty rotations were unpopular with residents.

These subspecialty inpatient service coverages fell largely to second year residents. After completing this rite of passage in second year, third-year residents were rewarded with a medicine consult rotation. This rotation was perceived to be an easy inpatient rotation during their final year of residency. Our medicine consult rotation was colloquially known as *"HO3" (House Officer 3)* where a third-year resident served as a 24/7 in-house medicine consultant and backup support for our nine inpatient teams. While the inpatient specialty service residents were unhappy with their schedule, the nighttime third year resident rotation (HO3) was viewed as a privilege for residents in their last year of training with a lighter workload.

A chief resident proposed using the nighttime HO3 to eliminate the 24+-hour shifts on the subspecialty services. Prior to any changes, the HO3 schedule consisted of four residents per block, each completing 5-6 daytime shifts alternating with four nighttime shifts over a 4-week block. The chief resident proposed consolidating the HO3 schedule into longer night stretches (~eight nights) thereby increasing the number of night shifts per resident on each block. By staggering and lengthening these night stretches between the HO3 residents, the subspecialty services could be covered overnight, eliminating the need for the previously required specialty service daytime resident. This would be great news to the second years on specialty inpatient services but might be a difficult change to accept for the current second-year residents looking to get the privilege of an "easy" HO3 rotation the following year.

The Internal Medicine Leadership Team supported the proposal but was skeptical about resident support and acceptance. The chief resident presented this proposal to the residents serving on our Inpatient Task Force (a selected group of residents elected to meet monthly with faculty supervisors to discuss inpatient issues and policies). The discussion included high resident engagement, particularly from second-year residents who would bear both the burden of 24+-hour shifts for the current year and the added HO3 duties after the change. The Inpatient Task Force endorsed the new schedule and asked a second-year resident representative on the task force to present the proposal to the residency program at large. With the help of the chief resident who devised this new schedule, the representative second-year resident presented the proposal to all residents at a monthly resident-wide meeting. With strong peer involvement, the proposal was well received, even by those residents most impacted by the change. The change was implemented at the start of the following academic year.

Despite the addition of extra night shifts to third-year residents' schedule, the elimination of 24+-hour shifts has been a major triumph for our residents and a common example of positive change referenced during recruitment season. Comments on our annual residency survey indicating dissatisfaction with the in-hospital call schedule have nearly ceased. The absence of negative feedback from the residents further supports its success, consistent with the Institute for Healthcare Improvement (IHI) Model for Improvement, which considers such outcomes as an indication that change did not introduce unintended negative effects.[5]

Conclusion

Eliminating 24+-hour shifts initially seemed impossible, especially since it required residents to support a change that would not benefit them directly—and would even increase their workloads in the short term. In a career where "back in my day, things were worse" is often used to justify the *status quo*, their commitment to embracing change reflected a commitment to improving conditions for future trainees. The key breakthrough came from resident stakeholders' direct involvement in the problem-solving process, allowing them to design a solution and advocate for it among their peers. Critically, the residents calling for change took on heavier rotations to make it happen, enabling our residency to end all 24+-hour shifts.

SGIM members may find this story as a compelling model for how meaningful change can happen when residents are empowered to lead reform—even when it comes with personal costs. It is true, back in the day, shifts were longer, but that is no longer a badge of honor. WFU is proud that our residents are committed to leaving the program better than they found it, just like the Scouts.

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SGIM

MORNING REPORT

AUTOIMMUNE HYPOTHYROIDISM WITH RAPID PROGRESSION TO AUTOIMMUNE HYPERTHYROIDISM: A CASE REPORT INCLUDING THE PATIENT'S PERSPECTIVE

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A 27-year-old female with no prior medical history presented to her primary care physician with three months of hair loss, brain fog, cold intolerance, swelling around the eyes, excessive sleepiness, and fatigue. Her presentation occurred in the context of significant stressors (completing graduate school national standardized examinations and moving across the country for work). She had not experienced similar symptoms prior. This article discusses her clinical course as she developed autoimmune hyperthyroidism after her initial diagnosis of autoimmune hypothyroidism.

Patient Perspective (EH): *"I first noticed symptoms around my licensure exam and starting my new job. I couldn't do high level critical thinking, and it took an unusual amount of mental effort to stay focused. I attributed these symptoms to stress, but I had never reacted to stress like this before. I was cold all the time, and in Nordic ski races I couldn't push myself to go fast even when I tried."*

Discussant (KM): Although fatigue and "brain fog" have a broad differential diagnosis, the associated symptoms of cold intolerance, alopecia, and periorbital edema strongly suggest hypothyroidism. Fatigue and cognitive impairment could also be caused by long COVID-19, disordered sleep, depression, chronic kidney disease, or myalgic encephalitis/chronic fatigue syndrome. I would inquire about any recent COVID-19 diagnosis and other symptoms of depression and thyroid disease, including constipation, or changes in weight or menstruation. On physical examination, I would assess for a thyroid goiter and findings suggestive of hypothyroidism, including delayed relaxation of reflexes and

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bradycardia. Given the high suspicion for hypothyroidism, I would order a thyroid stimulating hormone (TSH) and free thyroxine (T4) before testing for other conditions in this previously healthy young adult.

Her physical exam revealed no abnormalities. Laboratory work-up included a thyroid-stimulating hormone (TSH) of 220 uIU/mL (0.4-4.0 uIU/mL), free thyroxine (T4) of 0.3 (0.7-1.9 ng/dL) and thyroid peroxidase (TPO) antibody positive at 590 IU/mL (reference >34 IU/mL). Labs including complete blood count, comprehensive metabolic panel and iron studies were within normal limits. She was prescribed a weight-based dose of 88 micrograms levothyroxine. Her TSH normalized within three months, and her symptoms improved.

EH: *"I felt pretty good over the summer on levothyroxine; I was able to do some races and push it, felt more awake and focused at work, and I didn't feel horribly behind on sleep."*
KM: The TSH of 220 uIU/mL supports the diagnosis of hypothyroidism, which can be confirmed with a low serum free T4. The positive anti-TPO antibody is consistent with Hashimoto's thyroiditis. The normal CMP and CBC exclude chronic kidney and liver disease as well as anemia. The positive response to levothyroxine is expected. With normalization of the TSH and her symptoms, a TSH should be repeated annually.

At a follow-up visit five months after initial presentation, her symptoms of fatigue, brain fog, and lethargy had recurred.

EH: *"By the fall I thought the last of my symptoms should have resolved, but I still wasn't back to my usual self. I felt more anxious and was back to feeling sluggish at work and with exercise. I couldn't get my heart rate up with exercise the way I could in the summer."*
KM: The recurrence of fatigue and brain fog warrant retesting of TSH and free T4. Levothyroxine absorption can be altered by food, over-the-counter medications, pregnancy, and gastrointestinal conditions. Barriers to adhering to prescribed therapy should be considered when a condition does not respond as expected.

Thyroid labs revealed a TSH of >0.01 uIU/mL and free T4 of 3.5 ng/dL. Her Levothyroxine was reduced to 75 micrograms. Her symptoms of fatigue, brain fog and lethargy persisted despite the dose change. Additionally, she developed heat intolerance, palpitations, hyperhidrosis, tachycardia, and exercise intolerance.

EH: *"Even though we were decreasing my dose, I was getting really warm and sweaty, was sleeping hot and didn't feel rested. When skiing at what would previously have been an easy pace, I would feel fine for 5-10 minutes, then feel overwhelmed like I had 'hit a wall' and would have to stop and rest. If I went too hard too fast, I would get palpitations before I felt overwhelmed by the effort."*

Follow up labs revealed continued hyperthyroidism with a TSH >0.01 uIU/mL, and her dose of levothyroxine was reduced to 50 micrograms. Her repeat physical examination revealed no abnormalities.
KM: Repeat thyroid testing revealed hyperthyroidism, which was first assumed to be iatrogenic. However, her symptoms and low TSH persisted despite levothyroxine dose-reduction, and she now reports symptoms of hyperthyroidism, including heat intolerance, hyperhidrosis, anxiety, and palpitations.

Rare patients with autoimmune thyroid disease can transition from Hashimoto's thyroiditis to Graves' disease, due to the development of antibodies that stimulate the TSH receptor. I would discontinue levothyroxine and measure TSH receptor antibodies as well as TSH, free T4 and T3 levels.

Two months later, despite the second levothyroxine dose reduction, her symptoms persisted. Labs showed a TSH >0.01, free T4 of 7.2 ng/dL, and T3 of 414 ng/dL (79-165 ng/dL). Her levothyroxine was discontinued, and TSH receptor antibody levels returned positive with a thyroid stimulating immunoglobulin index of 3.3 (reference >1.3). She was diagnosed with Graves' disease and prescribed methimazole and propranolol. At a follow-up visit six months after her Graves' disease diagnosis, her hyperthyroidism symptoms continued to slowly improve.

EH: *"Some daily symptoms are improving; I am not constantly sweating anymore, but I still feel brain fog at work. My symptoms with Nordic skiing persist, the palpitations have decreased, but now I get a headache when I go hard (at what would have been an easy, conversational pace two years ago). I think this is because of my current dose of propranolol. My goal is to do a running race in a few months but I'm not sure when it is okay to start doing intervals/training."*

Discussion

This case illustrates a rare clinical phenomenon of rapid progression from autoimmune hypothyroidism (Hashimoto's thyroiditis [HT]) to autoimmune hyperthyroidism (Graves' Disease [GD]). A meta-analysis of 50 similar cases found patients typically progress to GD years to decades after their HT diagnosis.[1] The same meta-analysis described only two cases where patients developed GD within one year of diagnosis of HT (both cases occurred within two months of initial presentation). Our patient developed GD nine months after HT diagnosis, with clinical evidence of hyperthyroidism within six months of HT diagnosis. Limited

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data suggest that progression from HT to GD may be associated with smoking, and personal or family history of autoimmune disease;[2] our patient did *not* have either risk factor.

Autoimmune thyroid disease symptoms can vary depending on the relative amounts of the specific TSH receptor antibodies (TRAbs) present.[3] A recent case report and literature review suggests that HT and GD can coexist with varying levels of thyroid stimulating antibody (TSAb) and TSH-stimulation blocking antibody (TSBAb).[4] Hypothyroidism or hyperthyroidism symptoms subsequently manifest depending on the predominant antibody type at that time.[4] As many as 9% of HT patients are positive for TSAb,[5] suggesting that early or concurrent positivity of TSAb does not necessarily predict development of GD. It remains unclear by what mechanism patients develop GD after HT, especially in such an abbreviated time.

Our report, written in partnership with the patient (EH), underlines the substantial physical and emotional toll of this condition. This highly active patient experienced significant limitations in exercise and mental clarity. Her quality of life and ability to pursue her passions remain significantly impacted. Her experience illustrates a rare clinical syndrome and highlights the human burden that arose from what initially was a straightforward and commonly addressed problem. SGIM physicians should remember that while common presentations are typical, physicians must maintain a broad differential for common issues.

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ANOTHER BIG HURDLE FOR FIRST-GENERATION PHYSICIANS: IMPLICATIONS OF THE BIG BEAUTIFUL BILL ACT ON FUTURE PHYSICIANS

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The One Big Beautiful Bill Act (later referred to as the "Act") is a comprehensive piece of legislation with far-reaching healthcare consequences.[1] The media extensively covered the Medicaid work requirements and the expiration of premium tax credits for the Affordable Care Act marketplace. Less attention has been paid to other impacts from this legislation, including changes to federal student loans that will directly impact medical students. This legislation introduces two particularly alarming provisions: a lifetime borrowing limit of $200,000 for professional programs (including medical school) and the outright elimination of the Grad PLUS loan program for new borrowers effective July 1, 2026.[1] These provisions, if enacted, would have devastating consequences. They would severely impact future first-generation physicians as well as students from low-income backgrounds who cannot afford the exorbitant cost of medical school without the vital support of student loans. In this article, I offer my perspective as a first-generation physician on the financial obstacles that currently exist in medical education and discuss how the Act creates an insurmountable barrier, exacerbates existing disparities, and undermines the accessibility of the medical profession.

As a first-generation physician, I experienced the financial struggles many aspiring medical professionals face. My journey began below the poverty line, with my family relying on Social Security survivor benefits after my father's passing when I was 15 years old. The path to medicine, unbeknownst to me then, would be riddled with financial hurdles.

The cost of becoming a physician begins before acceptance to medical school with exam preparation and application fees. I was fortunate to have won a Medical College Admission Test (MCAT) preparation course at a pre-med event. The MCAT is a crucial component of the medical school application process; I would not have been able to afford the same preparation tools as my peers without this opportunity. To complete the medical school application process, I relied on fee waivers, a necessity that allowed me to pursue my dream of medicine but limited the number of applications I could submit. There are also indirect costs of building a medical school application, such as dedicating time for volunteer experiences and shadowing. These choices can be particularly challenging for students from lower-income backgrounds who may need to work to cover ongoing educational expenses. The Association of American Medical Colleges (AAMC) reports that only 12-15% of medical students are first-generation, and the cost of applying to and attending medical school contributes to this statistic.[2] Since my time as an applicant, the competition for medical school matriculation has increased substantially. Decisions, such as limiting one's number of applications or choosing a paid non-clinical job over unpaid shadowing, are financially prudent. However, these decisions undeniably disadvantage applicants with less financial means.

In 2025, the average cost of attendance for a four-year in-state public medical school was $286,454.00, and more for private schools.[3] Both of these costs are well above the new lifetime borrowing limit set by the Act. In both college and medical school, I received a combination of need-based grants and merit-based scholarships. Despite attending in-state institutions, the cumulative burden of tuition and living expenses resulted in a significant student loan debt of $180,000.00 by the time I graduated in 2012. This figure, daunting as it is, pales in comparison to the current financial landscape for medical students. The rising cost of medical education poses a substantial barrier for talented individuals from diverse socioeconomic backgrounds, threatening to limit the medical profession to only those who can afford it.

My firsthand experiences and the escalating costs of medical education fuel my deep concern regarding the Act. My journey to medicine was nearly derailed by financial barriers. As I consider the profound implica-

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tions of the Act, I renew my commitment to advocate for policies that ensure medical education remains accessible to *all* qualified individuals, regardless of their socioeconomic background. Across SGIM, advocacy efforts are being encouraged. The Health Policy Education Subcommittee maintains its dedication to ensuring access to financial aid, including student loans through collaboration with other stakeholder organizations. Membership in the Health Policy Interest Group is growing. A Grassroots Advocacy Toolkit[4] has been added to SGIM's resource library. SGIM members are equipped with the tools to advocate for policies that protect medical education and cultivate a highly skilled primary care physician workforce capable of serving the needs of all communities.

As we enter 2026, these changes to federal student loans will impact the incoming class of future physicians. I urge SGIM members to advocate for policies at their institutions that will support first-generation students despite these federal changes. These include transparency about the actual cost of attendance, financial aid counseling prior to matriculation, and prioritization of need-based scholarships. Not addressing this issue risks exacerbating the financial challenges faced by first-generation students to an unmanageable degree.

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