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SGIM FORUM

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ANNUAL MEETING UPDATE

BEYOND THE MARBLE STEPS: REDEFINING ADVOCACY AT THE 2026 SGIM ANNUAL MEETING

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When internists hear the word "advocacy," a specific taxonomy of images often fills the mind of SGIM members. We imagine "Hill Day": crisp early morning flights to Washington, DC, dress shoes clicking against marble steps, and hurried walks through the humidity to Capitol Hill. We think of the polished "elevator pitch" delivered to a legislative aide, the orchestrated letter-writing campaigns, the fiery op-eds, and the high-level policy statements drafted in boardrooms. This is "Capital-A" Advocacy. It is bold, public, and undeniably necessary. It is the mechanism by which we move the heavy levers of federal funding, GME support, and healthcare policy. However, if that is the only lens through which members view advocacy, we overlook the power inherent in our identity as General Internists. We risk creating a dichotomy where "advocacy" is something we do *outside* of our work—on a scheduled Tuesday in November—rather than recognizing it as the marrow of our daily work.

As we look toward SGIM26: Individual Voices, Collective Impact (#SGIM26), we aim to expand members' views regarding advocacy. We must recognize that as internists, we hold the key to a distinct and potent form of advocacy—one that relies not only on lobbying but also the accumulation of deliberate acts of excellence. This article explores how SGIM members can be advocates in their work as educators, clinicians, and investigators.

The Educational Imperative: Advocacy as Pedagogy

One of the most potent keys we hold is our influence over the next generation of physicians. Advocacy in medical

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education is rarely about teaching students how to write a letter to a senator; rather, it is about teaching them what are important foci for advocacy.

For decades, medical education focused on "cultural competency"—a framework that reduced systemic issues to individual traits. One example of advocacy in medical education is the shift toward upstream drivers of health. When a Director of Medical Education insists on integrating Social Determinants of Health (SDOH) not as a sidebar, but as a physiological force equal to the Krebs cycle, that is advocacy. Education becomes advocacy when it trains clinicians to recognize that poverty, racism, and housing instability are not problems to delegate to social workers, but medical conditions requiring clinical attention.

> **"We must recognize that while our voices may be distinct, when raised together in the service of General Internal Medicine, they create a resonance that cannot be ignored. The 2026 Annual Meeting theme 'Individual Voices, Collective Impact' invites you to bring your specific version of advocacy to the table."**

Consider the educator who redesigns a residency rotation to move beyond the biomedical management of Diabetes Ketoacidosis (DKA). Instead of solely presenting a patient with recurrent DKA as a failure of "compliance," the team maps the patient's neighborhood food deserts and transportation reliability. This shifts the clinical gaze from individual blame to structural etiology. By shifting the frame for 20 residents, that educator advocates for the thousands of patients those residents will treat over their careers.

As SGIM members, we must advocate through the hidden curriculum of those we uplift. This is most visible in the intentional mentorship of Underrepresented in Medicine (URiM) trainees. By acknowledging that a diverse physician workforce is fundamental to improving communication, trust, and clinical outcomes, we transform the act of mentorship into a high-yield advocacy intervention. The attending physician who spends an extra hour helping a URiM intern navigate a research proposal is not merely "teaching"—they are actively advocating for the health equity of the future patient population.

The Clinical Encounter: The Micro-Advocacy of the Exam Room

If medical education shapes the future, the clinical encounter defends the present. As internists, we are detectives of the human condition, seeing systemic friction points and safety-net holes long before policymakers do.

We often view administrative burdens—paperwork, peer-to-peer discussions—as the antithesis of "real work." Yet, reframing these acts reveals a hidden landscape of advocacy. When an internist spends 40 minutes on hold to overturn a medication denial, it is not merely drudgery, but a declaration that a patient matters more than a corporate algorithm—"clinical tenacity" shielding the vulnerable.

Consider language access. We know professional interpreters reduce errors, but time pressures often deter their use. The hospitalist who pauses busy rounds to wheel in a video interpreter for a patient nodding without understanding is doing more than communicating: they are advocating for autonomy against the institutional pressure of efficiency.

These moments are rarely captured in Curricula Vitae or Relative Value Units, nor do they lead to Capitol Hill. They constitute instead the moral fiber of our profession, representing the "Individual Voice" fighting for the dignity of the patient in front of them.

The Research Path: Giving Data a Voice

Researchers play a unique role in advocacy. Writing a grant to study a disease or delivery system involves persuasion, and reviewers must be convinced the topic is critical. Meeting with program officers and regulatory committees requires researchers to advocate for their studies to create knowledge that impacts patients.

For example, when a researcher in Pittsburgh identifies a disparity in kidney transplant allocation, that is an individual insight. But when that data is presented at SGIM, validated by peers, and amplified by SGIM's collective voice, it can become a guideline. When it becomes a guideline, it can alter practice patterns in Seattle, Austin, and Boston. The individual voice of inquiry becomes a collective impact on equity.

Harmonizing Voices: The Role of #SGIM26

The danger of focusing on the "individual voices" of the quiet mentor, the tenacious clinician, or the curriculum designer is the potential for fragmentation. A thousand doctors shouting into the wind may remain unheard. This is where the theme of SGIM's upcoming Annual Meeting (#SGIM26)—Individual Voices, Collective Impact—becomes relevant. t#SGIM26 is not merely a celebration of the solo practitioner doing good work. It is also an inquiry into how we harmonize these voices to create systemic resonance. Let's make this 2026 Annual Meeting our amplifier.

When we convene in 2026, we gather to synergize our distinct versions of advocacy. We need the "Hill

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Day" advocates to fight for GME funding, and we need the curriculum designers to ensure that funding trains physicians who understand structural racism. We need health services researchers to generate the data that lobbyists carry to Congress. And we need frontline clinicians to remind us of the human stakes involved.

A Call to Reclaim the Narrative

As we approach #SGIM26, we invite members to reflect on their definition of advocacy with deep introspection. Look at the "mundane" aspects of your week—the e-mails sent, the lessons taught, the extra minutes spent listening—and re-classify them:

- If you are fighting for a patient's dignity in the face of a denial letter, you are an advocate.
- If you teach a new subject so trainees can better care for specific populations, you are an advocate.
- If you rewrite a lecture to be more inclusive, you are an advocate.
- If you use data to shine a light on inequity in your hospital system, you are an advocate.

The 2026 Annual Meeting theme of "Individual Voices, Collective Impact" invites you to bring your specific version of advocacy to the table.

SGIM members should come together to share not just our science, but our strategies for change. We must recognize that while our voices may be distinct, they create a resonance that cannot be ignored when raised together in the service of General Internal Medicine. This is how we advocate excellence—not just for the profession we love but also for the patients who trust us with their lives.

Our #SGIM26 plenary lineup reflects this passion for change, highlighting three leaders representing the full spectrum of advocacy: Dr. Sondra Zabar redefining medical education, Dr. John Balbus driving legislation and planetary health, and Dr. Kevin B. Johnson transforming practice through Artificial Intelligence.

Bring your critical advocacy issues to #SGIM26 as we join our collective voices to advocate for GIM. We are moving beyond the marble steps of the Capitol and recognizing that the ground regarding advocacy is everywhere we stand. SGIM

FROM THE EDITOR

THE ART OF MENTORING: RULES AND ROLES FOR MENTORS AND MENTEES

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

"The delicate balance of mentoring someone is not creating them in your own image but giving them the opportunity to create themselves."[1]

Reflecting on my professional journey, my first mentoring relationship started with high school guidance counselors who helped provide me with a steady path to navigate the academic year. There were no long-term discussions about what I wanted to be or where I would go to college. The focus on the "here and now" provided the information and encouragement to survive ninth grade. As high school progressed and college decisions approached, the guidance sessions transitioned to both short-term and long-term goals which included surviving and thriving in high school with additional focus on college preparation. In retrospect, these scheduled and required mentoring sessions met my needs at that time.

In college, there were few mandated mentoring sessions. The only scheduled requirement was the annual meeting with the assigned college counselor to ensure students were on track for graduation. For me and many others, this started the process of identifying mentors to guide us along the path of personal and professional development. College and medical school professors were willing to lend an ear and provide guidance once I recognized I was not "bothering them." I learned that a career in academics comes with an expectation of mento-

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ring students, colleagues, and even our patients. Those early self-generated appointments for guidance (e.g., surviving organic chemistry, medical school application, residency decision, and academic progression) would have been more productive if I better understood my role as a mentee. When individuals started seeking my guidance as a mentor, I realized I needed more information to better help my mentees. In this article, I provide guidance on rules and roles for mentors and mentees to yield the maximum benefits and a productive relationship.

> **"Mentoring is the essence of SGIM. These personal connections drive members to proclaim 'SGIM is my professional home.' I challenge every SGIM member to pay it forward and be a mentor."**

The Role of Mentoring

Arranged or pre-selected mentor-mentee relationships may serve a short-term purpose but are less likely to lead to long-term relationships. Being assigned as the "big brother" for the new high school student or the assigned mentor for the new employee may meet the goals for orientation or starting a position. But unless there are common goals or interests, these arranged relationships struggle to maintain longer term connections.

When mentoring is not mandated, the burden of establishing mentorship falls on the mentee. A mentor can offer advice that may lead to a mentoring relationship, but the mentee must acknowledge their receptiveness to a mentoring relationship and the guidance offered. This self-awareness of needing mentorship is the critical first step in fostering a mentoring relationship. For the mentee, the recognition that mentors are willing to share their time and wisdom occurs gradually. The "I am bothering them" or "they don't have time for me" theme is a common barrier to initiating the first conversation to seek mentorship. The reality is that these individuals achieved success due to effective mentorship. Realizing that most individuals will share advice is an important aspect of being a good mentee.

Finding the right mentor is a different challenge. Understanding the "ask" is essential to the successful mentor-mentee relationship. The mentee must identify the specific assistance they seek to strategically select the mentor best suited to meet their needs. Mentors have individual strengths and weaknesses, so a strategic mentor selection starts with identifying the underlying questions for which guidance is sought.

Recognizing that multiple mentors can provide answers for different questions can be career altering. Successful individuals often have mentors for personal and professional development. However, there will be times when a mentee needs additional mentors to answer specific questions and offer advice. The successful mentor needs to be transparent in communicating their lack of experience and knowledge when they do not possess that expertise. Since mentoring basics include listening and asking thought provoking questions, there may still be benefits to a conversation. Successful mentors will recommend multiple mentors to meet the varied needs of the mentee.

There are common rules of engagement that should be utilized when establishing mentoring relationships. These include:

- *Confidentiality is paramount:* Information discussed during mentoring sessions should not be shared without the permission of the other party.
- *Set scheduled meetings knowing that "life happens":* Meetings should be scheduled so they are a priority for both parties with protected time. But life happens and scheduled meetings get cancelled. A prescheduled back up meeting creates an option that can be cancelled if not needed.
- *Avoid distractions:* If the meetings are virtual, devote complete attention to the meeting with no multi-tasking. For in-person meetings, select areas where neither party will be interrupted.
- *Acknowledge the end:* If reached, both sides should acknowledge the end of or pause in the mentoring relationship (understanding that it might resume in the future) so there is a mutual understanding.

These basic concepts will form the foundation of any mentoring relationship.

Roles and Rules for the Mentee

"Believe it's possible for you, and seek out models, mentors, and coaches."[2]

- *Seek mentors with shared interests in areas you are seeking guidance:* Strategically select the mentor who can best give advice on the pressing topic.
- *Be prepared:* Prepare a meeting agenda that can be shared with the mentor prior to each mentoring session.
- *Know your "Ask":* Identify your questions and why the mentor was selected. Use this as the North Star for the relationship even as other topics are covered.
- *Respect the time/boundaries of the mentor:* Mentors have busy schedules. Set meeting times and duration. If additional meetings or added time are needed, politely ask for more with the understanding that this may not happen.
- *Seek guidance from other mentors as needed:* Successful mentees have internal and external men-

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tors for specific purposes. My first section chief was a mentor but insisted I develop external mentors. They stated there could be times when they needed to make decisions in the best interest of the section which might not be in my best interest. This recognition made me seek external mentors to guide my professional development.

- *Provide feedback to the mentor for advice offered:* Share what worked or did not work from their guidance. This helps the mentor adjust their guidance to better assist the mentee.
- *Pay it forward—Recognize your potential as a mentor:* Everyone has strengths that can be shared with others. A resident can be a successful mentor just like a faculty member.

The mentee has significant work to ensure the meeting is productive and beneficial.

Roles and Rules for the Mentor

"The mediocre mentor tells. The good mentor explains. The superior mentor demonstrates. The greatest mentors inspire!"[3]

- *Be honest:* This is a must for a good relationship.
- *Listen attentively and ask clarifying questions:* A productive mentoring relationship involves bidirectional communication. Suboptimal mentoring involves unidirectional advice from the mentor to the mentee without understanding and confirming mentee needs. Employ open ended questions before narrowing down to specifics.
- *Provide feedback that is direct:* Offer positive guidance and identify opportunities where things could have been done differently.
- *Share personal stories illustrating the offered feedback:* Stories can be easier to remember and implement than delivery of guidance via facts and abstract concepts.
- *Recognize the mentee as an equal:* In mentoring relationships, both parties should be equal even though differences exist outside of the relationship. Neither party should benefit at the expense of the other.

The mentor provides guidance and feedback for productive relationships.

Mentoring Models

There are many successful models for initiating and continuing successful mentoring relationships. The Five Cs Model of Mentoring (Challenges, Choices, Consequences, Creative Solutions, Conclusions) provides multiple questions that can be used when establishing a mentoring relationship.[4] Developing and maintaining a mentoring relationship requires dedicated time and invested efforts by the mentor and mentee.

Conclusion

I have personally participated in several SGIM mentoring programs as a mentor and a mentee, including the Annual Meeting One on One Mentoring program, peer mentoring, and serving as a LEAD mentor. Mentoring is the essence of SGIM in which these personal connections drive members to proclaim "SGIM is my professional home." I challenge every SGIM member to pay it forward and be a mentor. I hope my shared advice will help foster improved SGIM mentoring relationships. As acclaimed actor Denzel Washington notes: "Show me a successful individual and I'll show you someone who had real positive influences in his or her life. I don't care what you do for a living—if you do it well, I'm sure there was someone cheering you on or showing the way. A mentor."[5] Many SGIM members are successful today because of their influential mentors along the way.

References

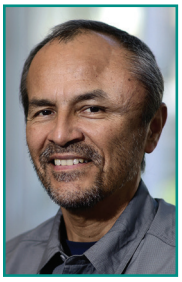
1. Wise K. 20 inspiring mentoring quotes: (see quote 4, Steven Spielberg). *Mentor Resources*. https://www.mentorresources.com/mentoring-blog/20-inspiring-mentoring-quotes. Published May 7, 2020. Accessed January 15, 2026.
2. Usanmaz O. Mentorship quotes: 100+ inspirational insights for growth & leadership (see quote 23, Jack Canfield). *Qooper*. https://www.qooper.io/blog/30-best-inspiring-mentor-quotes-to-motivate-you. Published October 14, 2025. Accessed January 15, 2026.
3. Usanmaz O. Mentorship quotes: 100+ inspirational insights for growth & leadership (see quote 13, LB Traynor). *Qooper*. https://www.qooper.io/blog/30-best-inspiring-mentor-quotes-to-motivate-you. Published October 14, 2025. Accessed January 15, 2026.
4. The Five Cs Model of Mentoring. *Scribd*. https://www.scribd.com/document/146051006/The-Five-Cs-Model-of-Mentoring#:~:text=Mentoring%20Model%20Explained-,The%20document%20describes%20the%20Five%20Cs%20Model%20of%20Mentoring%2C%20which,%2C%20Creative%20Solutions%2C%20and%20Conclusions. Accessed January 15, 2026.
5. Wise K. 20 inspiring mentoring quotes: (see quote 10, Denzel Washington). *Mentor Resources*. https://www.mentorresources.com/mentoring-blog/20-inspiring-mentoring-quotes. Published May 7, 2020. Accessed January 15, 2026.

SGIM

CHARTING NEW PATHS: HOW FIRST-GENERATION DOCTORS FOUND THEIR HOME IN SGIM

Carlos Estrada, MD, MS, FACP
President, SGIM

"As SGIM President, I am preoccupied with finding ways to build communities, whether virtual or in person.... I encourage SGIM members to make time to get to know other members during virtual and in-person meetings—these interactions strengthen individual relationships and our organization."



In a prior SGIM Forum article, I highlighted families consisting of multiple SGIM members and shared my path to medicine as the first in my family to become a doctor.[1] In this article, first-generation SGIM physicians share their stories of what drew them to medicine, how SGIM shaped their careers, and a fun fact about themselves (**FF**). I hope you draw inspirational lessons from the stories of these amazing first-generation female physicians who have achieved remarkable success in their careers.

Emily N. Bufkin, MD (Assistant Professor, University of Texas Southwestern Medical Center)

In high school, I worked at The Mustard Seed—a Mississippi faith-based community for adults with intellectual and developmental disabilities (IDD). This experience led me to medicine and guided me to Med-Peds. My passion in caring for young adults with special healthcare needs is why I volunteer with Special Olympics Texas and focus my academic work on improving trainee education in IDD and neurodiversity.

SGIM has been a warm and welcoming academic home. Through SGIM, I found collaborators nationwide who inspire and teach me, while sharing a commitment to person-first care. I look forward to regional and national meetings to reconnect with familiar faces and build new friendships. SGIM consistently reminds me I'm never doing this work alone.

FF: In my office, I proudly display a vibrant painting from the Seedsters (young adults from the Mustard Seed). It makes me smile—grounding me in what drew me to medicine and keeps me well.

Laura C. Hart, MD, MPH (Assistant Professor, The Ohio State University College of Medicine)

When I chose to pursue medical school, I had a grandfather, uncle, and two aunts who were pharmacists—but I decided to chart my own path, "going rogue" if you will. During my primary care research fellowship after residency, my grandmother asked why I was "going backwards" since a master's is "lower" than an MD. My family loves and supports me, but they don't always "get me."

SGIM gave me the support to know I was charting the right course, even when it differed from others' expectations. I love the blend of clinical time and research that academic primary care offers. With help from SGIM mentors—including one from the SGIM One-on-One mentoring program—I've navigated to an amazing job.

FF: My grandfather filled a prescription called in by his granddaughter, the doctor.

Jennifer Haas, MD, MSPH (Professor, Harvard Medical School)

I knew early on that I wanted to become a doctor—not from family influence, inspiring role models, or a desire to help humanity. My motivation was simpler: I wanted to escape the instability I grew up with and recognized that medicine could provide the economic and personal security I craved.

I never anticipated I would find a research and primary care career that allows me to collaborate with individuals to improve their health while studying populations to advance access, equity, and better outcomes. For nearly 40 years, SGIM has been my professional home. It was where I first presented research and remains the meeting I most anticipate each year to reconnect with colleagues. At a time when my core principles are threatened, I'm proud to belong to an organization that reflects my values.

FF: I am a weekend printmaker.

Kathryn M. Humes, MD (Assistant Professor, Wellstar Medical College of Georgia Health)

I was nine when my grandmother had a stroke. I witnessed her progressive neurological findings, then watched her decline in hospice. As she also struggled with alcoholism, I saw my family balance caregiving with resentment

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over her choices, which exposed me to complex family dynamics. This experience inspired me to help families navigate difficult medical and social decisions, which led to my current role as an academic hospitalist.

SGIM has been my community of academic internists committed to serving vulnerable populations and teaching future physicians. The Academic Hospitalist Academy was transformative, inspiring my career commitment while connecting me with colleagues nationwide to advance our profession together.

FF: I danced on Wake Forest's varsity team for three years on a scholarship. My favorite memory was being courtside when our men's basketball team hit a buzzer-beater three-pointer to win their national tournament game in New Orleans—the entire tournament experience was unforgettable!

Saloni Kumar Maharaj, MD (Assistant Professor, Stanford University)

My parents (a father in engineering and a mother in education) immigrated from India seeking better opportunities. They instilled values of learning, caring for others, and service that profoundly shaped me. Growing up in a family navigating a new country, I was drawn to medicine for its meaningful work and the opportunity to care for people at their most vulnerable, thus carrying forward my parents' values while serving my community.

SGIM was the first national society where I found my voice as a new faculty. I developed as a regional leader, served as president, and then joined the annual meeting planning committee. SGIM connected me with mentors who challenged me, gave me confidence to pursue my ideas, and enabled cross-institutional collaboration. It has been central to shaping me as a clinician, educator, and leader.

FF: I was co-captain of my college Bollywood dance team. I loved being able to bring people together to create, dance, and celebrate our culture.

Kira L. Ryskina, MD, MSPH (Associate Professor, University of Pennsylvania)

I grew up surrounded by engineers and teachers. I trace my interest in medicine to early childhood when my infant brother suffered a vitamin D overdose due to a prescribing error, leading to home visits from an inspiring woman pediatrician. Nevertheless, my path to medicine was circuitous, including professional ballet and management consulting.

My interest in GIM was sparked by reading a book on primary care and working for a solo practitioner in college. Since medical school, I consider SGIM my professional home finding mentors, collaborators, and growth opportunities including chairing the SGIM Research Committee.

FF: My family immigrated from Baku, Azerbaijan (USSR at the time) to the United States the summer before I started high school. During a summer job, I made deliveries to Bruce Springsteen's house!

Carla L. Spagnoletti, MD, MS (Professor, University of Pittsburgh School of Medicine)

Per my mom, I spoke about becoming a doctor around age seven—peculiar since no one in my family was in medicine. My mom worked in an office by day and as a

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waitress by night; my dad was a detective. I remember my family doctor who rewarded my bravery with lollipops after each vaccine. In college, I shadowed him for dozens of hours, admiring his warmth, problem-solving, and independence—confirming my interest in primary care.

As a medical student, my attending said I "think like an internist" and encouraged me to submit a clinical vignette to SGIM, which became my professional home. Over 25 years, I've presented countless posters and workshops, reviewed hundreds of abstracts, served on JGIM's editorial board, chaired the Education Committee, and engaged fellows and junior colleagues in serving the organization. SGIM has inspired me to explore all facets of academic medicine: clinician, teacher, mentor, scholar, administrator, and leader.

FF: I worked on a farm as a teenager and learned to drive a tractor before learning to drive a car!

Erica Swanson, MD (Assistant Professor, Indiana University School of Medicine)

I was drawn to medicine early. In 2001, I watched physicians care for 9/11 victims on television and welcomed my brother's birth. I saw my family trust surgeons for my grandfather's open-heart surgery and watched doctors

These personal images shared by SGIM first-generation physician members demonstrate what brings joy to these members. From top left, clockwise: Saloni Kumar Maharaj enjoying nature near Donner Lake, California. Kathryn M. Humes (far right) on front porch with her family. Erica Swanson visiting the gorgeous mountainside of Cameron Highlands, Malaysia. Jennifer Haas (center, holding pole) hiking with her family. Emily N. Bufkin enjoys this painting from the Seedsters, a faith-based community group. Laura C. Hart with her son on his first international flight! Kira L. Ryskina (far left) with classmates from her 15th medical school reunion. Carla L. Spagnoletti (center, with bunny ears) celebrating with some of her former Academic Clinician-Educator Scholars (ACES) fellows.

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guide my other grandfather through his final cancer months. Their intelligence, calmness, and kindness inspired me. That Halloween I told my mom, "I want to take care of adults"—not knowing I'd later become a general internist doing exactly that.

SGIM has been central to my growth. At my first national meeting as a third-year resident, I thought, "These are my people." SGIM has given me mentors, collaborators, and a professional home, opening doors to leadership roles and renewing my commitment to advocating for patients and colleagues.

FF: I've recently begun learning pottery, and it's been a fun, creative outlet for me.

Summary

These personal narratives reveal both individual passion and SGIM's vital role in supporting professional growth. As SGIM President, I am preoccupied with finding ways to build communities, whether virtual or in person. During Council meetings, we take deliberate breaks to connect and get to know each other. This allows SGIM leaders to bring the human aspect to our work. It is more fun and much easier to work with people you know. I was pleasantly surprised to learn that at least 10 members of SGIM Council are the first in their families to enter medicine! I encourage SGIM members to make time to get to know other members during virtual and in-person meetings as these interactions strengthen individual relationships and our organization.

References

1. Estrada C. Professional home, Family bonds: Celebrating SGIM's medical families. SGIM Forum. https://www.sgim.org/article/professional-home-family-bonds-celebrating-sgims-medical-families/. Published December 2025. Accessed January 15, 2026.

SGIM

FROM THE SOCIETY

REFLECTIONS ON THE UNIQUE VALUE OF SGIM

Eric B. Bass, MD, MPH

Dr. Bass (basse@sgim.org) is the CEO of SGIM.

As an organizational member of the Council of Medical Specialty Societies (CMSS), SGIM leaders recently participated in a CMSS survey designed to assess the value of medical professional societies to their members.[1] The survey was completed by members of the CMSS CEO Council, CMSS Professional Peer Groups, and participants in the CMSS Governance and Leadership Excellence Across Medicine (GLEAM) Program. Four themes emerged from the survey that merit consideration of the following questions about how to maximize the unique value of SGIM to our members.

Theme One: What should be done to enhance the value of SGIM's programs for continuous professional development?

The survey results emphasized the importance of having professional development resources and support throughout the careers of members, from training through retirement. Respondents indicated that they expect societies to provide access to content from unbiased experts using leading-edge educational methods that promote collaborative learning.

SGIM seeks to provide an array of career development programs that are relevant to the roles of members in our mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine.[2] Current programs include the following offerings:

- *ACLGIM's LEAD program:* for junior- to mid-career faculty who wish to strengthen their leadership skills.
- *ACLGIM's Unified Leadership Training for Diversity (UNLTD) program:* for junior and senior faculty committed to diversifying leadership in academic organizations.
- *Leadership in Health Policy (LEAHP) program:* for those who aspire to be leaders in health policy advocacy.
- *TEACH certificate program:* for junior clinician-educators to refine their teaching skills.
- *MedEd Scholarship Faculty Development Program:* for clinician-educators who wish to catalyze and disseminate innovative scholarship.

- *Career Advising Program:* to help junior- and mid-career faculty navigate academic advancement.
- *Academic Hospitalist Academy Programs: Launching Your Career,* or those newer to academic hospital medicine, and *Advancing Your Career,* for leaders to strengthen their leadership capabilities, teaching effectiveness, and scholarly pursuits.
- *JGIM Editorial Fellowship:* to enhance editorial and academic writing skills.

Although most of the programs were designed for members early in their careers, members farther along also benefit from participation in their roles as mentors and members of the networks created by the programs. Together, these programs reflect SGIM's commitment not only to skill-building but also cultivating a vibrant, interconnected community of academic general internists.

Theme Two: What should be done to enhance the value of networking, community, and leadership opportunities?

Survey respondents highlighted the importance of having a professional home that offers lifelong connections to a professional community with mentoring available across career stages. Members also want opportunities to develop leadership skills and advance in their roles within the professional society.

SGIM's career development programs have created strong networks within the organization. These networks help to nurture an ongoing sense of community valued by participating members. The programs also create many leadership and mentoring opportunities.

In recognition of the importance of providing members clear, equitable opportunities to pursue leadership positions within the organization, SGIM's Council formed a Leadership Pathway Workgroup to develop welcoming, transparent, inclusive, and accessible pathways to regional and national leadership in SGIM and ACLGIM.[3]

Theme Three: What should be done to enhance the value of clinical resources developed by SGIM?

Respondents from participating societies reported they want evidence-based clinical resources that can be directly applied to clinical practice in a time-efficient manner. Such resources must be derived from trustworthy sources free of commercial bias.

SGIM has invested a lot of effort in developing a learning portal, GIMLearn,[4] to assemble high-quality evidence-based content on subjects of interest to our members that may not be available from other societies. Recognizing that our members have access to clinical content from many sources, the GIMLearn Editorial Advisory Board has focused on developing content most relevant to the clinical and teaching roles of academic general internists.

Theme Four: What should be done to enhance the value of SGIM's advocacy and representation of members' interests?

Lastly, survey respondents expressed strong appreciation of the power derived from having a collective voice that amplifies the concerns of individual members about specific issues relevant to their daily work. A society's advocacy efforts are most valuable when members are engaged and have opportunities to participate.

At SGIM's annual meeting in May 2025, more than 200 members attended a forum held by our Council to discuss SGIM's advocacy priorities amidst many threats to the clinical, educational, and research parts of our mission.[5] A major focus of the forum was to encourage members to engage in advocacy at individual, institutional, and professional society levels. Our advocacy is strongest when it reflects the collective expertise and engagement of our members, and I am encouraged by the growing number of members stepping into this work led by our fabulous Health Policy Committee. The committee continues to be extremely active in addressing threats and opportunities relevant to our mission.

Overall, these reflections reinforce for me the importance of continually asking SGIM's leadership team what should be done to maximize the value of SGIM to our members. I pledge to keep asking these questions.

References

1. Council of Medical Specialty Societies. Medical Specialty Society Survey Unique Value Propositions. Summary of Themes. (Personal communication)
2. Professional & career development—Programs. *SGIM*. https://www.sgim.org/professional-career-development/programs/. Accessed January 15, 2026.
3. Bass EB, Sikon AL. Q & A with SGIM's CEO and the Leadership Pathway Program chair: What we wish we learned earlier about becoming a leader in SGIM. SGIM Forum. https://www.sgim.org/article/q-a-with-sgims-ceo-and-the-leadership-pathway-program-chair-what-we-wish-we-learned-earlier-about-becoming-a-leader-in-sgim/. Published November 2024. Accessed January 15, 2026.
4. Professional & career development courses—Courses: GIMLearn. *SGIM*. https://www.sgim.org/professional-career-development/courses-trainings/. Accessed January 15, 2026.
5. Bass EB, Bussey-Jones J, Estrada C. Council's response to the SGIM25 community forum on engaging in advocacy. SGIM Forum. https://www.sgim.org/article/councils-response-to-the-sgim25-community-forum-on-engaging-in-advocacy/. Published October 2025. Accessed January 15, 2026.

SGIM

ASK AN ETHICIST: MANAGING CHALLENGING CONVERSATIONS SURROUNDING BRAIN DEATH

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For "Ask an Ethicist" articles, members of the SGIM Ethics Committee respond to real ethics cases and questions submitted by SGIM members. Responses are drafted with input from the Committee, but do not necessarily reflect the views of the Committee or SGIM. To submit a case or question, visit: https://www.sgim.org/communities/other-sgim-committees/ethics/ask-an-ethicist.

Scenario

A 62-year-old man with poorly controlled hypertension and diabetes was found unresponsive at home. He was intubated by emergency medical services due to absent spontaneous breaths and was transported to the emergency department. On arrival, his exam revealed a Glasgow Coma Scale score of 3, fixed and dilated pupils, and absent brainstem reflexes. A CT scan demonstrated extensive bilateral cerebral infarctions with transtentorial herniation.

> **"SGIM members can provide compassionate care by engaging surrogates early, clearly explaining the methods and risks of confirmatory testing for brain death, and being mindful of working WITH the families through these difficult decisions."**

The neurology and critical care teams evaluated the patient and suspected brain death. Initial assessments showed no respiratory effort on mechanical ventilation, and repeated cranial nerve testing confirmed the absence of neurologic function. Following institutional protocol, the team recommended confirmatory testing, including an apnea test and ancillary studies such as cerebral angiography or EEG, to definitively establish brain death.[1]

However, the patient's family members adamantly refused confirmatory testing despite multiple discussions clarifying the legal and physiological rationale for testing. The family cited strong religious convictions that a person with a beating heart is alive and insisted that the apnea test not be performed. In this article, members of the SGIM Ethics Committee address the question posed to the hospital's Ethics Consult Service on how to proceed with brain death assessment when a family refuses the apnea test.

Analysis

Determination of brain death in the United States was standardized in 1980 under the Uniform Determination of Death Act. This Act states that biological death can be diagnosed via either the irreversible loss of cardiorespiratory function or the irreversible loss of all functions of the entire brain ("brain death").[1] The diagnosis of brain death requires a protocolized evaluation to detect any remaining neurologic function.[2]

Families are informed about the potential outcomes of catastrophic brain injury. Medical teams communicate that if a patient is clinically determined to be brain dead, they will proceed with withdrawal of all somatic support. The team usually does not seek explicit consent for the neurologic evaluation because these exams are seen as an extension of standard care.[2]

This case presents a challenging ethical dilemma. Here, the family is not uninformed but actively objects to the apnea test. The apnea test, often necessary for confirming brain death, also carries risks of hypercarbia and potential hemodynamic instability. This can worsen cerebral ischemia and paradoxically push a patient with severe, potentially reversible brain injury into brain

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death. Ethicists argue that informed consent from a surrogate decision maker should be ethically required for apnea testing because of the risk of these complications.

Although legal guidance supports proceeding with confirmatory testing for brain death, doing so without addressing families' concerns can undermine trust and worsen distress in an already emotional situation. The medical team could pursue several strategies in this case. It could be helpful to start by approaching the family non-confrontationally and attempt to understand their perspective. In addition to their religious convictions, are there other reasons for the family's objection to further brain death testing? They may be resisting the diagnosis of brain death itself or frustrated with other aspects of the patient's care. They may also be struggling to cope with their loved ones' deterioration and need more time to come to terms with what happened.[3]

In some cases, families might fundamentally disagree with the law and clinical practice regarding brain death determination. Johnson and Westphal point out that, while brain death has been part of professional medical practice and decision making since 1968, many Americans still do not understand or support the practice from cultural or religious perspectives.[4] While adherents to several religious traditions do not see brain death as consistent with their belief system, each individual case must be approached on its own basis. Pre-conceptions about religious and cultural practice often break down in the face of real-world complexity.

Johnson and Westphal suggest a four-step approach to working with families: Appreciation, Accommodation, Negotiation, and Explication.

1. **Appreciation:** *Involves understanding the patient's and family's values, beliefs, and preferences through respectful inquiry, avoiding unnecessary attempts to change their cultural or religious practices, and consulting religious leaders when needed.*
2. **Accommodation:** *Focuses on fulfilling patient and family requests, when possible, such as facilitating religious rituals while carefully considering legal and ethical implications for requests that conflict with medical standards.*
3. **Negotiation:** *Emphasizes fostering two-way communication to find mutually acceptable solutions that respect the family's beliefs and the medical team's obligations, often involving cultural or religious leaders to mediate and bridge understanding.*
4. **Explication:** *Used as a last resort when no reconciliation is possible, requiring clinicians to clearly explain the medical and legal rationale behind their decisions while continuing to show respect for the family's beliefs and providing support during the mourning process.*

This four-step process acknowledges families' deeply held beliefs, communicates with compassion, and involves religious leaders when appropriate while also prioritizing medical and legal responsibilities.

State law and institutional policy often provide guidance on brain death determination and managing somatic support. For example, the Texas Health and Safety Code states that if artificial means of support preclude the determination of spontaneous respiratory and circulatory cessation, a person is declared dead "when, in the announced opinion of a physician, according to ordinary standards of medical practice, there is irreversible cessation of all spontaneous brain function."[5] While Texas law does not provide a timeframe for withdrawing somatic support after brain death is declared, hospital policies may provide guidance. In this case, the hospital policy allowed for 24 hours from the time of brain death before somatic support would be withdrawn. While the medical team may be legally authorized to withdraw somatic support immediately after brain death determination, allowing families additional time with their loved one, when possible, can be a gesture of compassion. This could also allow time for discussion surrounding organ procurement, for additional family members to arrive, or for performance of cultural or religious rituals.

Case Outcome

After several additional meetings supported by the Ethics Consult Service and chaplaincy, the clinical team identified that the family's objection was rooted not only in religious belief but also in fear that the apnea test would "cause" the patient's death. With this clarification, the team shifted their approach from reiterating legal standards to addressing the family's concerns more directly. The neurologist reviewed ancillary testing options and explained that a cerebral blood-flow study could confirm the absence of brain activity without the physiologic stress associated with the apnea test. After this discussion, the family agreed to proceed with ancillary testing. The study demonstrated no cerebral perfusion, and the patient was formally declared dead by neurologic criteria. Although still grieving, the family expressed appreciation for the time the team spent understanding their viewpoint and allowing space for their spiritual practices. They accepted withdrawal of somatic support the following day and were able to perform bedside rituals before saying goodbye.

Conclusion

Discussions with family members over declarations of brain death demonstrate the tension between adherence to medicolegal standards of care and compassion towards a patient's family. Clinicians have an ethical responsi-

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bility to respectfully and compassionately manage cases involving devastating neurologic injury. SGIM members can provide compassionate care by engaging surrogates early, clearly explaining the methods and risks of confirmatory testing for brain death and being mindful of working *with* the families through these difficult decisions.

References

1. Uniform Law Commission. Uniform Determination of Death Act. *ULC*. https://www.uniformlaws.org/viewdocument/final-act-49?CommunityKey=-155faf5d-03c2-4027-99ba-ee4c99019d6c&tab=librarydocuments. Published 1980. Accessed January 15, 2026.
2. Greer DM, Kirschen MP, Lewis A, et al. Pediatric and adult brain death/Death by Neurologic Criteria Consensus Guideline (published correction appears in *Neurology*. 2024 Feb 13;102(3):e208108. doi:10.1212/WNL.0000000000208108). *Neurology*. 2023;101(24):1112-1132. doi:10.1212/WNL.0000000000207740. Epub 2023 Oct 11.
3. Franz D, DeJong W, Wolfe SM, et al. Explaining brain death: A critical feature of the donation process. *J Transplant Coord*. 1997 Mar;7(1):14-21. doi:10.7182/prtr.1.7.1.287241p35jq7885n.
4. Johnson DO, Westphal CG. Addressing religious or cultural opposition to brain death diagnosis. *J Hosp Palliat Nurs*. 2018 Jun;20(3):252-259. doi:10.1097/NJH.0000000000000435.
5. Texas Health and Safety Code § 671.001b (2017). *TCS*. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.671.htm. Accessed January 15, 2026.

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SIGN OF THE TIMES

FROM OFF-LABEL TO UNLABELED PRESCRIBING: A DANGEROUS NEW TREND?

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In clinical practice, it is common for patients to take unproven treatments, whether dubious over-the-counter supplements or prescriptions used far afield of their original labeling. It is the price to be paid in an increasingly influencer-driven health economy. However, an emerging illegal medication trend of providing unapproved medications through compounding pharmacies coordinated through telehealth or boutique clinics is worsening the already precarious landscape of unproven therapeutics.

A popular unapproved medication being readily prescribed and compounded by local pharmacies is retatrutide—a three-medication combination including glucagon-like peptide 1 (GLP-1), glucose-dependent insulinotropic polypeptide (GIP), and glucagon (GCG) agonists. A next-generation weight loss drug colloquially named *Triple G*, retatrutide is not yet approved by the US Food and Drug Administration (FDA). It is currently undergoing phase three trials by Eli Lilly to treat diabetes and obesity. Weight loss on the medication has been impressive, with a phase two double-blind trial showing an average weight loss of 24% of body weight after 48 weeks at the highest dose.[1]

This emerging trend raises significant legal questions. In this article, we explore two critical issues: (a) What medications are legally permitted to be commercialized? and (b) Under what circumstances is compounding legally allowed?

FDA Drug Approval

An FDA-approved drug is a drug that has been shown to be *safe* and *effective* through an approved New Drug Application (NDA) for brand-name drugs or an Abbreviated New Drug Application (ANDA) for generic drugs. Approved drugs can be commercialized in the United States. Unapproved drugs are drugs that lack an FDA-approved NDA or ANDA and are said to be *misbranded*. Under section 301(a) of the federal Food,

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Drug, and Cosmetics Act (FDCA), misbranded medications are prohibited from being introduced into interstate commerce.[2]

Patients can access unapproved therapeutics through preapproval access pathways (legal mechanisms that provide access to unapproved investigational drugs and medical devices outside of clinical trials). In the United States, there are three preapproval access pathways: Emergency Use Authorization (EUA), Expanded Access Program (EAP), and Right-to-Try (RTT). EUA, as the name suggests, is only available during declared emergencies and was the common pathway for marketing novel therapeutics during the COVID-19 pandemic. EAP and RTT require serious and life-threatening medical conditions. These three programs are coordinated through the unapproved investigational drug or medical device manufacturer (the details and requirements of these programs are beyond the scope of this article). While acknowledging the seriousness of obesity and its associated comorbidities, these preapproval pathways were neither intended nor available for access to unapproved investigational anti-obesity drugs.[2]

Unapproved drugs are to be distinguished from off-label medication use, defined as use of an approved therapeutic "for indication, dosage form, dose regimen, population or other use parameter not mentioned in the approved labeling."[2] From the FDA's perspective, once a drug is approved for an indication by the FDA, barring any other law/regulation, the drug can generally be prescribed in clinical practice for any indication. The FDA repeatedly reminds stakeholders that the FDA does not regulate the practice of medicine. Off-label use is customary, common, and legal—many common medications are commonly prescribed off-label (especially in primary care). Examples include propranolol and topiramate use for migraine prevention, selective serotonin reuptake inhibitors (SSRIs) for premature ejaculation, and trazodone for insomnia.[2]

Compounding Laws

In recent years, compounding of GLP-1 drugs has become increasingly widespread. Until recently, most compounding was done for FDA-approved GLP-1 drugs. Now, compounding has expanded to include unapproved drugs within a novel drug class (i.e., retatrutide). Sections 503A and 503B of the FDCA allow pharmacies to compound medications under certain conditions. The conditions required by the FDCA most relevant to this discussion include: (a) compounded medications cannot be a copy of a commercially available drug unless there is a clinical need (which includes drug shortages), and (b) compounded medications cannot be an unapproved drug. Pharmacies that comply with sections 503A and 503B of the FDCA are then exempted from certain FDA regulations and are subject to minimal oversight by the FDA. Product quality can vary significantly as a result. Thus, while compounding of certain approved drugs may be legally permissible, compounding retatrutide, an unapproved investigational drug, is not permitted.

Due to GLP-1 drug shortages starting in 2022, combined with the popularity and associated profit margins of these drugs, certain pharmacies have been very active in compounding GLP-1 drugs and distributing them through multiple online distribution sites.[3] Although some of these shortages have resolved, the FDA has been slow in taking enforcement action against compounding pharmacies that remain in violation of the FDCA. In turn, this has emboldened some pharmacies to also engage in compounding unapproved drugs in violation of the FDCA.

Practical Implications

Other than the preapproval access pathways discussed earlier, there are no other legal pathways for patients to access unapproved medications outside of a clinical trial. In a press release, the FDA noted retatrutide cannot be compounded and reminded pharmacies that "these are not components of FDA approved drugs and have not been found to be safe and effective for any condition."[4] As of early-December 2025, at least 10 companies selling retatrutide have been sent warning letters from the FDA noting that they are in direct violation of federal law.[4]

Despite the FDA's warnings, a quick internet search revealed wellness clinics in multiple states offering retatrutide, many without a prescription. Though no FDA-approved label exists for this unapproved drug, these clinics provide a "helpful" up-titration schedule and "confidently" outline exactly what to expect at each dosage step.[5] Perhaps, off-label use of unapproved drugs is the next frontier in an age of lax FDA enforcement! However, if the FDA continues to resort only to warning letters, rather than taking meaningful and consequential legal action, this trend will continue and will place the public's health in danger.

Conclusion

Given the proliferation of compounding pharmacies, their increasingly brazen patient-recruitment tactics, the substantial financial incentives involved, and the rising patient demand for these medications, it is more critical than ever to counsel patients on obtaining FDA-approved medications from legitimate and reputable sources.

Note: This is for informational purposes only and does not constitute legal advice. For legal matters, please consult a qualified attorney.

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References

1. Eli Lilly and Company. Clinical development pipeline. *Lilly.com*. https://www.lilly.com/science/research-development/pipeline. Published 2017. Accessed January 15, 2026.
2. Pasha AS. Drug and medical device law. In: Pasha AS, ed. *Laws of Medicine: Core Legal Aspects for the Healthcare Professional*. 1st ed. https://doi.org/10.1007/978-3-031-08162-0_23.
3. FDA's concerns with unapproved GLP-1 drugs used for weight loss. *FDA*. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/fdas-concerns-unapproved-glp-1-drugs-used-weight-loss. Published September 25, 2025. Accessed January 15, 2026.
4. Warning letters. *FDA*. https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/compliance-actions-and-activities/warning-letters. Accessed January 15, 2026.
5. Retatrutide dosage: A complete guide. *Gard Wellness Solutions*. https://gardwellnesssolutions.com/retatrutide-dosage/. Accessed January 15, 2026.

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HEALTH POLICY CORNER

SGIM'S STAND ON THE HEALTH OF INCARCERATED PEOPLE: EXPANDING MEDICAID TO INCARCERATED INDIVIDUALS

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The transition home from incarceration is often deadly, marked by an increased risk of overdose, heart attack, and all-cause mortality.[1,2] Fifty years into the era of mass incarceration, general internists are on the front line of caring for patients after release from incarceration, bearing witness to the challenges that occur during community re-entry. This period is commonly marked by disruptions in health insurance and medication access, compounded by competing basic needs: housing, food, physical safety. Chronic diseases from HIV to diabetes quickly become uncontrolled. Patients often end up in the emergency department either because it is their only reliable access to routine care or because gaps in continuity lead to life-threatening complications. This article describes the key role general internal medicine (GIM) physicians play in caring and advocating for a marginalized population often overlooked in our healthcare system.

Many general internists will interact with patients transitioning from a carceral setting back to the community. You may have provided end-of-life care for a patient with no brain activity who experienced a drug overdose days after jail release. You may have cared for a patient nearing hyperglycemic crisis because they could not access care before their insulin ran out. While precepting trainees, you may have struggled to explain to them how to piece together a history from a patient with numerous sequelae of advanced atherosclerotic cardiovascular disease but no access to their health records after three decades of incarceration.

These outcomes are not inevitable. They are the predictable consequences of policy choices. The Medicaid Inmate Exclusion Policy (MIEP), embedded in the 1965 Social Security Act (which created the Medicare and Medicaid programs), prohibits use of federal Medicaid funds for anyone incarcerated with few exceptions.[3] This

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includes individuals held in pretrial detention (i.e., legally innocent) who have not yet been convicted of a crime.

Cut off from the funding streams that finance health care for low-income individuals in the community, carceral systems must rely on other means to fund health care for incarcerated populations. Carceral systems often focus on cost control at the expense of quality care. As such, the MIEP has become a mechanism for sustaining hundreds of siloed second-tier healthcare systems. This amplifies health disparities among populations already marginalized by structural violence, costing society in inefficient care and lost human potential. Despite a constitutionally mandated right to basic health care, evidence suggests that healthcare delivery in our country's prisons and jails often falls below community standards. This is outside of the regulatory control of the Centers for Medicaid and Medicare Services (CMS), which functions to ensure quality of community-provided health care.

The recently adopted SGIM position statement calls for repealing this exclusion and expanding Medicaid funding for people in carceral settings.[4] It is past time to normalize the financing and provision of health care in carceral systems in the United States. This formal policy language of the position paper only tells part of the story.

Evidence for Medicaid Coverage

When society fails to provide continuous health care for people leaving incarceration, the consequences ripple through the community; for example, untreated substance use disorders and exacerbated mental illness destabilize families. Infectious diseases spread when treatment is interrupted. Emergency departments have become the default source of primary care, straining health systems and increasing costs.

The evidence for extending Medicaid coverage to this population should be more compelling to physician policy leaders. Post-release Medicaid coverage is associated with increased use of outpatient mental health services and, given the risk of overdose, increased treatment for opioid use disorder.[5] Expanding access to medications for opioid use disorder (MOUD) has a proven and dramatic mortality benefit for people leaving prisons and jails. Increased Medicaid coverage for people with a history of incarceration has been associated with decreased recidivism and increased employment.[6] Investing in healthcare continuity within our criminal legal system is not only the right thing to do but also it produces measurable returns for individuals and communities.

Policy Paths Forward

Fortunately, today there are accessible policy levers to actualize these benefits. CMS is currently encouraging states to pursue Medicaid 1115 demonstration waivers which would allow states to provide Medicaid-covered services during the 90 days before release. This 90-day window is crucial for transition planning.

Since waivers are optional and time-limited, implementation varies widely. The future support for this work at the federal level remains in question, and many states have been slow to act due to technical administrative burdens and complex political dynamics.[7] Furthermore, limiting the use of Medicaid funding to only the 90 days prior to release is insufficient to put an end to the two-tiered health financing system for incarcerated populations. A federal law reversing the MIEP would ensure more universal and durable policy change. Both policy options would allow for Medicaid to fund transitional services, mandate access to treatment for substance use disorder and mental health needs and introduce the standard of care that all community health providers must uphold to receive CMS reimbursement.

In 2023, California became the first state to receive approval for an 1115 reentry demonstration waiver from CMS. (Nineteen other states have subsequently had waivers approved, with another nine states with pending applications.) As a result, Medicaid-funded services are potentially available for up to 90 days prior to release for all incarcerated people who would otherwise be eligible for Medicaid coverage. This has led to an expansion of re-entry case management services, telemedicine-delivered physical and mental health consultations to plan for reentry health needs, and expansion of community health worker services delivered by professionals with shared lived experience of incarceration. The structural changes mandated by implementation of this policy have required revisiting every facet of carceral healthcare, from provision of medications for opioid use disorder to requiring correctional physicians to meet CMS billing requirements.[8]

A Call to Our Colleagues

We wrote this SGIM-approved position statement because we believe general internists must advocate clearly on issues of health equity that impact our patients and communities. Our professional integrity compels us to push back against a criminal legal system that harms our patients. By adopting this position, SGIM aligns itself with most major physician organizations (e.g., American Medical Association, American College of Physicians, American College of Obstetrics and Gynecology, American Association of Pediatrics, and American Academy of Family Physicians) in publicly advocating for the health of patients in the criminal legal system. SGIM's voice adds the perspective of generalists who understand the longitudinal care these patients need from the front lines.

The SGIM position statement represents our organization's commitment to caring for marginalized populations while simultaneously advocating for good governance. Now the work begins of translating position

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into policy achievement and, eventually, realizing change. Adequate care must be accessible for the 2.3 million people who cycle through carceral settings and back into our clinics, emergency departments, and hospitals in an accessible, continuous, and coordinated care fashion. Delivering health care just as we would provide for all our other patients.

References

1. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—A high risk of death for former inmates. *N Engl J Med*. 2007 Jan 11;356(2):157-65. doi:10.1056/NEJMsa064115.
2. Wang EA, Wang Y, Krumholz HM. A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries. *JAMA Intern Med*. 2013 Sep 23;173(17):1621-8. doi:10.1001/jamainternmed.2013.9008.
3. Social Security Act § 1905(a)(27)(A), 42 U.S.C. § 1396d(a)(27)(A) (1965).
4. Hawks L, Howell BA, Berk, J, et al. A Society of General Internal Medicine Position Statement on Expanding Medicaid Coverage to Incarcerated Individuals. SGIM Forum. https://www.sgim.org/wp-content/uploads/2025/09/SGIM_PositionStatement_CarceralHealth.pdf. Accessed January 15, 2026.
5. Burns ME, Cook S, Brown LM, et al. Association between assistance with Medicaid enrollment and use of health care after incarceration among adults with a history of substance use. *JAMA Netw Open*. 2022 Jan 4;5(1):e2142688. doi:10.1001/jamanetworkopen.2021.42688.
6. Jolin JR, Barsky BA, Wade CG, et al. Access to care and outcomes with the Affordable Care Act for persons with criminal legal involvement: A Scoping review. *JAMA Health Forum*. 2024 Aug 2;5(8):e242640. doi:10.1001/jamahealthforum.2024.2640.
7. Barsky BA, Jolin JR, Rosenthal MB. Reevaluating state Medicaid waivers targeting the reentry population. *JAMA Health Forum*. 2025;6(7):e252625. doi:10.1001/jamahealthforum.2025.2625.
8. Divakaran B, Bloch N, Sinha M, et al. The Reentry Health Care Hub: Creating a California-based referral system to link chronically ill people leaving prison to primary care. *Int J Environ Res Public Health*. 2023 May 12;20(10):5806. doi:10.3390/ijerph20105806.

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POSITION PAPER

A SOCIETY OF GENERAL INTERNAL MEDICINE POSITION STATEMENT ON EXPANDING MEDICAID COVERAGE TO INCARCERATED INDIVIDUALS, 2025

Prepared by Laura Hawks, Benjamin A. Howell, Justin Berk, Toby Terwilliger on behalf of Incarceration, Health, and Justice Interest Group and Health Policy Committee and the Society of General Internal Medicine

The United States incarcerates more of its citizens than any other country in the world, and a substantial body of literature finds that carceral settings confer detrimental health effects.[1] Minoritized and marginalized populations, especially people who are Black, Latino, or of Indigenous heritage, are overrepresented in our nation's prisons and jails, a legacy of racism and structural violence in our criminal legal system.[2] The prevalence of a range of diseases, including chronic medical conditions, infectious diseases, mental health and substance use disorders, are higher in incarcerated populations than the general population.[3] The transition home after release from incarceration is a particularly high-risk period for poor health outcomes, as individuals transition from carceral healthcare services to community healthcare providers. This period is commonly marked with a disruption in health insurance and medication access.[4-6] People in reentry often face competing basic needs such as housing, food and physical safety.[7] Return to the community after release from incarceration is associated with high risk of hospitalization[8] and mortality.[9] Addressing health disparities conferred by the United States' criminal

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legal system and mass incarceration is therefore a crucial part of achieving health equity and reducing healthcare and criminal justice expenditures in our country.[10]

Through the Medicaid Inmate Exclusion Policy (MIEP), incarcerated individuals lose access to state-sponsored Medicaid health insurance.[11] This can lead to major barriers in healthcare access throughout incarceration and during times of community re-entry, contributing to the high risk of negative health outcomes during this vulnerable period.[12] Ensuring intact health insurance coverage upon release can improve health outcomes and reduce recidivism.[13] Furthermore, the MIEP contributes to partitioning of carceral health systems from the community health system, creating second-tier systems outside of standard oversight and accountability such as the Centers for Medicare & Medicaid Services (CMS). Evidence suggests that without such oversight, the provision of carceral health services is highly variable and most often, sub-standard when compared to that provided by non-carceral health systems.[14]

The Society of General Internal Medicine, in an effort to reduce health disparities to care for marginalized populations, supports efforts to increase access to standard medical care for patients who are incarcerated and approaching release through the expansion of Medicaid eligibility to people in jails and prisons. This is in alignment with the American Medical Association (AMA), American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American College of Obstetrics and Gynecology (ACOG), American Academy of Pediatrics (AAP), and American Psychiatric Association (APA), and in line with current CMS guidance.

In summary, the Society of General Internal Medicine acknowledges that:

- The federal Medicaid Inmate Exclusion Policy (MIEP) obstructs the ability for individuals to obtain and maintain health insurance coverage during and after incarceration events.
- Moreover, by severing funding and oversight from the Centers for Medicare & Medicaid Services (CMS), the MIEP creates siloed systems of community versus carceral health care, with no current mechanism to provide oversight of carceral health systems.
- Transitioning between fragmented healthcare systems undermines continuous access to healthcare at times of community re-entry with well-documented negative impacts on health outcomes.
- Evidence shows Medicaid access for individuals with criminal legal involvement can improve health outcomes, reduce recidivism, and mitigate health disparities.

The Society of General Internal Medicine advocates:

- For Congress to repeal the "inmate exclusion" within the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
- For state Medicaid programs to apply for a Medicaid 1115 waiver to support access to health insurance for those re-entering the community, as encouraged by CMS.
- Advocates for greater collaboration between Medicaid and correctional health programs to increase access to medications included in the state's Medicaid formulary and bolster oversight and assurance of quality of care.
- Encourages SGIM members to be actively involved in planning state programs for these services with the following components:
  - **Funding should start no less than 90 days prior to expected release** to maximize this transitional time period. This should, when possible, include pretrial individuals. Because pretrial detentions typically last fewer than 90 days and have uncertain release dates, such individuals should have presumptive eligibility for pre-release benefits from the start of their detention (unless or until it is determined that their length of stay will be longer than 90 days, in which case their pre-release benefits can be suspended and deferred until a later date).
  - **Eligibility criteria should be broad**, such that all individuals expected to need care shortly after release are covered—at a minimum, any patient with a chronic medical condition, behavioral health condition (including substance use disorder), pregnant or postpartum, cognitive impairment. or mobility impairment.
  - **Covered services should be as broad as allowable under the state's Medicaid program**, with a particular focus on non-physician services including case management and community health worker coverage, behavioral health treatment, and medications to treat substance use disorder. Coverage of telehealth services may improve access to care, especially for patients in need of subspecialty care.

References

1. Curran J, Saloner B, Winkelman TNA, Alexander GC. Estimated use of prescription medications among individuals incarcerated in jails and state prisons in the US. *JAMA Health Forum*. 2023;4(4). doi:10.1001/jamahealthforum.2023.0482.
2. Khatri UG, Winkelman TNA. Strengthening the Medicaid Reentry Act—Supporting the health of people who are incarcerated. *New England Journal*

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of Medicine. 2022;386(16):1488-1490. doi:10.1056/NEJMP2119571/SUPPL_FILE/NEJMP2119571_DISCLOSURES.PDF.
3. Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *J Epidemiol Community Health (1978)* . 2009;63(11):912-919. doi:10.1136/jech.2009.090662.
4. Wang EA, Wang Y, Krumholz HM. A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: A retrospective matched cohort study, 2002 to 2010. *JAMA Intern Med*. 2013;173(17). doi:10.1001/jamainternmed.2013.9008.
5. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—A high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157-165. doi:10.1056/nejmsa064115.
6. Alsan M, Yang CS, Jolin JR, Tu L, Rich JD. Health Care in U.S. correctional facilities—A limited and threatened constitutional right. *N Engl J Med*. 2023;388(9). doi:10.1056/nejmms2211252.
7. Wilper AP, Woolhandler S, Boyd JW, et al. The health and health care of US prisoners: Results of a nationwide survey. *Am J Public Health*. 2009;99(4). doi:10.2105/AJPH.2008.144279.
8. Nowotny KM. Health care needs and service use among male prison inmates in the United States: A multi-level behavioral model of prison health service utilization. *Health Justice*. 2017;5(1). doi:10.1186/s40352-017-0052-3.
9. Olson MG, Khatri UG, Winkelman TNA. Aligning correctional health standards with Medicaid-covered benefits. *JAMA Health Forum*. 2020;1(7). doi:10.1001/jamahealthforum.2020.0885.
10. Albertson EM, Scannell C, Ashtari N, Barnert E. Eliminating gaps in Medicaid coverage during reentry after incarceration. *Am J Public Health*. 2020;110(3). doi:10.2105/AJPH.2019.305400.
11. Howell BA, Hawks L, Wang EA, Winkelman TNA. Evaluation of changes in US health insurance coverage for individuals with criminal legal involvement in Medicaid expansion and nonexpansion states, 2010 to 2017. *JAMA Health Forum*. 2022;3(4). doi:10.1001/jamahealthforum.2022.0493.
12. Fiscella K, Beletsky L, Wakeman SE. The inmate exception and reform of correctional health care. *Am J Public Health*. 2017;107(3):384-385. doi:10.2105/AJPH.2016.303626.
13. Centers for Medicare & Medicaid Services. HHS releases new guidance to encourage states to apply for new Medicaid reentry section 1115 demonstration opportunity to increase health care for people leaving carceral facilities. Press Release. Published April 17, 2023. Accessed March 15, 2024. https://www.cms.gov/newsroom/press-releases/hhs-releases-new-guidance-encourage-states-apply-new-medicaid-reentry-section-1115-demonstration.
14. KFF.org. Medicaid waiver tracker: Approved and pending Section 1115 waivers by state. Published March 1, 2024. Accessed March 15, 2024. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

SGIM

LIVING LOSS

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She imagined a life for him–
when he was small, pushing a toy car across carpeted floors.

She remembers a time when things were normal,
when life, both hers and his, did not revolve around a substance.

Then came illness:
fatigue, pallor, bruising which
became low cell counts, uncertainty, leukemia.

Then came the slow invasion
initially a drink after work which
became a habit that encroached each second.

Her planner fills with appointments,
therapies she cannot even pronounce–
the "new normal."

Her day fills with worries, calls to lawyers,
rehab centers, landlords, the bank–
the "last chance."

Prospects of college,
careers, grandchildren – shattered.

Prospects of recovery,
stability, grandchildren – indefinitely postponed.

She keeps that same toy car,
glued to the dash as a reminder
that while sterile hums of machines
have replaced his effortless laughter,
not all is lost – hope remains.

She keeps an old cellphone wallpaper photo of him
that lingers as a reminder.

3:03 a.m. – a call breaks through, interrupting.
It's him. Her eyes flicker to the screen.
She will always be there.

"Will he live to see his second decade?"
She is grieving,
though he is still here.
That is what she battles with.

"Will I be fueling his disease?"
Guilt swells.
This, too, is what she battles with:
a living loss.