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SGIM FORUM

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MEDICAL EDUCATION

A MEDICAL EDUCATORS' TOOLBOX FOR GENERATIVE ARTIFICIAL INTELLIGENCE

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GenAI in Medical Education

Artificial Intelligence (AI) is rapidly transforming medical education with the potential to revolutionize both teaching and learning. Generative AI (GenAI) refers to artificial intelligence systems that create new content—including text, images, code, and multimedia—by learning patterns from vast datasets and generating human-like responses to user prompts. GenAI can produce content such as lesson plans, assessment questions, patient cases, and detailed explanations tailored to specific educational needs.[1] Consistent with SGIM's position statement on the use of GenAI in medicine,[2] our approach positions GenAI tools as supplements to medical education that support, rather than supplant, its intrinsically human aspects. In this article, we provide a practical "starter kit" for medical educators new to GenAI, emphasizing strategies to harness it for immediate practical benefits and longer-term educational innovation. We introduce the SPACE framework (Specific, Parameters, Act As If, Context, Evaluate) as a systematic approach to prompt engineering.

Prompt Engineering

The first step in leveraging GenAI for medical education is to provide clear instructions to your chosen tool and iteratively refine them to improve the output. This approach is referred to as *prompt engineering*.[3] We propose the following SPACE mnemonic as a practical foundational framework for prompt engineering:

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Applications of Generative AI in Medical Education with Sample Prompts Using the SPACE Framework	
AI Application	**Refined AI Prompt Using the SPACE Framework**
Individualized Learning Plans	**S:** Create an individualized learning plan (ILP) for a medical student focusing on cardiology and pulmonology.
	P: Output as a structured plan with measurable goals via attached SMART goals and NBME results.
	A: You are an expert medical educator.
	C: MS-3 student who struggled on their cardiology rotation with medical knowledge.
	E: Is the ILP easy to read? Are the goals impactful and achievable?
Generating Teaching Cases	**S:** Create a teaching case to practice diagnostic reasoning for a patient with borderline autoimmune markers and liver injury.
	P: Output as a case with structured questions. Include history, lab findings, and discussion questions.
	A: You are an attending hepatologist.
	C: MS-3 students on a GI elective.
	E: Do discussion questions reinforce key diagnostic reasoning steps?
Simulation and Role-Play	**S:** Generate a simulation scenario for residents to practice delivering bad news to a family whose loved one experienced unexpected complications during a routine procedure.
	P: Output as a dialogue-based script with three learning objectives using the SPIKES communication framework via the attached article. Include debriefing points and suggested language.
	A: You are a palliative care expert.
	C: PGY-1 internal medicine residents on their palliative care rotation without prior formal training on the SPIKES protocol.
	E: Is the scenario realistic? Does it highlight core elements of SPIKES?
Scholarly Work	**S:** Help me strengthen my study methodology.
	P: Format as the methodology section of a JGIM article with notes explaining why each change is suggested.
	A: You are an expert in mixed-methods educational research.
	C: Planned validation study for custom GPT for internal medicine residents.
	E: Are the methods sound and feasible for your project?
Case-Based Discussions	**S:** Generate two realistic clinical scenarios presenting ethical dilemmas regarding patient autonomy and resource allocation for a resident ethics workshop.
	P: Output as case descriptions with follow-up discussion questions.
	A: You are a bioethicist.
	C: Cases should reflect common ethical conflicts in clinical medicine.
	E: Do discussion questions explore multiple perspectives?

- *S: Specific.* Specify the task you want the GenAI to perform. Consider which keywords to include.
- *P: Parameters.* Provide clear parameters. This may include structure (e.g., paragraph, list, table), word count, tone (e.g., informal, professional, humble, persuasive), and permitted resources (e.g., access to specific articles or databases).
- *A: Act As If.* Ask the AI model to adopt a specific persona by "acting as if" it was a content expert relevant to your goal, so it can simulate the knowledge, skills, and communication style of someone in that role. For example, "Act as if you are a heart failure specialist." This technique can also be used to specify audiences (e.g., "Act as if you are explaining this to a first-year medical student.").
- *C: Context.* Provide context for your request. In bedside teaching, this could include a patient's "one-liner." In curriculum development, it could include the number and type of learners, the intended audience, the learning environment, and the source materials.
- *E: Evaluate.* Evaluate the output and revise it iteratively. Unlike the earlier elements of this mnemonic, which

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pertain to the content of the prompt, "evaluate" is an instruction to human users to critically appraise the output and its applicability to their teaching goals.

While this may not encompass every technique available, it serves as a useful starting point.

The table presents examples of prompts relevant to clinician educators that incorporate the key elements of the SPACE format. While effective prompts typically integrate these elements seamlessly, we present them as distinct components here for instructional clarity.

General Purpose Large Language Models vs. Retrieval Augmented Generation

General purpose large language models (LLMs) include ChatGPT, Claude, and Gemini. These tools can assist clinician educators streamline administrative tasks such as outlining curricula, enhancing letters of recommendation, and brainstorming ideas for scholarly work.

OpenEvidence, Perplexity, and DoximityGPT are current examples of GenAI tools that provide evidence-cited answers to queries, directly citing relevant literature or websites. This is often referred to as *Retrieval Augmented Generation*. Some tools target a medical audience, while others answer more general queries. The evidence cited by such tools varies in level of scientific rigor. Users should verify the validity of the sources cited and carefully assess the conclusions drawn.

Generative AI Use and Disclosure

GenAI can accelerate and democratize scholarly work through its ability to translate across languages and refine prose for publication standards.[4] However, authors must meticulously verify content developed with these tools. Educators using generative AI in scholarship must follow applicable journal guidelines, and faculty should disclose their use of AI to learners.

Implementation Considerations for Medical Education

The widespread adoption of GenAI has not eliminated its inherent challenges. A recent review of GenAI in graduate medical education outlined key risks including hallucinations, user automation bias, plagiarism, and security vulnerabilities.[5] Understanding the limitations of specific GenAI tools is crucial because training data and real-time internet access vary among platforms, making it essential for users to verify the outputs reflect accurate evidence, particularly for clinical decisions. Additionally, in medical education, educators and learners will require knowledge of LLMs for responsible decision-making, and faculty development will thus necessitate curricular expansion, requiring allocation of time and space.[4]

As GenAI makes clinical answers more accessible, the ability to critically appraise the underlying medical literature becomes increasingly important. Experienced clinicians are well-positioned to model responsible AI use by applying metacognitive "think-aloud" approaches to demonstrate how to weigh and trust AI outputs appropriately across different contexts. Medical educators should emphasize healthy skepticism and a deep understanding of the nuances of AI-presented data. Lastly, it is important to prioritize human connections in clinical learning environments, recognizing that humanistic skills may become physicians' most important competencies.

Conclusion

GenAI has emerged as a transformative tool in medical education, enhancing efficiency and empowering educators to focus their time and attention on innovation and creative problem-solving. However, this potential must be balanced with an awareness of GenAI's limitations. Educators must engage in faculty development to build AI-related skills and knowledge. We encourage SGIM members to start with a narrow scope by identifying a specific educational challenge and experimenting with an AI tool from this "starter kit" to determine its impact.

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SGIM

"YOU HAVE CANCER"—INTERNISTS' ROLE IN LIFE-ALTERING CONVERSATIONS

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

"Cancer can take away all of my physical abilities. It cannot touch my mind, it cannot touch my heart, and it cannot touch my soul."[1]

"*You have cancer.*" Three simple words. Life-changing implications. How many times have SGIM members uttered those words to patients? Many physicians will deliver these words to patients on numerous occasions over their career. But, as physicians, do we understand the implications of these words to our patients? Do we comprehend the fear it instills in our patients of a future cut short, opportunities missed, and concern for loved ones? Do we recognize those patients that need extra support? In this article, I address the key role that internists play in the care of cancer patients as they embark on their cancer journey.

> **". . . as physicians, do we understand the implications of these words to our patients? Do we comprehend the fear it instills in our patients of a future cut short, opportunities missed and concern for their loved ones? Do we recognize those patients that need extra support?"**

Early in January 2026, I picked up the *AARP The Magazine* that my wife left on the counter. Yes, it is true—I have reached that age where not only do I qualify to be an AARP member, but I am also as likely to read this magazine as *Sports Illustrated*. When I joined AARP, I told myself and others that my joining was just to get the AARP discounts I was now eligible for. Now, I find myself reading the "old people articles" that are increasing relevant to me. Sometimes, there are articles that just stand out as extra relevant.

Opening to the table of contents, one article title caught my eye: "Facing Cancer Together—How one family went to war against the disease. Plus, a 15-step plan to help you or a loved one fight back."[2] Writer Jamie Metzl, a technology and healthcare futurist who writes books and speaks to healthcare professionals about the future of health care, shares a poignant and personal story of his father's (Kurt) three-year battle with stage 4 metastatic neuroendocrine cancer. As an accomplished writer, Jamie skillfully weaves together the story of his father's cancer odyssey from diagnosis to his father's passing in December 2025 at age 90. He offers glimpses into Kurt's life, including a childhood escape from Austria in 1938 as the Nazis closed in to his eventual profession as a pediatrician in Kansas City. The article also includes Kurt's passion for the Kansas City Chiefs, his beloved football team, and memorable family events. One paragraph from his story captured my attention: "But this story is not just about my father. It's about how all people diagnosed with cancer, and their families, can play a crucial role in contributing to the quality of their care and increasing the odds of the best possible outcomes. It's about how, after the horrifying mix of fear, sadness, confusion, and even helplessness that accompanies any cancer diagnosis, patients and their families can harness a force that can sometimes be even more impactful than fast-reproducing cancer cells: informed and empowered hope."[2]

Jamie shifts the focus to describe how to get the care the patient needs. He describes the care that he researched to assist his father and care team. He describes whole genome sequencing as a first step in the fight to identify the cancer. This form of precision medicine was suggested by Jamie to the internist (not the oncologist) caring for Kurt. Jamie reveals that this was not a test that the internist planned to order but "this standard of care, when ordered by a doctor, may be covered by Medicare after a stage 3 or stage 4 diagnosis and ideally should be one of the first steps after all late-stage cancer diagnoses. (Unfortunately, only a small percentage of cancer patients…ask about this sequencing)."[2] This was new information to me, and I would have been one of the surprised internists if presented with this information by the family. Jamie proceeds to describe other efforts undertaken to assist in their

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fight such as a patient-derived tumor organoid test (an interesting read if you are unaware of this technology as I was). Jamie's highlighted section on "Your 15-Point Cancer Battle Plan" describes multiple steps that cancer patients and their care teams can undertake during this daunting time to optimize cancer care.[2]

But this article triggered concerning thoughts that haunted me for several days. "While there's been astounding progress in medical research, clinical trials, and cutting-edge applications, even the most beneficial new treatments are often unevenly distributed among medical centers and slow to reach patients. The faster our technology advances, the harder it is for all of us to keep up, including health care providers."[2] This mantra sets the stage for his battle call for families to step up to assist in the research of options and care delivery for their loved ones.

I thought of my many current and former patients at the VA and Charity Hospital in New Orleans, Louisiana. Many of them would not have been able to tackle this 15-point plan. They lacked resources, such as computers to find information, education to ask the probing questions, and inconsistent medical coverage. Some of them had no family to assist and support them in their fight. Oftentimes, the healthcare team was their only option and support. My patients were different than Kurt and Jamie as they lacked access to critical resources and support.

With this scenario in mind, I recommend the GIM Doctor's Dozen for internists to play a critical role in the lives of their cancer patients:

1. Be honest.
2. But provide hope when possible.
3. Explain all options including doing nothing.
4. Find out what matters most to the patient, including advanced care planning.
5. Help to coordinate the care especially when multiple specialists are involved.
6. Remember that other medical conditions exist that need your attention.
7. Ensure all resources are offered when appropriate (e.g., nutrition, social work etc.).
8. Offer Mental Health referral early.
9. Identify community resources that are specific to your patient's needs.
10. Advocate for your patient to get the care they need even when they do not qualify.
11. Learn what test/treatments/clinical trials are available so that internists can expedite the eventual treatment plan.
12. Listen to your patients as goals and plans will change over the course of the battle. Inform and involve family (if applicable) with patient's permission.

Just diagnosing our patients is not enough. We need to do more. Many internists are aware of these concepts and regularly implement most if not all of them. But as a trusted resource to patients struggling with the details of their cancer battles, internists should follow *all* of them.

Stuart Scott, ESPN sportscaster, who died in 2015 from appendiceal cancer at the age of 49 said, "When you die, it does not mean that you lose to cancer. You beat cancer by how you live, why you live, and the manner in which you live."[3] Cancer patients want to live. As internists, we are often the first to become involved in the "fights of their lives." For those patients with resources, be there for them, encourage the patients and families to live life, be involved, and bring forth questions as active members of the care team as per Metzl's 15-point plan. For those who do not have the resources or wherewithal to tackle Metzl's battle plan, institute the GIM Doctor's Dozen. You may be their only hope, their reason for fighting for the next day, their reason for living.

Jamie Metzl's compelling story offers a playbook for patients and families. As members of the healthcare team, we need to be part of that team and help address their 15-point plan. Jamie notes "The legacy of our struggle against his cancer would help others in theirs."[2] But this plan involves resources and support that are not available to many of our SGIM physicians' patients. It does not mean that they should not get what they need or that we should not fight and advocate for them. We just need to change the battle plan. As Jim Valvano, noted college basketball coach (who died of metastatic adenocarcinoma at age 47), said in his famous 1993 ESPY Awards speech, "Don't give up, don't ever give up."[4] SGIM members, do not give up the fight!

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SGIM

STEP AWAY TO MOVE FORWARD: THE VALUE OF "MICRO-SABBATICALS" IN ACADEMIC MEDICINE

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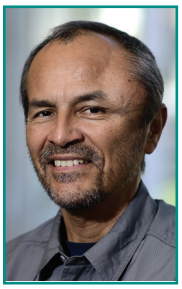
"Because a traditional long-term sabbatical is out of reach for most in academic medicine, consider the 'micro-sabbatical.' These shorter experiences provide significant benefits—such as new skills and fresh perspectives—with less disruptions to clinical practice."



Time is our most precious resource. As individuals and professionals, we have finite time to live the life we choose. Society's focus on productivity as well as the demands of medical training and practice leave little time to devote to the people and places that exist beyond the workplace. A sabbatical offers the opportunity for directed time away from the pressures of medical practice to think differently.

A sabbatical shouldn't be just time off—it's a chance to grow, connect, and return home with fresh ideas. Sabbaticals help expand your network, gain new perspectives, develop leadership skills, and even mentor others. Sabbaticals can be shaped around exploring new clinical models, devoting focused time to projects, or simply recharging in a new place.[1] Regardless of the focus, consider how this time can support your investment in exploring new ideas.

In this article, we reflect on our career "bookends" in academic general internal medicine. Our experiences represent various stages of professional life: Dr. Kane took time away prior to starting his first faculty position while Dr. Estrada saw the goal of a sabbatical materialize after 30 years in academic medicine. This reflection originated from the June 2025 Council meeting as Dr. Kane was preparing to depart for Italy.

A Junior Faculty Experience (RK)

After 11 years of medical training and several cross-country moves with my wife, a sabbatical in my early career was a dream we sought to prioritize. My wife's 5-year tenure at her technology company afforded her a paid month-long sabbatical, while my transition from the National Clinician Scholars Program at Duke University to a new position at Tufts University created the perfect window for our shared sabbatical.

The focus of our sabbatical was clear: spend concerted time together completely disconnected from work and do what we love—eat, hike, explore, and spend time with each other. After prolonged medical training journeys, we should recognize not only our personal but also our loved ones' sacrifices as we pursue our medicine career. A shared sabbatical was one way for me to recognize my wife's sacrifices.

Time within a sabbatical offers space to think and to dabble with or without purpose. My month allowed for reflection and to envision the focus of my future work. This space for big thinking allowed me to synthesize the direction of my work and consider how it may fit into developing clinical and research plans to address societal challenges. Conversely, the unstructured time allowed my non-work mind to rekindle a love of science fiction novels and invest in my atrophied watercolor skills. Most importantly, this sabbatical brought connection, adventures, new memories, and conversations from our time spent together.

The Power of the "Micro-Sabbatical" (CE)

Hearing about the sabbatical experiences of SGIM members was fascinating. One colleague spent time in Italy writing a book while another traveled to Argentina for a research project. Others spent months in Japan or Israel immersing themselves in their academic counterparts' work. I felt envious and inspired by their stories; the common thread was the gift of several months fully dedicated to new environments.

Years ago, I explored visiting another institution to study inter-professional education research. However, I felt a sense of guilt regarding the use of institutional reserves and time away from my family and clinical duties. During my leadership at the time, I designated

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those reserves to talented junior faculty. Looking back, I regret not pursuing an immersive opportunity.

As SGIM President-elect (2024-25), the idea of spending time at other institutions grew stronger. I eventually secured funding to visit other institutions, but competing demands limited my travel to two-week increments. Consequently, I took a series of "micro-sabbaticals" to the Cleveland, San Francisco, and Portland VA medical centers. I chose these sites for their robust academic programs and strong SGIM presence—a reminder that, in our field, relationships matter. I even aligned some visits with SGIM regional meetings to maximize the impact.

Each stop offered unique insights. In San Francisco, cross-specialty participation during case discussions fostered clinical reasoning in ways I had not anticipated. Portland's integration of behavioral health and procedural services into their primary care clinic was eye-opening (it later helped a faculty member at my institution refine plans for launching a procedure clinic). Cleveland's "Wicked Wednesdays," a debate-style forum, demonstrated how structured dialogue can tackle complex issues, and it was fun! Collectively, these experiences reminded me that innovation often comes from stepping outside our usual circles.

Our journeys, whether early-career or after decades in practice, taught us that there is much to be gained from these experiences.

The Reality: Most Physicians Aren't Taking Sabbaticals

Providing evidence-based, guideline-directed internal medicine care is ever more complex, especially in our new artificial intelligence-driven technological era. As individuals and professionals, we need time to refocus, recharge, and reinvest to be great physicians, researchers, educators, partners, and community members. The business world encourages sabbaticals to explore new skills or ideas, provide focused attention on a project, or allow space to alleviate work-related burnout.[2]

Statistics are revealing: sabbaticals are unusual in medical schools. A 2021 national survey found that only half of medical schools reported any faculty taking leave in the previous three years, with a median of just three participants per institution.[1] Most were tenured, full professors with PhDs—often leaving clinician-educators and junior faculty on the sidelines.[1]

While contemporary evidence on traditional sabbaticals for physicians is limited,[1,3] new models are emerging. Pillinger et al. describe "mini-sabbaticals," short rotations lasting weeks to months, within Clinical and Translational Science Award (CTSA) programs.[4] For early-career investigators and clinicians, these condensed experiences can be transformative, fostering durable mentorships and specialized skills. Sabbaticals should expand beyond an exclusive benefit to an approach for rejuvenation across all career stages.

How to Make It Happen

Despite these barriers, there are practical pathways forward for faculty at any career stage. Be proactive and don't wait for an invitation. SGIM offers numerous connections—interest groups, career development programs, and the annual meeting—where your personal network colleagues can open doors. Often, the first step is simply asking.

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Because a traditional long-term sabbatical is out of reach for most in academic medicine,[1] consider the "micro-sabbatical." These shorter experiences provide significant benefits—such as new skills and fresh perspectives—with less disruptions to clinical practice. Even shorter interactions, like visiting professorships, offer valuable exposure (a recent ACLGIM listserv post requesting a Grand Rounds speaker generated multiple expert recommendations within days)!

While every institution has its own process and funding can be complex, SGIM members should explore opportunities through specialty societies, career development awards, or foundation grants. In the era of team-based primary care and shift-based hospital medicine, a sabbatical may be more feasible than ever before. However, realizing this potential requires a culture shift. Leaders must model these behaviors, identify funding, and develop procedures to minimize gaps in patient care, research, and trainee education.

Moving Forward

Consider how a sabbatical might enrich both your career and your institution. Start the conversation with your division chief, build connections at peer institutions, and take that first step. Since a few days off are rarely sufficient to gain new skills, one effective way to move forward is to step away, returning with a fresh perspective and renewed energy.

Conclusion

The SGIM Presidency gave me the "permission" to overcome my guilt for using precious time and financial support. It can be challenging to visualize or understand a certain activity at another institution; but it can be a different observing the activity directly—what a difference being present can make! As SGIM president, I now understand that it was only by stepping away that I was able to step forward thanks to the power of my "micro sabbaticals."

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SGIM

Q & A ON REIMAGINING AN ADVOCACY HILL DAY FOR SGIM'S 2026 ANNUAL MEETING

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The theme of SGIM's Annual Meeting in May 2026—"Individual Voices, Collective Impact"—emphasizes advocacy extending beyond the marble steps of Capitol Hill. As the Annual Meeting Program Chairs explained in the lead article of the February issue of SGIM Forum, the Program Committee seeks to inspire meeting attendees to explore how they can be advocates for better health care through their work as educators, clinicians, and investigators.[1] To reinforce the emphasis on advocacy at this year's meeting that will be held only nine miles away from Capitol Hill, the Program Chairs invited Drs. Thaddeus Salmon and Avik Chatterjee to organize a new approach to connecting members with congressional representatives.

EB: Given the extent of the health policy changes that have occurred in the last year, how did you settle on a core theme to guide your approach for the advocacy initiative you're planning?
TS: The past year brought rapid shifts in health policies and institutional relationships. Medicaid funding changes and the roller coaster of Affordable Care Act premium subsidies sent many patients and hospitals reeling. While in previous years SGIM's leadership might have focused on a more specific patient population or issue, SGIM's members are now seeing policy changes at a more foundational level, and these risks adversely impact many vulnerable populations. For this reason, Avik and I chose to address access to care as the unifying issue that affects so many of our patients across the United States.

EB: Why do you believe it is more important than ever for SGIM members to reach out to their congressional representatives on a regular basis?
TS: As an SGIM member, you are an expert in your field, as well as in your community. Your knowledge is needed to let your government representatives know the realities experienced by your patients. In the past, SGIM has organized Hill Day visits to connect members with their representatives. The ease and effectiveness of in-person scheduling for large groups has decreased, while congressional offices now are much more receptive to scheduling virtual visits with constituents. This opportunity allows us to have more frequent interactions with legislators and/or their staff. I do not know whether Congress will be in session during the week of the Annual Meeting, so it may not be possible to schedule in-person meetings with your legislator. Still, Avik and I will do our best to facilitate making an effective collective effort virtually or in-person!

EB: How do you imagine the initiative being different from an in-person Hill Day?
AC: I attended a Hill Day in 2019, which involved an in-person orientation that morning, followed by groups of SGIM members collectively walking the halls of the legislative buildings to meet with legislators. This year, without a dedicated day for these activities, events will be structured differently. Thad and I plan to hold a virtual orientation, and participants will schedule legislative meetings on their own based on their time and flexibility while in the Washington, DC, area. Thad and I have reserved an "interest group" time slot to allow for in-person debriefing (or prepping, for people who have not met with legislators yet). We also hope to facilitate the option of virtual meetings with legislators and their staff outside of the conference period. There is also a plan for an online debrief after the Annual Meeting. We hope the hybrid nature of these events will allow for the largest number of energizing visits with legislators as a part of the 2026 SGIM Annual Meeting (#SGIM26).

EB: What do you hope to accomplish by demonstrating what can be done when SGIM members collaborate with a community-based organization in advocacy efforts?
AC: We have reached out to a community health center in Washington, DC, to help align legislative meeting take-home points with what is most important to health centers and physicians in DC. Coordinating advocacy efforts with local organizations can increase the groundedness of those efforts. They can also help provide a sense of solidarity which is crucial during advocacy efforts that often come with ups and downs.

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EB: What is the most important message you wish to convey to meeting attendees about engaging in advocacy efforts?
TS: Your voice matters, and this is the best time to speak up! Especially if you have never done anything like this before, Avik and I want to bring these advocacy activities into your comfort zone.
AC: The problems facing internists and our patients right now are daunting. But as general internists SGIM members are frontline witnesses to what communities are experiencing as a result of changing policies and are uniquely poised to communicate those stories to policymakers. Now is the time to use our skills as communicators and our frontline stories to leverage change!

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LEADERSHIP PROFILE

JOHNS HOPKINS' NATIONWIDE COMPETITION ENCOURAGES GIM PRIDE AND FOSTERS CAREERS: THE LEGACY OF DR. FREDERICK BRANCATI

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For the past 20 years, medical residents and early-career physicians have shown an overall decreased interest in pursuing research careers. Although not documented, it's reasonable to anticipate this trend has worsened over the past year. Residents face multiple barriers when considering academic medicine and research careers, including lower salaries in academic medicine, high burden of medical school debt, and concerns about decreased or stagnant federal and non-federal research funding.[1,2] The concerns regarding research significantly worsened in 2025, given funding cancellations, shifting priorities, and tenuous funding landscape from the National Institutes of Health and the decimation of programs at the Agency for Healthcare Research and Quality.[2] These agencies have traditionally supported early-career researchers with K awards and other small grant mechanisms to launch their independent careers.[2]

Frederick Brancati, MD, MHS, then Director of the Johns Hopkins Division of General Internal Medicine, poses for a photo on September 4, 2009, with the Baltimore City skyline as a backdrop. *(Photographer Unknown)*

Why General Internal Medicine (GIM) Is Vulnerable

GIM faces specific barriers to attracting research fellows and faculty. First, the shortage of medical students committing to primary care careers is expected to get worse. A 2023 study predicted a shortage of GIM physicians in less than a decade.[3] The study found that significantly fewer residents are choosing careers in GIM

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compared to a decade ago, a shift that could severely impact primary health care across the United States.[3]

Second, even among those who choose to pursue a research career, most graduating residents apply for post-doctoral GIM fellowships or the National Clinical Scholars program. The long-term viability of these fellowships training in clinical research is further threatened by the need to cobble together federal and other sources of funding to support these critical programs.[2]

A Deliberate Response at Johns Hopkins

In 2006, Dr. Frederick Brancati, an acclaimed diabetes researcher and Director of GIM at Johns Hopkins School of Medicine, anticipated the future needs of GIM and developed a vision to protect against these threats. He launched the Hopkins GIM Housestaff Research Awards Program,[4] with financial support from his own Division's shrinking funds.

This award program is a nationwide competition designed to recognize and honor exceptional research contributions by internal medical residents interested in pursuing academic GIM. The Hopkins GIM Housestaff Research Awards Program has evolved over time to serve as a powerful recruitment tool for Hopkins as well as academic GIM.

The Hopkins GIM Housestaff Research Awards Program

In March 2026, the Johns Hopkins Division of General Internal Medicine will celebrate its 20th year hosting the Housestaff Research Awards Program. The awards are named for internationally regarded Hopkins GIM mentors and researchers (many are longstanding SGIM members). Each year, awards are given to housestaff conducting research in one of the following five key areas:

- Medical Education (**L. Randol Barker–David E. Kern Award**)
- Evidence-Based Medicine & Systematic Reviews (**Eric B. Bass–Karen A. Robinson Award**)
- Behavioral Medicine & Health Disparities (**Lisa A. Cooper–Nisa M. Maruthur Award**)
- Health Services & Outcomes Research (**Daniel E. Ford–Jodi B. Segal Award**)
- Bioethics (**Mary Catherine Beach–Jeremy Sugarman Award**).

The following recipients will present their award-winning abstracts at a special ceremony on March 6, 2026, at Johns Hopkins Hospital:

- **Maxwell Droznin, MD, MPH, PGY-3,** Johns Hopkins Bayview Medical Center: **Bass–Robinson Award**
- **Michael Liu, MD, MPhil, PGY-1,** Brigham & Women's Hospital, Internal Medicine & Primary Care: **Cooper–Maruthur Award**
- **Rohan Khazanchi, MD, MPH, PGY-4,** Brigham & Women's Hospital, Boston Children's Hospital, and Boston Medical Center: **Ford–Segal Award**.

Twenty Years of Impact

Over the past 20 years, hundreds of housestaff have applied for these prestigious awards, and Hopkins GIM has awarded nearly 90 individuals for their research prowess. Residents across dozens of institutions have gone on to pursue fellowships, faculty positions, and leadership roles in academic GIM. Collectively, these successes suggest early recognition and mentorship can play a meaningful role in shaping a resident's future in academic GIM.

When asked how winning the 2008 Ford-Segal Award impacted him, Zackary Berger, MD, PhD, associate professor in the Hopkins GIM Division, said, *"This award gave me the confidence to pursue research as part of my clinical-educational career … I can't say enough about the importance of this award to my life as an academic internist."*

Former awardees like David Dowdy, MD, PhD, ScM, professor of Epidemiology and Executive Vice Dean for Academic Affairs, Johns Hopkins Bloomberg School of Public Health, described the awards program as a "jump-start" to his academic medicine career. *"I couldn't be more grateful to the Housestaff Research Awards for the key role it played at a pivotal time in my academic journey."*

Over time, the program has evolved into more than just an awards ceremony; it has become a powerful tool for guiding residents toward pursuing a future in GIM, specifically through and into careers in academic GIM.

Blair Golden, MD, MS, is an assistant professor in the Division of Hospital Medicine at the University of Wisconsin School of Medicine and Public Health. She received the Barker-Kern award in 2018 and describes this as *"a defining moment in my transition from residency to early-career faculty."* Dr. Golden cited this recognition as a moment that bolstered her confidence in seriously pursuing research as part of her academic career. *"Presenting my work at Hopkins served as one of my first major external speaking engagements and was a valuable professional development opportunity."*

Implications for the Future

Focus on this awards program is needed as interest in GIM careers has declined in recent years. Hopkins GIM is playing a pivotal role in reversing this concerning trend by using the Housestaff Research Awards as a platform to highlight the dynamic mentorship and academic career

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opportunities available in GIM. Matthew DeCamp, associate professor at the University of Colorado Denver–Anschutz Medical Campus comments that *"Receiving the [inaugural] Beach-Sugarman Award was more than the incredible honor of the award itself. It introduced me to the vibrant, innovative, and welcoming community that is GIM— showing me it truly was possible to practice medicine, teach, and do bioethics research alongside bright colleagues with many different interests. No doubt, it paved the way for my current career in academic GIM."*

It is crucial for medical schools to create avenues for involving students as early as possible in research. By tackling research challenges and implementing supportive strategies, these efforts empower the next generation of physician-researchers to embrace research, contribute to medical progress, and uphold the highest standards of patient care.

Programs such as the Housestaff Research Awards may serve as an example for other institutions to strengthen the weakening pipeline of future academic GIM researchers.

The Legacy of Dr. Brancati

Dr. Brancati was admired as a generous and selfless mentor to many students, residents, fellows, and junior faculty. He helped shape the careers of countless physician-researchers at Hopkins and in SGIM. In 2014, the year after Dr. Brancati's untimely passing from amyotrophic lateral sclerosis, SGIM and ACLGIM recognized his influential role in guiding trainees in academic GIM with the Frederick L. Brancati Mentorship and Leadership Award.[5]

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SGIM

SIGN OF THE TIMES

THE FALTERING TRIANGLE OF TRUST IN PRIMARY CARE: GRIEVING THE LOSS OF CONTINUITY AND CONNECTION

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I recently had a colleague retire. Her long-established patients moved to the care of a new physician who joined our practice; the new physician then left within her first year under abrupt and unusual circumstances. Clinic leadership said they could not discuss the new doctor's exodus with her clinic colleagues or the patients. While unusual, I see relationships like these terminate abruptly on an increasing basis. Sometimes physicians retire or move away with a plan set in place for transitioning patients. Sometimes the departure is sudden—a death or a mysterious disappearance with the phones disconnected and windows shuttered. Seeing few sustainable options, some doctors move to concierge practice, leaving many patients unable or unwilling to pay a premium to main-

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tain their relationship. This leaves the remaining doctors grasping at patient-physician relationships unmoored in uncertainty. In this article, I recap how these relationships matured and deteriorated as well as how physicians can process the effects of this cycle on our personal well-being.

Birth and Maturation of the Triangle of Trust

For many years, a triangle of trust linked three partners in population health: the patient, the primary care physician, and the healthcare system. Each depended on the others, and a bond developed over time.

- *Physician-Patient:* Trust builds between patients and physicians out of necessity, driven by uncertainty about health or disease. In moments of need, patients search for guidance and reassurance. Physicians have the privilege of creating a sacred space for people to share desires and fears. This trust can be as powerful as any treatment or cure.[1]
- *Patient–Healthcare System:* This relationship began as a way for employers to offer incentives and combat inflation during World War II.[2] Over time, it grew to include social safety nets, the maze of insurers and health plans we navigate today. It was less trust than agreement: As a patient, I will work, while you, the healthcare system, will keep me healthy so I can continue working.
- *Healthcare System–Physician:* Health insurance and healthcare systems stepped in as intermediaries. Medical advice still flowed between patients and physicians, but funding now went through this new bureaucratic layer. While depersonalizing the physician-patient connection, both sides had reassurance that bills would be paid, and practices would stay open.

For a while, this three-way relationship worked. Then, insurers shifted to for-profit models and prioritized shareholders over patients. The number of specialists increased, more training was required, and advanced procedures proliferated. Patients lived longer but their health often suffered, leading to more comorbidities and reactive care. Fee-for-service became the only sustainable model, leading to mergers and acquisitions. Regulatory demands grew. Workload and administrative strain led to physician burnout.

The Disintegrating Bonds of the Triangle

With the changing longevity and quality of these relationships, each entity is left with haunting questions to themselves about the future.

- *The Patient Perspective—Uncertainty: "I trusted this doctor with my care and personal information. What happens now? Will the new doctor know my story? Will we get along? What if we are not a good fit? Why did my doctor leave? Should I follow them to a new practice?"*
- *The Healthcare System Perspective—Utilitarian: "Primary care is not really generating a lot of revenue, and the doctors are always complaining about needing more time with patients and for administrative work. If another one quits, we can probably just offload the excess to local urgent care clinics or the ER. Patients just want access and quick answers."*
- *The Physician Perspective—Unsettled: "Every day my clinic is packed, and I spend extra hours addressing my inbox at home. Now we are another doctor down and I am supposed to manage all the refills and labs and calls from their patients too? Is there extra time or money for me to do their work? Why should I stay here slogging away when there could be an easier practice model for me?"*

With so much uncertainty swirling in our collective thoughts, it is understandable why some doctors would simply choose to remove themselves from this chaos.

How Can We Deal with the Loss of a Colleague?

I am a mid-career physician fortunate to have previously worked as a salaried employee for a large group practice with thousands of doctors—now, I currently work at an academic institution, so job security has not been a major concern. Still, I see colleagues struggling. I know primary care is not sustainable for everyone and I cannot fault anyone for choosing what is best for them. However, as I reflect on each departure, I move through my five stages of personal grief:[3]

1. *Denial:* I am sure we will be able to bring someone in for a warm handoff before my colleague leaves or that they will be able to give some more personal details about their patients. It is just something going on with them and we will be fine.
2. *Anger:* Why didn't they order any follow-up on this lab/imaging or discuss it with the patient? Why did they prescribe this medication? Where is any documentation as to what was going on here? Why am I the one this patient is upset with for not having any of this information when there was none to be had?
3. *Bargaining:* Okay, I do not feel great about this, but maybe I can just keep things steady, keep refilling medications, and then there will be more support around to help before too long. I can see the extra patients if I can be a little quick and impersonal; I will let the patients know I am just filling in to help for now until help comes.

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4. ***Depression:*** Was I supposed to have done more to keep other doctors here? Could I have been more supportive? How long before I am in the same shoes wanting to leave? It is not like there is any sign that things are getting better.
5. ***Acceptance:*** This is just how things are, I guess. If I do not continue, then what is going to happen when my loved ones need care? We cannot just devolve into a string of walk-in clinics with no continuity. I got into this business because I enjoy shooting the breeze with people and as long as I can continue to do that and balance it with being there for my family, I can make this work.

So, I grieve the slow death of primary care and the departure of colleagues.

Conclusion

The triangle, once built on trust, now teeters upside down on a single point—the steadfastness of the primary care physician. I see no easy answers or waves of help coming. I continue to practice, try to inspire students, and support peers. But every time a colleague leaves, I get closer to following. It is important that each of us understand and take the time to grieve these relationships as it is the only way to move towards acceptance. Focusing on and teaching the importance of building and nurturing the patient-physician relationship-the main one still within our control-is paramount. It is important for SGIM members to use the resources available as well as those emerging—looking squarely at artificial intelligence (AI) assistance for ambient documentation and inbox management—to give us back the rewarding ties with our patients and colleagues that bring value to our work-lives.

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LEADERSHIP AND HEALTHCARE ADMINISTRATION

UNLOCKING OUR GENERAL INTERNAL MEDICINE SUPERPOWERS: HIGHLIGHTS FROM THE 2025 ACLGIM SUMMIT

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The Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) held its December 7-9, 2025, ACLGIM Summit at the Mountain Shadows Resort in Scottsdale, Arizona. In these challenging times, it can feel as though superpowers are necessary to both sustain us as leaders and support those we lead. However, SGIM members already possess many qualities that can be discovered (or rediscovered) and utilized, while other skills can be learned. The Summit's goal was for attendees to identify and strengthen their "General Internal Medicine (GIM) Superpowers" through shared examples, contexts, awareness, and self-reflection. This meeting goal would be met by attendees sharing, restoring, and supporting their colleagues. More than 100 GIM division chiefs and leaders as well as administrative dyad partners explored and flexed their GIM superpow-

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ers. In this article, we highlight key aspects from the Winter Summit to help readers unlock their own GIM superpowers.

Summit Program

The 2025 ACLGIM Summit had a notable first offering: a "Pre-Session for Business & Operations Partners in Healthcare Administration." This inaugural ACLGIM gathering intentionally and specifically included dyad partners (paired clinical and administrative leaders). This session was led by Emily Buland, MBA, Executive Administrator, General Internal Medicine, University of Pittsburgh; Rachel Noon, MBA, Business Director, General Medicine & Geriatrics, Washington University School of Medicine; and Gena Weir, MPH, FACMPE, PMP, Director of Strategy & Operations, General Internal Medicine, University of Colorado Anschutz Medical Campus. This pre-session included a panel of dyads moderated by Cynthia Chuang, MD, MSc, professor of Medicine and Public Health Sciences, Penn State College of Medicine, discussing physician collaboration. Three case studies were included as table exercises for the dyads and other attendees. The pre-session ended with a closed portion for administrators only to allow continued discussions on administrative issues and networking. Many thanks to Gena and Rachel for proposing and leading this successful pre-session.

The first meeting day for all participants kicked off with the keynote address from L. Ebony Boulware, MD, MPH, Dean, Wake Forest University School of Medicine, Chief Academic Officer, Advocate Health, entitled "GIM Superpowers: Excelling as a Leader." In her inspiring address, Dr. Boulware narrated the story of her career, which highlighted and modeled several GIM superpowers including passion, perseverance, patient-centeredness, patience, and persistence. She illustrated how these superpowers helped her lead Wake Forest School of Medicine to develop a highly intentional and integrated approach to academic medicine. Following the keynote address, ACLGIM President Mitchell Feldman, MD, MPhil, professor of Medicine and Chief, Division of General Internal Medicine, University of California, San Francisco School of Medicine, spoke on "Mentoring Through Adversity." In this session, Dr. Feldman emphasized the skills that we can employ in getting ourselves and others through challenging times. His story of walking in a garden in Kyoto, Japan, as a visiting scholar described how choosing a different path within the same garden represents holding true to our ideals, even when the direction we might have intended is not the one we can follow. This story served as a common theme that other speakers and attendees circled back to throughout the meeting.

Care delivery innovations highlighted by the ACLGIM Hess Initiative followed. It was led by Jane Liebschutz, MD, MPH, Chief, Division of General Internal Medicine, University of Pittsburgh Medical Center, and Sabrina Taldone, MD, MBA, Associate Dean for Clinical Affairs, University of Miami Miller School of Medicine. Their presentation exemplified how GIM Divisions are following new paths for success. Dr. Liebschutz spoke of an improved compensation model, while Dr. Taldone described a successful team-based asynchronous workflow, followed by a question-and-answer session. The final session of the day included former SGIM President Martha Gerrity, MD, MPH, PhD, Chief, Division of General Internal Medicine, VA Portland Healthcare System, and co-Chair of the SGIM Philanthropy Committee Hollis D. Day, MD, MS, MHPE, Chief of Geriatrics at Boston Medical Center, and focused on "Building a Better Future Through Philanthropy." The first day at the Summit concluded with a welcome reception that afforded members the time to connect with new colleagues and reconnect with established friends.

The second day opened with three networking breakfast sessions:

1. "Clinical Leaders" facilitated by Surasri "Nat" Prapasiri, MD, MPH, Associate Chief Medical Information Officer for Ambulatory Services, University of New Mexico School of Medicine.
2. "Education Leaders" moderated by Anne Cioletti, MD, professor of Medicine, University of Utah School of Medicine.
3. "Research Leaders" led by Rachel Hess, MD, MS, Associate Vice President for Research, University of Utah.

Cara Alter, Founder of SpeechSkills, then presented "The Credibility Code" where members learned how to use body position, voice, intonation, and other verbal and non-verbal cues/behaviors to effectively communicate one's expertise and mastery. Be on the lookout for a future SGIM Forum article on this illuminating topic, which will make you self-conscious, but in a good way.

Ms. Weir and Mark Earnest, MD, PhD, Division Head, (the administrative dyad from General Internal Medicine, CU School of Medicine, University of Colorado Anschutz Medical Campus), followed up on the pre-session with "Unlocking the Power of Partnership" which demonstrated the success of a shared and collaborative approach to Division challenges. Next, Erika Miller, JD, a Partner at CRD Associates, and Michael Fischer, MD, MS, Chief of the Section of General Internal Medicine at Boston Medical Center, delivered a fantastic talk on "Health Policy Today: Updates, Impact, and Action." Ms. Miller covered the state of 2026 appropriations changes and anticipated changes in research, education, and clinical practice policies. Dr. Fischer described SGIM's

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advocacy efforts as well as various means by which SGIM leaders and members can be involved in advocacy. Lisa Rotenstein, MD, MBA, assistant professor, Medical Director of Ambulatory Quality and Safety at UCSF Health, concluded the second day with two ACLGIM Hess Initiative updates. The first update was a series of brief presentations on "Compensation Models," and the second was updates on "Team-Based Care." For the Compensation Models, three exemplars were described:

1. Richard Gitomer, MD, MBA, Associate Medical Director for Virtual Primary Care, MD Live on the model implemented at MGH-Brigham.
2. Erin Snyder, MD, Associate Director of Clinical Services, University of Alabama Birmingham School of Medicine, on the UAB model.
3. Marc Cohen, MD, Clinical Chief, Primary Care & Medical Director, Beth Israel Deaconess Medical Center, on the model developed there.

The second day ended with Dr. Rotenstein giving a brief update on the Team-Based Care working group.

After a networking breakfast start to the third and final day, Dr. Cioletti provided an update on the ACLGIM Hess Initiative regarding "Trainee Experience." She summarized the effort to propose recommendations prioritizing high-functioning primary care experiences and continuity for internal medicine residents, and shared that their recommendations recently published in the *Journal of General Internal Medicine* (JGIM).

A power packed panel discussion entitled "Pivot with Purpose: Achieving Goals Amid Uncertainty" followed and included Dr. Chuang; Eve Kerr, MD, MPH, Chief, Division of General Internal Medicine, University of Michigan Medical School; Jeffrey Linder, MD, MPH, Chief of the Division of General Internal Medicine and Geriatrics, Northwestern Feinberg School of Medicine; and Carol Mangione, MD, MSPH, Chief of the Division of General Internal Medicine & Health Services Research, David Geffen School of Medicine, University of California, Los Angeles. Panel members shared their experiences and insights on how to move forward with strategic goals despite uncertainty. The original plan for concluding the meeting with small group sessions for "From Struggles to Strategies: Learning from Each Other," was altered as the environment was open and safe with compelling discussions. Participants chose to remain in the large group and continue the engaging conversation.

Conclusion

This is a time when many would agree it is easy to accentuate the negative. While highly cognizant of the changes and challenges that have made the challenging work of leading in General Internal Medicine even harder, ACLGIM Summit attendees had the pleasure of great speakers and panels who provided examples of perseverance, passion, patient-centeredness, and patience. Whether on a personal or divisional level, the stories of innovation and the pursuit of mission-driven goals were inspiring. Through this, Summit participants were able to look at themselves and to each other to explore and unlock their GIM Superpowers.

ACLGIM leadership is already planning for the 2026 ACLGIM Summit and we hope you can join us! SGIM

ANNUAL MEETING UPDATE

GENERAL INTERNAL MEDICINE IS INTEGRAL TO ACHIEVING SUSTAINABLE AND EQUITABLE HEALTH CARE

Mehul Tejani, MD, MPH; Theresa Townley, MD, MPH

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SGIM members train physicians within systems facing the interconnected challenges of widening health inequities, rising costs, workforce burnout, and climate instability. At their intersection lies a simple truth: general internal medicine (GIM) is vital to achieving health care that is both equitable and sustainable.

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Dr. John Balbus, the former Director of the White House Office of Climate Change and Health Equity under President Biden from 2021-25, will address this intersection during his plenary session at the 2026 SGIM Annual Meeting (#SGIM26). Dr. Balbus will offer practical frameworks for integrating sustainability and climate resilience into systems operations.

The climate crisis poses a grave threat to human health. Our individual voices can collectively delineate actionable steps to prepare for and mitigate this crisis. This requires education in climate sensitive disease, advocacy for climate smart policies, and a healthcare system that doesn't exacerbate climate change and climate injustice. In this article, we discuss how general internists are best positioned to address climate change as a health risk, emphasize the environmental impacts of health care, and advocate for change.

Caring for the Whole Patient Requires Climate-Informed Care and Advocacy

Because GIM physicians care for patients in their full social and environmental context, they must understand how climate change affects health. Once this impact is recognized, physicians need to advocate for change. GIM physicians understand complexities of care and chronicity of disease. We treat patients while considering medical vulnerabilities and social determinants of health. Pragmatically, we might prescribe daily dosing of a long-acting insulin for a patient with housing instability rather than a combination of long-acting and short-acting insulins. We can extend that understanding of complexity to climate-informed medicine and climate justice by recognizing that a heat wave may render a continuous glucose monitor inaccurate or insulin vials may lose potency. In our treatment plan, we would discuss alternative methods to check blood sugars and precautions for insulin on excessive heat days.

Treating acute heat-related illnesses is increasingly common in emergency medicine. But general internists routinely treat patients with morbidities caused or worsened by chronic heat exposure, including chronic kidney disease, exacerbations of mental health conditions, and atherosclerotic diseases. Additionally, prescribed medications may impair a patient's ability to regulate body temperature. While GIM physicians utilize evidence-based therapies for diseases, we need to be aware that chronic heat exposure is also part of the exposome—the totality of exposure that leads to chronic disease.

To address social determinants of health, GIM physicians need to direct patients to resources that assist in managing heat, and advocate for access to cooling centers or air conditioners. A proactive electronic medical record could embed these recommendations to reduce cognitive load on clinicians and automate messages to patients during excessive heat or poor air quality days. Climate change is not only a public health threat but also present in our exam rooms and hospital beds.

General internists are also called to address the pollution which contributes to our patient's exposome. Worldwide air pollution alone is responsible for nine million deaths annually and disproportionately endangers populations that generate the least amount of air pollution.[1] Exposure to fine particulate matter less than 2.5 microns (PM2.5) has been linked to cardiovascular disease, lung disease, dementia, stroke, and type 2 diabetes. One-fifth of the global burden of diabetes has been associated with exposure to PM2.5.[2] In the United States, minoritized communities are more likely to be exposed to pollutants due to geographic inequity called *sacrifice zones* by Dr. Robert Bullard, the "father" of environmental justice.[3] Furthermore, pollution synergizes with poor food quality and lack of exercise spaces to accelerate propensity for type 2 diabetes. In their community, if individual general internists advocate for closure of a local coal powered plant this could collectively reduce local rates of diabetes and other disease.

Health Care's Contribution and Sustainable Solutions

The healthcare industry is a major contributor to greenhouse gases and solid waste. However, general internists can be part of the solution by relying on our established values. The healthcare industry contributes 8.5% of domestic greenhouse gases (GHG).[4] Globally, if health care were a country, it would be the fifth largest producer of GHG.[4] Healthcare facilities, transportation, supply chain, and even metered dose inhaler propellants all contribute to this over-sized carbon footprint.[4] An estimated ~400,000 Disability-Adjusted Life Years are lost due to emissions and toxic air pollutants in the United States, which is comparable to the number of lives lost due to medical errors.[5]

Health care also harms our planet by generating plastic waste (plastic is 98% derived from fossil fuels). Historically based on a goal of reducing infections, plastics have gained widespread adoption in medicine without rigorous testing showing improved patient outcomes or reduced infections. Healthcare providers use equipment wrapped in plastic with the assumption that plastic provides "sterility," then dispose of the waste without considering the downstream toxic legacy of microplastics, phthalates, and dioxins. Most plastic waste ends up incinerated, in landfills, or simply discarded into the environment. Near these sites, the world's most vulnerable populations live, breathe, play, and work. As a result, microplastics have been found in tissues throughout the body. Contrary to the principle of "first do no harm," health care itself leads to a substan-

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tial and measurable burden of disease and premature mortality worldwide.

Sustainability in health care is frequently framed through the lens of environmentalism, which can seem abstract or politically fraught. General internists, however, understand sustainability instinctively through our core values: cost-effectiveness, stewardship, fiscal responsibility, and high-value care. Minimizing unnecessary tests, choosing oral over intravenous medications, and preventing hospitalizations provide high value care as well as good environmental practice. When reframed, sustainability is not a distant environmental ideal, but a practical, ethical commitment to providing care that can endure.

Unsustainable health systems disproportionately harm patients with the fewest resources. Unsustainable care leads to overuse or misutilization, resulting in excessive costs. Unchecked costs narrow access for marginalized populations through reduced preventive services and greater reliance on emergency care. Educating learners to manage chronic diseases effectively and sustainably is therefore an act of advocacy; this protects patients from the harm of both overuse and underinvestment.

Anchor Institutions Shape Communities and Tomorrow's Physicians

General internists work in institutions, such as healthcare systems and universities, which anchor the surrounding neighborhoods. Because anchor institutions are inseparable from the communities they serve, their success depends on the long-term health and stability of these communities. GIM sits at the core of this mission, making our specialty uniquely positioned to align education, advocacy, and sustainable care delivery.

Medical education is where this alignment begins. The clinical environments in which SGIM members train learners send powerful messages about what the profession values. When residents observe fragmented care, unnecessary testing, preventable hospitalizations, and inequitable access to primary care, they are not only learning about medicine but also what systems tolerate. Conversely, when education emphasizes longitudinal relationships, population health, interdisciplinary teamwork, and thoughtful resource use, learners internalize stewardship as a professional responsibility rather than an administrative mandate.

Conclusion

Policies—such as investing in green infrastructure, sustainable food programs, reducing greenhouse gas emissions, and reducing over-reliance on plastics—can reduce the risk of chronic diseases and improve the bottom line. By investing in climate-friendly policies, the health sector can display public leadership while also improving health.

In treating our patients with pragmatic and evidence-based care, SGIM physicians can be planetary health practitioners. Climate change will have disparate effects on populations due to biologic differences, socioeconomic vulnerabilities, legacies of environmental injustice, and geographic inequity. By embracing our role within anchor institutions and reframing sustainability in language that resonates, SGIM members can lead health care toward a future that is financially viable while also just and enduring. Join us at the 2026 Annual Meeting to learn actionable steps from Dr. Balbus and SGIM Planetary Health Interest Group Members for climate smart medical education and health systems.

References

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