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SGIM FORUM

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ANNUAL MEETING UPDATE

STAND UP FOR MEDICAL ADVOCACY: THIS IS OUR LANE

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Edmund Pellegrino, the renowned bioethicist, asserted that medicine is not merely a technical enterprise but also a moral one. He argued that "the profession has enormous power to resist the forces it finds so inimical to the well-being of its patients and its own well-being."[1] To realize this power, advocacy must be understood to be a core clinical skill rather than an optional professional add-on. While medical training often prioritizes the mastery of pathophysiology and pharmacology, these tools alone are frequently insufficient to achieve the goal of healing.

Many trainees experience advocacy as an extracurricular or even risky activity. This disconnect is particularly striking in general internal medicine, where patients' health is shaped as much by social, structural, and policy forces as by medical diseases. This article explores how internists move advocacy from the periphery of medical education to its center, highlighting the vital role of the medical educator in achieving this shift. In the sections that follow, we outline practical opportunities to teach advocacy in both clinic and inpatient settings, equipping readers to build and sustain advocacy curricula within their own programs.

Why Advocacy Is Inherent to General Internal Medicine

General internists are uniquely positioned to identify and address healthcare inequities through everyday practice. Caring for broad and diverse patient panels allows internists and learners to witness firsthand how poverty, housing instability, food insecurity, language barriers, disability, and insurance status shape health

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outcomes. Effective patient care means helping people access affordable medications and equipment, and guiding those patients facing language barriers, low health literacy, or cognitive difficulties through complicated treatment plans. Most internists can recall moments of frustration when it was clear that excellent clinical care alone was insufficient; these moments should serve as catalysts for advocacy rather than endpoints of resignation.

The Hospitalist Perspective: Policy at the Bedside

Hospitalists occupy a critical vantage point at the intersection of policy and patient care. Discharge planning routinely exposes how legislation, insurance structures, and institutional regulations shape bedside decisions. They influence eligibility for post-acute care, create delays in medication access due to prior authorization, and constrain what constitutes a "safe" discharge. These tensions become visible when clinical recommendations collide with social realities, such as prescribing diuretics to a patient without reliable bathroom access due to housing instability, or deferring care to outpatient follow-up for a patient without a phone or transportation. These are not abstract policy problems; these realities are daily clinical dilemmas that shape patient outcomes.

How Learners Learn Advocacy

Advocacy is best learned through examples rather than abstraction.[2,3] Learners internalize professional norms through the formal and hidden curricula as well as observing what faculty emphasize or omit in the daily clinical work. When advocacy is absent from precepting conversations, case conferences, or informal teaching, learners may infer that it falls outside the scope of so-called "real" clinical medicine. Over time, this implicit messaging reinforces acceptance of systemic barriers as fixed realities rather than problems worthy of intervention.

When faculty openly engage in advocacy, learners begin to see it as legitimate and feasible within a busy clinical practice. Highlighting advocacy efforts explicitly matter. Sharing that you wrote a letter to a legislator, submitted public comment on a proposed regulation, or partnered with a community organization helps learners recognize these actions as part of their professional responsibility. Inviting learners to participate by providing a letter template, discussing relevant legislation during teaching rounds, or connecting policy issues directly to patient cases transforms advocacy from an abstract ideal into an active skill set. Framed through the lens of patient impact, advocacy need not feel partisan or political—it reflects instead the ethical obligation to address the barriers that prevent patients from receiving the care they need.

Building Advocacy into Medical Education

Integrating advocacy into medical education must begin at the bedside but should not end there. Hospitalists and outpatient internists alike can teach trainees to identify and highlight policy- and system-driven barriers during rounds, document social and insurance-related obstacles, and reflect on how these constraints influence outcomes. Formal curricula can build on these experiences by providing foundational knowledge of health policy, opportunities for skills-based learning, and structured reflection. Educators interested in advancing this work should assess whether their institutions already offer health policy or advocacy curricula for medical students and residents; if there is existing curriculum, educators should identify opportunities to strengthen or expand existing efforts.

Sustaining advocacy education, however, requires more than individual effort; it requires institutional and professional support. National organizations can provide the structure, community, and resources needed to make advocacy education practical and durable. For decades, SGIM has championed policies aimed at reducing health disparities and improving patient-centered care. Through its Health Policy Committee, advocacy-focused interest groups, and leadership development programs, such as the Leadership in Health Policy (LEAHP) Program, SGIM offers tools, mentorship, and opportunities for engagement that support clinicians and educators across all stages of their careers. These communities help demystify advocacy and enable internists to translate bedside and clinical care into coordinated action at the local and national levels.[4]

This call to move advocacy from the periphery to the center of medical education aligns perfectly with the vision Dr. Sondra Zabar will share in her plenary at #SGIM26. As a clinical and medical education leader who has pioneered the use of Objective Structured Clinical Examinations (OSCEs) to measure and teach social determinants of health, Dr. Zabar's work provides more of the "how" to our "why."[5] She challenges us, as internists at the front-line, to move beyond the realization of systemic barriers and toward a standardized, rigorous approach to teaching advocacy as a measurable skill. Her work reminds us that when we teach a resident to navigate a structural barrier, we aren't just solving a one-time clinical dilemma—we are training the next generation of leaders to reshape the landscape of academic medicine itself.

Conclusion

If medicine is, as Pellegrino argued, truly a moral enterprise, then advocacy must be woven into the foundation of general internal medicine education. Advocacy should start from the first clinical encounter and extend beyond

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the exam room. General internists witness daily how social and policy forces shape health outcomes; these are not peripheral frustrations, but catalysts for change. By modeling advocacy openly, highlighting it in teaching, and providing concrete tools for engagement, faculty can help learners transform these dilemmas into sustained action.

Advocacy must be treated as an inherent extension of excellent patient care, rather than an optional task. This will give trainees the confidence, skills, and professional identity to address inequities at every level. Institutional curricula, reflective practice, and national support from organizations like SGIM make this integration practical and enduring, turning individual moments of recognition into collective impact.

Dr. Zabar's plenary at #SGIM26 will advance this vision by demonstrating how advocacy can be taught and measured with the same rigor we apply to other clinical competencies—preparing the next generation of internists not just to navigate systemic barriers, but to dismantle them. Medical advocacy is not an expansion of our mission but an expression of it – and it is time we teach it that way.

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SGIM

FROM THE EDITOR

THE RELENTLESS PURSUIT OF PERFECTION: PREVENTING HEALTHCARE FAILURES

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Editor in Chief, SGIM Forum

"Perfection is not attainable, but if we chase perfection, we can catch excellence."[1]

As physicians, we are not perfect. We cannot defeat Father Time. But we have opportunities to make a difference in the lives of others. In this article, I describe my realization that although perfection is not attainable, we still play a key role in the lives of our patients.

I always remember one specific patient I took care of early in my career. I had been his outpatient clinic physician right out of residency training. Although Mr. X was an older gentleman with several comorbid conditions, he was fairly healthy with stable medical issues. He had good social support with a loving wife and several adult children who alternated taking him to his appointments after I convinced him to stop driving for his health (and the health of others). We conversed at the end of his visits about fishing, his prior life as a banker, and his military service. During one visit, I asked him about what was important to him should he become seriously ill. He laughed and stated that the future would take care of itself as he had lived a full life. He just hoped that he had done enough for others.

A couple of years later, I was practicing in the inpatient setting after surrendering my continuity clinic as my academic career changed. On post-call rounds, the

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admitting overnight resident started presenting the history and physical to the team. "*Mr. X is a 77-year-old male Veteran presenting with. . . .*" Recognizing the name, I was excited to learn that one of my favorite clinic patients was now under my care again.

As I entered his room with the team, I was shocked at how different Mr. X looked. Gone was the vibrant, smiling, able-bodied 74-year-old Veteran that I remember from my outpatient days. Instead, there was this elderly, frail, cachectic Veteran in bed who did not resemble my former patient. For a second, the thought crossed my mind that this gentleman was another patient with the same name. Mustering a half smile, the patient slowly raised the head of the bed and mumbled, "*Good to see you, Doc. I always wondered if our paths would cross again. They told me you would be coming today.*"

My upper-level resident later recounted that the wide smile plastered across my face seemed to hide the deeper concern that existed beneath it. "*It is great to see you again, Mr. X. I was not expecting you to bring your whole family with you for our reunion today, but it is awfully nice to see them as well.*" I turned to greet his wife and children seated around his bedside. His oldest son piped up, "*Man I am so glad to know that you are his doctor again, he's really had it rough lately.*" His wife added, "*You know he has never been the same health-wise since you took that other position. He really listened to you and trusted your recommendations. The doctors and hospitals haven't taken good care of him in the last few years.*"

As I reached out to shake his hand, I realized just how frail he was as I reached my hand down to his hand still resting on the dingy white sheets. With his permission, I sat on the edge of his bed to hear him better. "*Doc, I really could use your help right now, I am in a pretty tough firefight with the enemy and right now, the enemy is winning.*" For the next 20 minutes, I sat and listened. As we conversed, it was like two old friends talking; I forgot that there were a team of trainees and his family in the room with us.

I was re-oriented to time and place when his youngest son blurted out, "*So what do you think, is he going to get better?*" I told the family that we were waiting for his records to arrive from outside hospitalizations and clinic visits from the past few years so we could better understand the issues we were facing. Exiting his room, Mr. X looked at me with a sense of peace and said, "*Thank you. Doc. I know I am in good hands.*"

Later that afternoon, I realized the battle we would be facing. Poring through his chart and not realizing that others were around, my "*What the f*@% were they doing?*" comment startled a few healthcare professionals seated in the workroom. This was followed by the "*I can't believe they did that!*" and the "*Did they not see this result?*" After reviewing his records from our system as well as his outside records, I pushed the chair back from the desk and proclaimed to the team, "*We, as healthcare providers, have failed Mr. X. The system did not do what we were expected to do.*"

I then recounted to the team some of the major missteps in Mr. X's care. The downfall of Mr. X started with the missed abnormality on his abdominal CT scan when he presented with constipation, followed by the lack of timely colonoscopy. This was complicated by the pulmonary embolus that was not linked to the underlying cancer still waiting to be diagnosed. The lung lesion diagnosis as a metastatic process was delayed for many months. The eventual abdominal surgery resulted in sepsis after a gauze pad was left in the abdomen. A stroke ensued when the surgical team did not restart his blood pressure meds. During one ED visit, the nurse was too busy to help him to the bathroom and the subsequent fall resulted in a broken humerus. The meds he was prescribed for anxiety resulted in delirium due to lack of a follow-up visit. Documentation from several ED visits seem to lack substance and did not dive deeper into the underlying causes—"*Acute Kidney Injury: hydrate with one-liter normal saline, outpatient follow-up*"—with no recognition of his decreased PO intake. The litany of missed opportunities continued in my soliloquy for another few minutes. All of this happened to one patient within a 2-3-year span. "*Ladies and gentlemen, we failed Mr. X.*"

As the residents and interns churned through all the post-call duties, the medical students and I prepared for the heartbreaking discussion with Mr. X and his family. Toward the end of our hour-long conversation recapping the mistakes and missed opportunities along the way, Mr. X tearily interrupted the conversation, "*Doc, thank you for all this information, but I don't want to know anything else. I always knew that they were not listening to me when I told them something was wrong. I am happy now to know that I am under your care. Remember that conversation we had a while back on what I would want to do if I got seriously ill? I think we need to revisit that conversation now.*"

After his palliative care consultation, Mr. X and his family decided that home hospice was best for him. After addressing the acute issues that resulted in his hospitalization, we discharged Mr. X home with hospice where several months later, he expired peacefully surrounded by family and friends. A letter arrived a few weeks later from Mr. X's family thanking me and my team for listening to him and helping him reach a state of acceptance.

"[As a doctor] people will trust you, confide in you, and appreciate your efforts. You can do amazing things for people if you don't let the system get you down."[2] But what do we do as physicians when the system lets our patients down? Thinking back on the many times that the

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healthcare system failed Mr. X made me angry. I dwelled on his death far longer than would be expected and more than was healthy for my psyche. I scrutinized my records from clinic and his hospital stay. Did I miss something that failed Mr. X? Could I have caught something earlier?

"*The relentless pursuit of perfection*" is an advertising tagline that has always stuck with me.[3] Lexus captures the essence of continuous quality improvement in these five simple words. Health care is a human driven endeavor; as such, health care will never be perfect. SGIM members must always remember though that on the other end of our decisions is a patient (e.g., a husband, wife, parent, child). Their lives rest in our hands both for the things we do and the things we choose not to do. I just wish more healthcare professionals had done the right thing for Mr. X. The healthcare system failed him. He deserved better.

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SGIM

PRESIDENT'S COLUMN

STRATEGIC GOVERNANCE: HOW SGIM COUNCIL IS NAVIGATING CHANGE

Carlos Estrada, MD, MS, FACP
President, SGIM

"The field of general internal medicine, which in my view includes academic hospitalists and primary care physicians, is feeling constraints and identity issues."

SGIM is on a journey of continued improvement to guide members. As SGIM President, I am eager to learn and implement tactics that support our continued work as a high-functioning Council. Just as SGIM members pursue professional development, SGIM and ACLGIM leaders invest in learning how to strengthen our organizations.

This past year, four SGIM leaders—Jillian Gann, SGIM Director of Leadership and Mentoring Programs; Mitchell Feldman, MD, MPhil, ACLGIM President; Kay Ovington, CAE, SGIM Deputy Chief Executive Officer; and I—participated in the Governance and Leadership Excellence Across Medicine (GLEAM) program. The Council of Medical Specialty Societies (CMSS) developed this professional development program.[1] CMSS unites more than 50 specialty societies representing 800,000 physicians nationwide. CMSS programs differ from other leadership development activities because CMSS's focus is on leaders of professional organizations.

Effective governance requires boards to focus strategically while being aware of operational implications of their decisions. Council sets guiding principles and boundaries, ensures alignment with our mission, and establishes guardrails for organizational decisions. This approach protects trust, credibility, and equity in times of change. In January 2026, the winter retreat brought Council members and SGIM staff together for intensive strategic planning utilizing facilitated discussions and breakout sessions.

In this article, I describe three critical issues shaping SGIM's future that were discussed at the winter retreat: use of artificial intelligence and large language models (AI and LLM) in SGIM's governance, ways to better support

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academic hospitalists, and opportunities to support grassroots advocacy by members.

Strategic Use of Artificial Intelligence in Governance

I learned that other professional organizations are struggling and having to rapidly adapt to the seismic changes AI has brought. Professional societies have already experienced issues related to inappropriate AI use, underscoring the need for proactive guidance. Kay Ovington facilitated the discussion and challenged Council to understand how SGIM could intentionally use AI in organizational governance.

The discussion centered on these key considerations:

- Determining where human judgment should remain and how AI can enhance efficiency.
- Recognizing that AI's efficiency gains may inadvertently lead to mission drift, impacting both organizational trust and decision-making.
- Addressing equity concerns arising from uneven access to AI, as this can shape which perspectives are amplified.
- Establishing principles and guidance for Council on AI use in planning and operational activities.

A survey of SGIM staff showed that shadow AI is already happening within SGIM, as 76% of staff are already using AI. A staff member shared an example of how AI helped with coding to update the website—a task that would have been outsourced and cost SGIM financially. AI works well for tasks like this that humans can check.

Council applied a "Task-Risk-Judgment" (TRJ) lens to frame AI use which helped distinguish low-risk tasks from high-risk decisions.[2] Examples of low-risk tasks include drafting meeting minutes, survey analysis, and information research. However, governance decisions, such as strategy, ethical issues and discussions about diversity, equity, and inclusion, remain high-risk, where human judgment cannot be replaced.

Council discussed the ethical tensions AI brings, for example: "Did AI analyze member feedback, or was a human involved?" or "Was it disclosed?" Council acknowledged the tension between efficiency and accuracy. During the discussion, Council identified key principles around AI use for governance: humility, responsibility, transparency, and human centeredness. Council agreed that it must stay informed and adaptable but recognized that doing nothing also has risks.

Moving forward, SGIM will:

- Proceed with limited, experimental use of AI to support Council's governance responsibilities (e.g., generating or evaluating strategic proposals).
- Define clear guardrails for appropriate use and access to a secure platform that prevents information from being released externally.
- Update the guidance for internal use by staff and Council.

These steps will enable SGIM to adopt AI in governance thoughtfully by using it to enhance efficiency while protecting privacy and preserving human judgment as core principles. By setting clear boundaries and maintaining a values-driven approach, SGIM can leverage AI responsibly without jeopardizing its mission or integrity.

Support for Academic Hospitalists

I invited Attila Nemeth, MD, Chair of the SGIM Academic Hospitalist Commission, to facilitate this discussion. In preparation for the Council meeting, he sought input from Commission members and reviewed key challenges and opportunities from the literature.[3] About 20% of SGIM members identify as hospitalists.

The discussion started with "What should SGIM do to support collaboration between academic hospitalists and ambulatory general internists?" SGIM must think about commonalities between hospitalists and primary care physicians, such as "What do we share in our communities of practice?" Council discussed how to promote collaboration on scholarship within and across institutions. Small groups identified opportunities in clinical quality improvement, medical education, healthcare research, and health policy.

Moving forward, SGIM will:

- Host the Academic Hospitalist Academy with renewed emphasis on scholarship and mentorship.
- Explore strategies to increase hospitalist representation on SGIM committees and commissions.
- Leverage existing commonalities to foster scholarship, implementation science, quality improvement, and advocacy.

SGIM recognizes academic hospitalists as a distinct community of practice with a unique professional culture and strengths. The field of general internal medicine, which in my view includes academic hospitalists and primary care physicians, is feeling constraints and identity issues. SGIM should remain the academic home for *all* academic internists regardless of their main location of practice.

Grassroots Advocacy

Dr. Mark Schwartz, SGIM President-Elect, facilitated the discussion on how SGIM can further support member engagement in grassroots advocacy.[4] While SGIM

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already leads effective "grasstops" federal advocacy, many members want more local and individual advocacy pathways (while maintaining nonpartisanship). SGIM uses the following distinctions to clarify these roles and responsibilities:

- Grassroots Advocacy (Member-Driven) is the "collective action of individual members acting in their own professional capacities as clinicians, educators, researchers, and constituents to influence health policy, payment, workforce, and system-level decisions.
- Grasstops Advocacy (Leadership-Driven) is policy engagement carried out by SGIM's elected leaders, committees, and designated representatives, speaking with the authority of the Society.

Because health outcomes are shaped by local as well as national health policies, many members have strong interest in local or state-level advocacy that is difficult for SGIM to support with current staffing and infrastructure. One way to address this predicament is to give more attention to advocacy training and capacity building.

A survey of Council members revealed confidence that SGIM can engage members in grassroots advocacy, though the biggest barriers remain time constraints and lack of training. Helpful resources could include summary briefs, talking points, and training webinars. SGIM already provides monthly policy updates and congressional action alerts focused on national issues. SGIM also has expanded its health policy interest group and created a grassroots advocacy toolkit. A new approach to connecting members with congressional representatives before, during, or after our upcoming Annual Meeting in Washington, DC, is described in a March SGIM Forum article.[5]

Breakout groups at the Council retreat generated multiple suggestions to better support grassroots advocacy, including expanding training and skill building, spotlighting advocacy work at meetings, and helping members get academic credit for their policy work. Central to these recommendations is alignment with established SGIM advocacy initiatives and priorities, which require prioritizing our most valuable resources: people and time.

Moving forward, SGIM will:

- Proceed with pilot testing low-cost approaches to grassroots advocacy that align with our health policy priorities.
- Update our framework to guide decisions and provide guardrails to maintain a focus on nonpartisan priorities consistent with SGIM mission and core values.
- Consider resources and staffing implications which may require increasing staff support (if additional resources become available) or ending lower priority activities.

The decisions listed above align with Council's fiduciary role in protecting SGIM and its members. More details will emerge after the upcoming Council retreat in June when Council plans for the upcoming year.

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Conclusion

SGIM's journey of improvement calls for governance that balances innovation with core values. At the winter retreat, Council focused on three priorities: using AI responsibly to boost efficiency while preserving judgment, supporting academic hospitalists as key members, and expanding grassroots advocacy to amplify voices. These steps reflect our commitment to strategic governance—staying adaptable, mission-driven, and equity-focused as we navigate change together.

Disclaimer: The author acknowledges the use of publicly available Artificial Intelligence platforms to assist with writing this article.

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SGIM

FROM THE SOCIETY

MEMORIES OF JOHN GOODSON: ONE OF SGIM'S FIERCEST ADVOCATES FOR PRIMARY CARE

Eric B. Bass, MD, MPH; Anders Chen, MD, MHS; Mark D. Schwartz, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Chen (andersch@uw.edu) is an Associate Professor of Medicine at the University of Washinton and Co-Chair of SGIM's Health Policy Committee. Dr. Schwartz (Mark.Schwartz@nyulangone.org) is a Professor of Population Health at the New York University Grossman School of Medicine and SGIM's President-elect.

As members prepare for SGIM's Annual Meeting, with its heavy emphasis on advocacy for our mission,[1] we want to remember and celebrate the life of one of SGIM's advocacy heroes, Dr. John Goodson. John died on February 7, 2026, after a three-year battle with amyotrophic lateral sclerosis. We will always remember John for his decades-long service to SGIM and his unrelenting advocacy for better support of the essential care provided by general internists and other cognitive physicians.

John's fierce devotion to advocacy was matched by his devotion to patient care, teaching, and mentoring. At Massachusetts General, he will be remembered for being a superb clinician, dedicated educator, inspiring mentor, and leader of faculty education programs. For example, he pioneered a General Internal Medicine for Specialists course in 1995 that continues today.

At SGIM, John will forever be remembered as a tireless champion for primary care and physician payment reform. Through his work with the Cognitive Care Alliance, which he led for many years (with strong support from Erika Miller at CRD Associates), John succeeded in connecting SGIM with other professional societies that shared a compelling need to change the fee-for-service system that provides inadequate reimbursement for cognitive care. Thanks to John, SGIM

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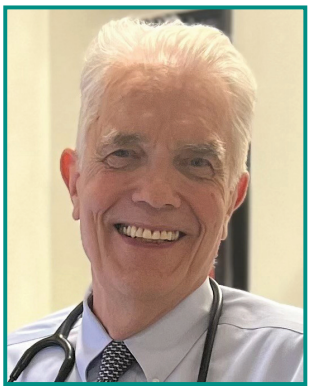
gained the ear and respect of policymakers at the Centers for Medicare & Medicaid Services, giving SGIM a stronger voice than a society of our size would have ordinarily. If you have used the new G2211 code to increase reimbursement for comprehensive longitudinal care you give your patients, you have benefited from John's advocacy.

At SGIM, we also will remember John as a cherished mentor for the Leadership in Health Policy (LEAHP) Program. Through the LEAHP Program, John's mentorship continues to ripple outward across cohorts since 2017, shaping scholars who now mentor and advocate in his image. As SGIM looks to the future, we are committed to ensuring that his generosity, courage, and clarity remain central to who we are and who we are becoming. We previously reached out to his mentees to share memories of John when we created the John Goodson Leadership in Health Policy Scholarship Program.[2] While his exceptional expertise in primary care payment reform and eagerness to teach were greatly appreciated, they were not the dominant themes. Instead, it was his kindness, generosity, desire to listen to their interests, and excitement for their passions which stood out the most. He inspired a generation of rising advocates with his expertise and his genuine devotion to the well-being and success of his mentees. To show our appreciation of John's tremendous influence on SGIM's advocacy efforts, we offer reflections from John's mentees in the LEAHP Program:



Dr. John Goodson will forever be remembered as a superb clinician and one of SGIM's fiercest advocates for primary care. (*Photographer Unknown*)

"John was incomparable in many ways, including in his extraordinary devotion to primary care and assuring its future. He showed me how to be relentless without being dogmatic, how to harness data - or illuminate the lack thereof - to assess the nature of physician payment distortions, how to tell a cohesive story, and how to build a coalition to make complex issues in primary care and payment reform more salient and accessible. Perhaps most inspiring, he led with a charismatic conviction that was rooted in both evidence and values, challenging all of us to be active, informed, audacious, and relentless in our advocacy for primary care and our patients."
(Jacob Berman, MD, MPH; 2017-18 Scholar)

"I so enjoyed my mentorship calls with John. He really listened to my interests and got excited about things with me. I really appreciated that he encouraged my outside-the-box thinking and projects, helping me to see where there could be a place for it, and encouraging me to advocate for myself."
(Elisabeth Askin, MD; 2021-22 Scholar)

"My experience with Dr. Goodson during my LEAHP year was equal to none. He is kind, and a true role model… Despite my project being in an area outside his niche, he took the time to become familiar with the issue at hand and helped me develop skills and provided me specific extremely helpful feedback to succeed."
(Maria Gaby Frank, MD; 2017-18 Scholar)

"I can never fully express my gratitude for John's mentorship. He was not only the quintessential internist—a true "doctor's doctor"—but also a "mentor's mentor." Though I can only aspire to emulate him, I carry his example with me each day. I hope, in time, to honor his legacy by paying forward the same generosity, wisdom, and kindness he shared."
(Amirala Pasha, DO, JD; 2018-19 Scholar)

"I will remember Dr. Goodson as an American hero. He inspires each of us to believe in the possibility of working toward The Greater Good, and that a foreign-born physician could affect United States health policy. John empowered me to find my unique voice and represent diverse American patients. John believed in me before I believed in myself, and that made all the difference."
(Sophia Peng, MD; 2022-23 Scholar)

"I was fortunate to have Dr. Goodson as my LEAHP mentor. It was an honor to receive advice every month from such an accomplished and respected general internist, researcher, and health advocate… During that pivotal time for me, as I transitioned from training to independent practice, John helped me recognize my identity as a physician, beyond the scope of my advocacy. He always asked me, 'Who is Betty?' - pushing me to prioritize my true values. John's triumphant story of his role in achievement of near universal coverage in Massachusetts is a reminder that with determination, vision, and flexibility in the face of changing political landscapes, we can improve the lives and health of many."
(Betty Kolod, MD; 2020-21 Scholar)

"Meeting with John meant having the ear of someone who not only had a wealth of experience but also took the time and put in the energy to make sure the work I was doing was worthwhile to me. He approached our time together generously and collegially, encouraging questions while gently guiding me in a productive direction. He also made a point to ask about my life and sent me a book of wisdom collected over his years of life and practice. I came away from the experience feeling lucky that I had the opportunity to spend time with someone so distinguished and experienced as John who was in equal measure approachable and kind."
(Erica Heiman, MD; 2021-22 Scholar)

FROM THE SOCIETY *(continued from page 9)*

We join John's mentees in their gratitude for everything he did for SGIM and the field of medicine. We intend to honor his legacy by continuing the John Goodson Leadership in Health Policy Scholarship Program.[2]

Memorial donations to the program can be made at https://sgim.users.membersuite.com/donations/donations-workflow or via the accompying QR code.

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SGIM

PHILANTHROPY

FORGING THE FUTURE: GIVING TO SGIM SHOULD NOT WAIT

Hollis D. Day, MD, MS, MHPE; Elizabeth D. Davey, MBA; Patrick G. O'Connor, MD, MPH, MACP

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An e-mail from SGIM appears periodically in your inbox asking you to consider a donation to SGIM. Although it's easy to delete these messages, this article explains why participation in SGIM's Forging Our Future program is critically important.

The term *philanthropy* derives from the Greek roots meaning "love of humanity" (*philein* + *anthropos*). At its core, philanthropy is an active commitment to promoting human welfare and improving the lives of others. Philanthropy can take many forms—giving money, time, or talent—but its purpose is always the same: to address societal challenges and advance the public good. Everyone can be a philanthropist, regardless of wealth.

In our roles as Co-Chairs of SGIM's Philanthropy Committee and SGIM's Development Officer, we believe donors to SGIM must understand the important distinction between charitable giving and philanthropy. Charitable giving focuses on a one-time gift for immediate relief, while philanthropy takes a longer, more strategic view—seeking lasting, systemic change. Although both are vital, philanthropy looks beyond today's needs to build tomorrow's opportunities for education, growth, and sustained impact.

The Philanthropy Committee's stewardship of SGIM donations is carefully managed with a deep commitment to maximizing the impact of every cherished donation. The committee is grateful for every donation received regardless of the amount. The following are recent examples of how the Philanthropy Committee has overseen these finances:

- Members' generosity allowed SGIM to navigate the financial challenges of the COVID-19 pandemic.
- With your help, SGIM developed GIMLearn, a learning portal offering high-quality evidence-based content on subjects of interest to our members that is not available from other societies.
- Donor dollars provide an array of SGIM career development programs cultivating innovative educators, researchers, and clinicians in academic general internal medicine, including the TEACH Certificate Program,

PHILANTHROPY (continued from page 10)

Leadership in Health Policy Program, Unified Leadership Training for Diversity, the MedEd Scholarship Faculty Development Program, the Career Advising Program, and Academic Hospitalist Academy Programs. While many SGIM programs are designed for those early in their careers, members of all career stages benefit by participating in networking and mentoring.

"Donor dollars have a large impact on the development and sustainability of SGIM's hallmark programming. Through their donations, SGIM members revitalize our organization and assure our success at advancing the mission, vision and values of SGIM."

Donor dollars have a significant impact on the development and sustainability of SGIM's hallmark programming. Through their donations, SGIM members revitalize our organization and assure our success at advancing the mission, vision, and values of SGIM.

Introduced in 2020, the Forging Our Future program stimulated member giving to SGIM and is closing in on one million dollars raised over the last six years![1]

- The program met its initial goal of raising $500,000 from 2020 to 2023.[2]
- The percentage of SGIM members giving increased from 3% to 11%.
- Annual giving increased every year by 5-15% since 2020.
- SGIM raised $141,870 in individual donations in 2025, a 15% increase over the previous year.

The Forging Our Future program has significantly increased total dollars raised and member giving since its inception in 2020.

Philanthropy has a very human face—these faces are visible as you stroll through the poster sessions at each annual meeting. These are the faces of trainees who attend the Annual Meeting because of donations supporting the National Young Scholars in GIM program. This program awarded 70 scholarships last year and, thanks to SGIM donors, will support a similar number of attendees again this year.

While exploring the poster sessions and reviewing scholarship recipients in the meeting app, you will have the opportunity to speak with trainees such as Alex Hoffner-Heinike, an internal medicine resident at Massachusetts General Hospital in Boston, Massachusetts. Alex shared that the scholarship he was awarded by the National Young Scholars program made it financially possible for him to attend the conference:

"One of the greatest advantages to coming is being able to network and learning how we can advocate for our patients, both treating them individually as well as on a broader scale, which is important now more than ever. Allowing new trainees the opportunity to come and jump start their careers is really beneficial and I think will benefit patients in the long run."

As SGIM approaches its 50th anniversary, members have a unique opportunity to think boldly and strategically about the future of academic general internal medicine. Our anniversary philanthropy efforts will focus on strengthening the GIM pipeline by investing in the next generation, particularly GIM fellows and junior faculty. With member support, the Philanthropy Committee hopes to build on the current Investing in GIM program to create a robust, sustainable system of support at this pivotal stage of career development.

We will officially introduce these efforts at the 2026 Annual Meeting (#SGIM26). In the meantime, what can members do right now?

- **Make a gift online:** A quick and secure way to support SGIM. Scan the QR code below or visit SGIM.org and click the "DONATE" button today to make your gift.
- **Add a gift when you renew your SGIM membership or register for regional and national meetings:** When renewing your membership or registering for a meeting, you can add a contribution. Every dollar donated helps to expand opportunities for our community.
- **Give monthly:** Set up a recurring gift to provide steady support throughout the year. Even small monthly contributions (think the cost of a coffee!) add up to a significant impact and recurring gifts help secure the future of SGIM.
- **Donor-Advised funds (DAFs):** A donor-advised fund is an increasingly popular way to give that offers strong tax benefits while supporting the causes you care about. If you have a DAF, you can recommend SGIM as a recipient and make a lasting impact on the future of general internal medicine.[3]
- **Planned giving:** Leave a legacy by including SGIM in your estate plans. Consider participating in our Legacy Program for Bequests and Planned Giving which allows members to designate a portion of their estates, investments, and retirement funds to support SGIM's innovative activities and vital core operations.

For more information on these opportunities to donate to SGIM please contact Liz Davey at daveye@SGIM.org.

PHILANTHROPY *(continued from page 11)*

As we approach the Annual Meeting, stay alert for opportunities to contribute—look for QR codes at upcoming meetings and participate when you see them. There is no contribution too small and no voice too quiet to help secure the future of our organization. "Don't wait to make a difference." Your support is the engine behind SGIM's work and we rely on SGIM members like you to drive real change.

Click the QR code to fuel our mission today!

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SGIM

LEADERSHIP AND HEALTHCARE ADMINISTRATION

MENTORSHIP AND SPONSORSHIP IN CHALLENGING TIMES

Mitchell D. Feldman, MD, MPhil, FACP

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Introduction

Mentorship plays a central role in supporting trainee and faculty well-being, career satisfaction, scholarly productivity, and retention in academic medicine. Mentors also benefit from these relationships; mentoring can extend professional impact, expand networks, and provide opportunities for professional fulfillment and personal growth.

However, over the past few years, the mentoring environment has become increasingly complex. Volatility in federal research funding, tightening institutional budgets, and growing misalignment between individual values and organizational priorities have altered the conditions under which academic careers unfold. These pressures affect mentors and mentees alike and challenge assumptions about linear career progression, stable opportunity, and predictable professional advancement. In this context, mentors may struggle with how to offer guidance that is both realistic and sustaining, while mentees may experience loss of momentum, uncertainty about their future, or difficulty translating reflection into action.[1]

In this article, I highlight five practical tips for mentors and mentees to sustain effective, supportive mentoring relationships when career pathways feel constrained or less predictable. Rather than focusing on crisis response, these strategies emphasize presence, listening, values-based reflection, empowerment, and sponsorship as tools to maintain professional momentum and meaning.

Tip One: Attend to Capacity and Presence

When professional and personal demands intensify, attention to basic physical and emotional well-being becomes foundational to effective mentoring. Adequate rest, physical activity, nutrition, and social connection enable mentors and mentees to engage with clarity and patience.

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Entering a mentoring conversation while depleted can unintentionally lead to rushed guidance, excessive problem-solving, or emotional disengagement.

Before a mentoring meeting, both mentors and mentees benefit from pausing to assess their capacity to be fully present. Naming the broader context in which the conversation occurs can normalize strain and reduce unspoken tension. When appropriate, mentors may briefly share strategies they have found helpful for maintaining balance, while remaining mindful not to shift focus away from the mentee. Establishing confidentiality and psychological safety is essential to creating a space in which honest reflection and exploration can occur.

Tip Two: Practice Humility and Listen Actively

Unstable and uncertain times may prompt mentees to raise fundamental questions about identity, values, and career direction. These questions rarely lend themselves to rapid resolution. Mentors need not (and should not) provide definitive answers; instead, they can offer careful listening and thoughtful partnership.

Mentors can role model humility in the face of uncertainty which can be powerful to normalize for mentees that there is no "right" answer. Humility in mentoring involves acknowledging the limits of one's own knowledge and resisting the impulse to prematurely "fix" the problem. Active listening is not only a core competency for both mentors and mentees but also a powerful and necessary skill to use during uncertain times. The traditional Chinese character for listening—(聽, ting)—offers a useful metaphor, incorporating the elements of ears, eyes, undivided attention, and heart. In practice, this means listening for content and the nuance of emotion and meaning.

Reflecting back what is heard helps confirm understanding and provides validation. Asking open-ended questions such as "What strengths do you consistently draw on in difficult moments?" or "What resources or relationships would make the greatest difference right now?" can foster insight and agency. Concluding with a question that invites commitment to a next step reinforces self-efficacy and helps mentees move from rumination toward action.

Tip Three: Recalibrate Career Direction through Values and Opportunity

At certain points, mentors and mentees may find it useful to step back and consider whether a career "pivot" is warranted as a response to uncertain times. This process is not about abandoning core values and skills, but about reassessing alignment between evolving values, available opportunities, and current roles. Remember that a pivot means that one foot remains grounded while the mentee considers and explores multiple options before choosing a path forward.

Values-based reflection can guide this process. What aspects of the mentee's work have been most meaningful? Where do mission, skills, and motivation intersect? How might these elements be expressed differently given current constraints? Pragmatism is essential, but so is intentionality. Mentors should recognize and name the emotional weight of this reflection. Physicians and scientists often hold deeply rooted professional identities, and contemplating change can evoke grief, doubt, or loss. Acknowledging these emotions, while also affirming the possibility of growth and renewal, can help mentees navigate recalibration with resilience and clarity.

Tip Four: Reinforce Empowerment and Self-Efficacy

When future pathways feel less predictable, mentees may experience diminished control and confidence. Mentoring conversations should conclude in ways that restore a sense of agency. Identifying clear, achievable short-term goals paired with a plan for follow-up can counter feelings of stagnation and reinforce momentum.

It is particularly important in challenging times for mentors to explicitly support mentee self-efficacy. Self-efficacy refers to the belief in one's capacity to carry out actions necessary to achieve desired outcomes. This quote from a mentee from a qualitative study[2] on mentorship captured this impact succinctly:

> *"[She] continues to . . . challenge me to seek higher personal achievement than I would on my own. So, [she] is an outstanding mentor* ***because she saw what I could become.***" (emphasis added)

Belief from a trusted mentor can be a powerful catalyst for self-belief. In addition, engaging in advocacy can be empowering for both mentors and mentees. Getting engaged in advocacy activities, be they local or national, can help provide a needed boost to a sense of empowerment when faced with a constantly shifting national landscape.

Tip Five: Lean into Sponsorship

Mentorship alone may be insufficient to support advancement during challenging times. Sponsorship, a relationship in which an individual in a position of influence actively advocates for another's career progression, plays a distinct and critical role. While sponsorship has roots in the business sector, it is increasingly recognized as essential in academic health systems.[2]

Sponsorship is proactive and outward facing. It includes nominating mentees for awards, leadership roles, and opportunities; facilitating introductions; and making visible the mentee's contributions to decision-makers. Evidence suggests that sponsorship is important for women and individuals historically underrepresented

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in the health professions, for whom informal access to opportunity may be limited.[3,4]

Mentors should be intentional about identifying sponsorship opportunities and encouraging mentees to seek sponsors in addition to mentors. For mentees, recognizing that sponsors can expand networks, amplify visibility, and affirm potential can help counter hesitation about asking for support.

Conclusion

In an era of constraint and uncertainty, mentorship and sponsorship are essential to sustaining meaning, connection, and professional momentum in academic medicine. By attending to presence and their own physical and emotional resilience, listening deeply, grounding decisions in values, reinforcing self-efficacy, and actively engaging in sponsorship, mentors and mentees can navigate complexity without losing sight of purpose and opportunity. Even when career paths are less predictable, intentional mentorship and sponsorship can continue to support growth, resilience, and fulfillment.

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SGIM

SIGN OF THE TIMES

WHEN TRANSFORMATION BECAME TAKEOVER: MEDICINE IN THE AGE OF CORPORATE HEALTH CARE

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Dr. M called me, her voice carrying that exhaustion I've learned to recognize among colleagues. *"They're making me see twenty patients a day now,"* she said. *"Twenty! The new productivity targets came down from corporate this morning."*

At that moment, I saw what I hadn't considered in our careers: the unexpected erosion of what we'd thought medicine would be. *"How are you supposed to provide good care with that schedule?"* I asked, though we both knew the answer.

"That's just it," she replied. *"I don't think they care about good care anymore. They only care about throughput."* In this article, I share my learned understanding of the corporate capture of American medicine, a transformation that has distorted the meaning of healthcare change.

When Transformation Lost Its Way

In his Pulitzer Prize-winning 1982 book, sociologist Paul Starr chronicled how the medical profession evolved from a fragmented array of practitioners into what he termed a *Sovereign profession* (a profession wielding unprecedented cultural authority and autonomy over clinical decisions).[1] Even Starr could not have anticipated the corporate transformation reshaping American medicine today. The numbers are stark: 55% of physicians

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now work in practices they don't own, down from 58% a decade ago, while hospital employment has risen to 27%.[2] Behind those statistics are stories like Dr. M's in which physicians are caught between clinical judgment and corporate mandates.

Healthcare transformation should include fundamental changes aimed at improving quality, efficiency, and accessibility. It should involve rethinking care delivery, integrating technologies that enhance patient relationships, and fostering collaboration that prioritizes healing over profit margins. Instead, we've witnessed the systematic dismantling of "professional sovereignty."

The Mechanics of Corporate Capture

What we're experiencing isn't natural evolution—it's engineered capture. Private equity firms now control hundreds of hospitals and a substantial share of emergency rooms nationwide. Their model is consistent: acquire healthcare entities through leveraged buyouts, load them with debt, extract profits through aggressive cost-cutting—reducing staffing ratios, deferring capital maintenance, eliminating services deemed unprofitable—and exit within 3-7 years, regardless of the long-term impact on patient care.[3]

> "If enough of us choose patient care over corporate efficiency, clinical judgment over compliance, community health over investor returns, we can still reclaim the true meaning of healthcare transformation."

The profit extraction phase unfolds predictably. First comes rhetoric about "operational efficiency." Then, mandatory productivity targets make thoughtful patient care nearly impossible. Staff cuts follow, with nurse practitioners substituted for physicians in complex cases. Finally, pressure to provide additional procedures to meet revenue targets. Research shows that physician autonomy significantly affects professional satisfaction and patient outcomes.[4] Corporate entities routinely violate these principles.

The Human Cost

What breaks my heart is how this transformation has betrayed medicine's fundamental promise. During residency, we discussed evidence-based care, shared decision-making, and patient-centered treatment. We believed technology and systematic approaches would enhance our ability to heal. Instead, I watch colleagues implement "standardized protocols" designed not to optimize care, but to maximize billing.

Dr. P, who practices emergency medicine at a private equity-owned hospital, described the pressure to order additional tests, not because they are clinically indicated, but because they generate revenue. *"I feel like I'm betraying everything I learned about appropriate resource use,"* she said. *"But if I don't hit their numbers, they'll find someone who will."* This erosion of clinical autonomy drives the burnout epidemic plaguing American medicine.

Reclaiming True Transformation

Genuine healthcare transformation should entail the following:

- Enhanced patient outcomes through personalized care.
- Improved access through community-centered delivery.
- Strengthened clinician-patient relationships through adequate time and resources.
- Sustainable systems that prioritize long-term community health over short-term investor returns.[5]

I've worked in settings that prioritize these values—practices that provide adequate patient time, community hospitals that maintain local governance, and academic centers that balance efficiency with educational missions. In these environments, I have observed what authentic transformation achieves: improved patient satisfaction, enhanced clinical outcomes, and greater physician satisfaction.

Moving Forward Together

Dr. M called again last week. She had decided to leave her corporate-owned practice for an academic group prioritizing patient care over metrics. *"I know the salary will be lower,"* she said, *"but I want to practice medicine the way we were trained."*

Her decision gives me hope. If enough of us choose patient care over corporate efficiency, clinical judgment over compliance, community health over investor returns, we can still reclaim the true meaning of healthcare transformation. We must also model these values for trainees, the residents, and medical students who will practice long after this battle is decided. They need to see that patient-centered medicine remains worth fighting for.

Within the SGIM community, we have both expertise and responsibility to advocate for genuine transformation. This means supporting policies that preserve physician autonomy, maintain community control over essential services, and ensure that organizational innovations enhance rather than replace the human elements of care. We have the expertise; now we must act. The question is whether we'll do so before the corporate capture of American medicine becomes irreversible. The health of our patients and the soul of our profession hang in the balance.

SIGN OF THE TIMES *(continued from page 15)*

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SGIM

MEDICAL EDUCATION

THE POWER OF BEING PRESENT AT THE BEDSIDE: A RESIDENT-ATTENDING CALL FOR ACTION

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Introduction

Bedside rounds are not merely a nostalgic tradition but a vital, modern clinical tool. These rounds sharpen diagnostic accuracy, deepen patient engagement, and provide context-rich dynamic learning data not replicated by Electronic Medical Record (EMR) based assessments.[1] Bedside rounds are essential to preserving the human connection at the core of medicine. Most articles on this topic have been written by attending physicians, who practice and teach this skill regularly. However, the perspective of trainees—closest to the tension between digital efficiency and embodied clinical care—is often missing.

The case here describes a subtle neck pulsation detected by an observant resident on rounds that had gone unnoticed during chart review. This discovery led to a diagnosis of an unrecognized cardiomyopathy and the avoidance of potentially harmful chemotherapy. Such moments highlight the irreplaceable value of practicing mindful presence, observation, and intentional bedside engagement by resident and attending team leaders. Based on the shared experiences of a resident and attending, this article offers adaptable practical bedside rounding strategies for the complex demands of inpatient care. These strategies help trainees and attendings reclaim the bedside as a space where clinical skills, presence, and humanism converge to educate future physicians.

Clinical Case

The morning had been hectic; all the pre-charting and diligent copying of hospital EMR information didn't leave the team enough time to see patients for more than a brief morning visit. This female patient was admitted for initial chemotherapy; she reported no cardiopulmonary symptoms, and her chart showed stable vital signs. As the medical student presented, there was no mention of an assessment for the jugular venous pulse. However, the subtle pulsation along the patient's neck had caught the eye of the senior resident as the team had entered the room. The student was prompted to take a closer look at the patient's neck.

A quick bedside ultrasound supported the concerns for elevated right atrial pressures. Observation of that slight, rhythmic movement in the patient's neck would change the plan of care. Chemotherapy was postponed,

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and subsequent imaging confirmed the suspicion of undiagnosed cardiomyopathy. An astute observation of a physical sign saved this patient from receiving cardiotoxic chemotherapy that could have exacerbated an underlying heart condition.

Discussion

Bedside rounds have long been a cornerstone of medical education. Although the practice has evolved, their value remains irreplaceable in modern health care. Noted physician Sir William Osler once said, *"To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all."*[2] In our modern medical landscape, we may say that *"Learning tools and EMRs provide the map, but bedside assessment provides the journey, all necessary for comprehensive patient care."*

Despite efforts by training programs to promote bedside rounds, unique challenges including time constraints, competing priorities, increased documentation burden and the lure of the EMR often make conference room rounds more appealing to the team. This space becomes a cozy digital cocoon that avoids the messy realities and unpredictability of the patient's bedside.

But medicine isn't meant to be practiced in a cocoon. Famed neurologist Dr. C. Miller Fisher, an astute diagnostician who championed the art of direct observation, wisely noted *"The bedside can be our laboratory."*[3] What a laboratory it is! Where else can trainees simultaneously hone diagnostic skills, practice bedside manners, and occasionally discover that the patient's "stage II ulcer" offers an in-depth revival of medical school anatomy?

> **"Bedside rounds have long been a cornerstone of medical education. Although their practice has evolved, their value remains irreplaceable in modern health care."**

Bedside rounds also offer multiple additional benefits. Patients have a chance to be more than a collection of lab values and imaging studies. Their experience of being valued as a person and educator for medical trainees engages the patient to become an active participant in their care. Trainees receive immediate feedback and context-based learning. Classroom teaching, without real-time patient context, can be associated with memory decay of the material taught, a phenomenon tested by Dr. Fisher in his practice.[3] However, patient context makes learning visceral, immediate, and long lasting. Trainees are more likely to remember the technique for assessing jugular venous distention when demonstrated on a patient than watching a video.

Efficiency, the holy grail of modern medicine and constant worry for resident physicians, can be improved through bedside rounds. Instead of playing phone tag with nurses or deciphering cryptic consultant messages, issues can be addressed real-time as team members are co-located with the patient. It's like a well-choreographed dance, where each team member knows their steps and moves in harmony around the patient, ensuring that care is coordinated and efficient.

Effective Bedside Rounding Strategies

Practicing mindfulness, intentionality, and flexibility will help residents and attending physicians deliver effective teaching while managing patient care. Being mentally present at the bedside is a foundational strategy for teachers. The clinical case illustrates that simply going through the motions of bedside rounds is not enough. True presence requires focused attention and actively observing the demeanor and nonverbal cues of the patient and team members. By paying close attention to the words, tone, and nonverbal expressions, active listening fosters deeper understanding and connection with the patient.

Mindful assessment involves approaching the physical exam with intention, and a hypothesis-driven, discovery-oriented mindset. Establishing a holistic perspective incorporates the patient's overall clinical and psychosocial picture rather than isolating individual data points at a single moment in time. By intentionally grounding oneself in the present at the bedside, subtle yet critical findings are uncovered that might otherwise be missed. It transforms bedside rounds from a routine task into a powerful diagnostic and therapeutic tool. This intentional presence uncovers a world of teaching points which can be used in combination with open-ended questions for real-time, context-based teaching at the bedside. The accompanying table lists additional strategies to improve bedside rounds.

These valuable tips will help trainees and educators maximize bedside round experience, improve the clinical care of patients, and reinforce educational concepts for trainees.

Conclusion

Physician work should not be confined to computer screens that reduce patients to digital avatars that are cared for through the EMR interface. The true art of medicine unfolds at the patient's bedside through patient engagement, human connection, and attention to detail. Like a painting whose essence eludes the casual observer, genuine understanding emerges through direct engagement. In table rounds, each brushstroke gets dissected, but it is at the bedside where the masterpiece reveals itself

MEDICAL EDUCATION *(continued from page 17)*

Practical Tips for Residents and Attendings to Incorporate Bedside Rounds	
Tip	**Example**
Time management	Weave in flexible yet specified rounding times during the day to combine care for patients with teaching for trainees.
Thoughtful patient selection	Starting out, it may help to focus initially on patient(s) who are relatively stable, have abnormal physical findings, or need patient friendly discussion on illness or medical decision.
Manage and prime expectations	State what to expect and learn at the bedside. For example, "In this patient, we will focus on heart failure exam findings or discussing treatment options."
Introduce the team, state the purpose of the visit, and obtain patient permission	"Today we would like to hear your story, examine your heart, and discuss your treatment plan. Would this be okay with you?"
Practice active listening and observing	Focus on verbal and nonverbal clues from the patient and team; use them to create teaching pearls.
On rounds, allow technology to gather information and address tasks in parallel	Demonstrate heart failure findings through a Point of Care Ultrasound and chest x-ray images while placing diuretic orders with a portable computer.
Use open-ended questions to encourage clinical reasoning	"What are some reasons why we see a pulsation on the patient's neck. How can this guide us?" Such questions limit the risk of a trainee feeling the pressure of being caught in a "wrong answer" trap.
Create a safe space to reflect, debrief, and create future plans	Outside of the patient's room, debrief, summarize teaching for context-based learning reinforcement, seek input on improving the experience.

in its entirety. Let's step away from our digital cocoons, brave the wilds of the hospital floors, and embrace the bedside.

The bedside rounding strategies described here include a resident's experience and commentary on this practice. This viewpoint adds a unique perspective on the importance of bedside rounding for SGIM Forum readers. Our call to action is for the SGIM community to intentionally lead teams to bedside rounds, model effective strategies, foster professional growth, and reclaim the joy of medicine.

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