MAY 2026 V49, NO. 5

SGIM FORUM

IN THIS ISSUE:

The Coaching Confidence Myth—And a Simple Fix for Immediate Improvement ... 1
History of SGIM's Southern Region ... 4
Why We Gather—And Why It Matters ... 8
Q & A on SGIM's Primary Care Priorities ... 10
Cultivating Joy and Meaning in Hospital Medicine: A Qualitative Study of Hospitalists' Experiences ... 13
The Human One-Liner: Reclaiming Joy in Patient Care ... 15
Go and Listen to the People: A Case for "Narrative Street Medicine" ... 17
Reimagining Cardiovascular Care for Young Black Adults in the Age of Artificial Intelligence ... 19
Clinical Reasoning for Gastrointestinal Bleeding: Consider GI Amyloidosis When You See the Atypical ... 21

LEADERSHIP AND HEALTHCARE ADMINISTRATION

THE COACHING CONFIDENCE MYTH—AND A SIMPLE FIX FOR IMMEDIATE IMPROVEMENT

Cara Hale Alter

Ms. Alter (cha@speechskills.com) is the author of The Credibility Code,[1] an international keynote speaker, and the founder of SpeechSkills.[2] Her 25 years of experience and deep understanding of how nonverbal communication shapes the perception of leadership presence was showcased in her featured presentation at the ACLGIM Winter Summit.

How is it that some individuals walk into a room and we immediately have faith in their expertise? Clearly it is not magic, but we must be responding to observable cues in their body language, vocal quality, and mannerisms.

There's a common misconception that our assessments of other people are purely subjective. However, as the founder of *SpeechSkills*,[2] I've spent 25 years researching specific observable cues that most influence the perception of confidence, trustworthiness, credibility, and gravitas. The term I like to use to tie these qualities together is *Visible Credibility*—the ability to project confidence and competence so that your value is immediately recognized. If we want to maximize the potential of our teams, we need to stop assessing qualities and start identifying behaviors. In this article, I will review how to cultivate Visible Credibility, discuss the impact of behavior-based feedback, and offer perspective into our own blind spots and how to initiate change.

How to Cultivate Visible Credibility

In my work with physician leaders, I often hear a familiar concern. A department chair or medical director will say "*She's clinically excellent, but she doesn't project confidence*," or "*He's clearly capable, but he doesn't yet have the assertive presence we expect at this level.*"

When I ask a follow-up question—"*What explicit behaviors need to be adjusted?* "—the answer is often, "*I can't quite put my finger on it.*"

This isn't a failure of leadership judgment: it's a human processing problem. Our brains have evolved to

 (continued from page 1)

rapidly assess all the observable cues we witness and instantly correlate these behaviors into an assessment: "*Not confident enough. Not strong enough.*" The ability to shortcut the assessment process is valuable when we need to make fast decisions. However, it can be detrimental when we are trying to identify the specific cues driving our judgments.

As someone who works across industries, I've always admired how medical professionals approach assessments. Information is gathered about observable symptoms, specific behaviors, and tangible diagnostics. Only then is the patient given a practical plan for improvement. The same should be true for cultivating Visible Credibility. Coaching someone by saying "*You need to be more confident*" would be like a physician telling a patient "*You need to be healthier.*" Perhaps this is true, but the feedback is too incomplete to be helpful.

As it turns out, a relatively small number of keystone behaviors have a disproportionately large impact on one's visible credibility. These behaviors function like load-bearing walls. Strengthen them, and everything else improves. Some of the most influential behaviors include the following:

- **Strong posture:** literally a strong spine and level head.
- **Strong voice:** consistent, optimal volume that doesn't trail off.
- **Strong eye contact:** held long enough to establish a true connection.
- **Physical stillness:** the absence of self-soothing movements.
- **Concise language:** free of excess verbiage and filler words.

The Credibility Code

Self-evaluation Checklist

POSTURE	YES	NO
Spine is tall and strong	○	○
Weight is balanced equally over both feet	○	○
Head is level	○	○
Nose is pointed directly at listener	○	○
Head and arms move freely in space	○	○

GESTURES	YES	NO
Face and hands are relaxed (no "masking")	○	○
Gestures are engaged from beginning of conversation	○	○
Hands consistently reach out	○	○
Gestures stay primarily within gesture box	○	○

DERAILERS	YES	NO
Free of uses of filler words	○	○
Statements end in downward inflections	○	○
Free of extraneous movement	○	○
Free of "self-commenting" and apologies	○	○

VOICE	ABSENT	BELOW AVERAGE	ADEQUATE	OPTIMAL	TOO MUCH
Volume is full and consistent	○	○	○	○	○
Articulation is crisp and clear	○	○	○	○	○
Pacing is relaxed	○	○	○	○	○
Message is highlighted with expression	○	○	○	○	○
Vocal quality is supported and resonant	○	○	○	○	○

EYE CONTACT	ABSENT	BELOW AVERAGE	ADEQUATE	OPTIMAL	TOO MUCH
Contact is held for three to five seconds per person	○	○	○	○	○
Eyes engage everyone in the room	○	○	○	○	○
Focus is consistently up	○	○	○	○	○
Eyes, hands, and face interact with listener	○	○	○	○	○

For info about our workshops and online courses, visit speechskills.com

Although none of these behaviors reflect intelligence, training, or clinical skill, they influence whether others experience someone as grounded, confident, and credible. When verbal content and nonverbal behavior are aligned, credibility feels effortless. When they are misaligned—strong ideas delivered with soft volume, dropped eye contact, or constant movement—listeners experience uncertainty, even if they can't name why.

The Impact of Behavior-Based Feedback

Once we train ourselves to filter the qualities of visible credibility through the keystone behaviors above, it becomes significantly easier to pinpoint nonverbal cues that either support or undermine someone's effectiveness. A truly helpful coach acts like an outside eye to identify

what is working and what is not. Compare the different approaches below:

Standard Approach	Optimal Approach
"You need to sound more confident."	*"Your volume is very soft, making it difficult to hear you, and you often trail off at the end of your sentences."*
"You seemed nervous."	*"Your pace was very fast, and you used a significant amount of filler words – about two or three per sentence."*
"You need to connect more with your audience."	*"Instead of making eye contact, you looked down at your notes about 70% of the time. Even when you looked up, you seemed to scan the group rather than to truly see the individuals in the room."*

In each case, the optimal approach focuses on the behavior rather than the assessment. This approach preserves personal identity, reduces defensiveness, and pinpoints the explicit behavior that needs adjusting. For those responsible for developing the potential of others, this shift is powerful. Additionally, focusing on behavior-based feedback is an excellent way to diagnose where we ourselves can improve. An exceptional leader should also be an excellent role model. It can be a bitter pill to swallow, but our bad habits are notoriously difficult to self-diagnose.

We Are Blind to Our Own Blind Spots

If we're ineffective, it is almost certainly unintentional. No one is ineffective on purpose. If we aren't performing at our best or aren't representing ourselves accurately, it's usually because of a blind spot. We're unaware that we are exhibiting a certain behavior or we are unaware of the impact of that behavior.

It makes sense that we're relatively unaware of our own mannerisms since there is no way we can actively focus on the hundreds of signals we exhibit at once: posture, gestures, volume, pitch, pace, articulation, inflection, eye contact, head movement, and so on. To focus on higher-level communication skills, such as forming words into sentences and interpreting reactions, we lock these lower-level behaviors into our muscle memory, or subroutines, so that they run on autopilot.

Understanding subroutines also helps us understand the cause of unintentional behaviors in our style. Once a bad habit creeps into a subroutine, we pay no attention to it. It becomes embedded in the program. This is why smart, capable people can be oblivious to their own bad habits.

The great news is that simply raising awareness about an unconscious habit is sometimes all that's needed to spark immediate improvement. We may be fully capable of making the adjustment, we just didn't know it was necessary. And the fastest and most direct way to increase self-awareness is video feedback.

The Courage to See Yourself as Others Do

It's a fairly universal truth that people do not like to watch themselves on video. However, after coaching thousands of individuals, when I dig deeper into why they dislike the exercise, they'll almost always admit that they don't like what they see. Their outside view of themselves doesn't sync up with how they felt from the inside.

While it may cause a momentary deflation of confidence, this realization is a powerful motivator for growth. If we become aware that we aren't representing ourselves accurately, we have a fierce drive to align our outside behaviors to our internal sense of self.

It's helpful to capture a video clip of yourself (or mentee) in action leading a staff meeting, giving an update, or making a formal presentation. If that's not possible, set up a mock conversation and record it on your cell phone or virtual meeting platform. While it may not be as accurate as a real-world interaction, you can still gain valuable insights since our communication subroutines tend to follow us around from conversation to conversation.

When evaluating, take on a coaching mindset by focusing on behaviors rather than judgements. If you find yourself jumping to negative assessments ("shy, unsure, self-conscious, distracted, or insert-adjective-here"), force yourself to identify the explicit nonverbal cues that are creating those impressions. Then, come up with an action plan to counteract any undesirable behaviors.

As outlined earlier, you can cultivate a practical scaffolding for projecting visible credibility by focusing on strong posture, strong voice, strong eye contact, avoiding extraneous movement, and eliminating filler words. A detailed self-evaluation tool (see figure) can assist you in assessing your personal behaviors.[3]

It takes much courage to take an honest and critical look at yourself. However, whether we're self-evaluating or offering guidance to team members, we can take the sting out of difficult feedback by focusing on observable cues and actions.

Conclusion

One of the most liberating realizations for physician leaders is that credibility is not an abstract trait, but a set of behaviors that can be defined, observed, coached, and modeled. We move away from the myth that presence is something you either have or don't, but rather a tangible skill set ripe for development. SGIM members should feel empowered to adopt this skill set and use it in their toolkit as they work on giving feedback to others and themselves.

References

1. Alter CH. *The Credibility Code: How to Project Confidence and Competence When It Matters Most.* Meritus Books, 2012.
2. SpeechSkills. https://www.speechskills.com. Accessed April 15, 2026.
3. Self-evaluation checklist. *SpeechSkills*. https://www.speechskills.com/assets/pdfs/Self-Eval-Checklist.pdf. Accessed April 15, 2026.

SGIM

FROM THE EDITOR

HISTORY OF SGIM'S SOUTHERN REGION

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

"Whoever wishes to foresee the future must consult the past; for human events ever resemble those of preceding times."[1]

On Christmas Eve in 2008, as president of the Southern region of SGIM (SSGIM), I sent the following e-mail to several founding members of the Southern region:

> *"All,*
>
> *I have a request for the group as senior members of our regional SGIM. I would like to put together a list, if possible, of members who have been active in the Southern region or have been supportive of the Southern region by sending or supporting faculty/trainees to attend.*
>
> *I would like to list these individuals who have 20 years or more attendance (if we have some) or at least 15 years. I am not sure of the history here as to when the Southern region of SGIM came to be as there is no posting of this anywhere. This might be a future posting that we can have on the Southern regional site of our regional history. In reviewing the bylaws, it appears that they were accepted in February 1988 which would make this either our 20th or 21st meeting (if anyone knows for sure, please let me know if this is the 20th since we can point this out at the meeting).*
>
> *We would like to present certificates to these members with long standing commitment to the Southern region either directly through their attendance or through their support for others to attend from their institutions.*
>
> *Please send me a list of names or comments on this thought at your convenience.*
>
> *Thanks, and Happy holidays to all,*
> *Michael Landry, MD"*

FROM THE EDITOR *(continued from page 4)*

The subsequent e-mail exchanges between Andy Diehl, Stephen Miller, Henry Perkins, Eugene Boisaubin, Bob Centor, and me generated great dialogue and fond memories for SSGIM founding members. Steve Miller took the lead in generating the history below which I have since revised and updated in this article. This history was shared at the 2009 Southern regional meeting (but not published elsewhere). The history of SGIM and each region can perhaps be recorded in a similar fashion as we prepare to celebrate the 50th anniversary of our organization.

History of Southern SGIM

The organization and meetings of SSGIM were a consequence of the growth of national SGIM in numbers and credibility. SGIM began as a national meeting and organization in 1978 under the name "Society for Research and Education in Primary Care Internal Medicine" (SREPCIM) before becoming SGIM in 1988. Early members of SREPCIM began attending the annual Southern Society for Clinical Investigation meetings in New Orleans, Louisiana, to present their research and establish a network of generalist academicians. Southern medical schools were establishing new Divisions of General Internal Medicine, and many attendees of the New Orleans meetings were selected as division heads or key faculty. In 1981, an informal group of eight SREPCIM members encouraged by Council member Anderson Spickard, Jr., (Vanderbilt University) met to form what would become the Southern Regional Chapter of SGIM.

Early Meetings

Steve Miller (University of Tennessee, Memphis) organized the first official Southern regional meeting in 1982. The topics of the first meeting outlined the diverse focus of members and indicated that the long-standing missions of academic generalists were firmly rooted in our early history. Topics included: Management of Symptoms by Clifton Meador (University of South Alabama), Primary Care Internal Medicine Tracks by Rick Walker (University of Virginia), Ambulatory Teaching Time by Roberta Munson (University of Arkansas), Behavioral Science Curriculum by Eric Jensen (University of North Carolina), and Geriatrics Curriculum by Bill Applegate (University of Tennessee). The first meeting demonstrated the involvement of numerous academic units throughout the Southern Region.

The first meeting also demonstrated the commitment and enthusiasm of the early participants. The day before the meeting, an airplane crash occurred at Washington National (Reagan) Airport, when an Air Florida plane developed iced wings on the runway and struck the 14th Street Bridge at take-off. Only five of the 79 passengers survived. Colleagues from the University of Virginia were waiting on a runway on another plane when the accident closed the Washington, DC, airport for the remainder of the day. The Virginia contingent returned to Charlottesville on icy roads, obtained another flight the next day, and made it to New Orleans 36 hours after their planned departure just in time for the opening session.

At that meeting, Gene Boisaubin (Baylor College of Medicine) made the important observation that the meetings should also include presented research if Southern SREPCIM was to grow into a respected academic chapter. Educational discussions should and would continue to be part of Southern SREPCIM (later SSGIM), but Southern SREPCIM should also develop its research agenda and not leave that component of academic work to the other societies. Gene committed to be the Scientific Program Chair for subsequent Southern SREPCIM meetings, and for the next few years, he and Henry Perkins (University of Texas-San Antonio) designed the meetings of Southern SREPCIM and ensured their success.

At the second meeting in 1983, 13 research abstracts were on the program, including management issues in COPD, hypertension, and diabetes mellitus. In addition, research addressed physician errors, readmissions to the hospital, and costs of inpatient versus outpatient care. These topics remain relevant today and illustrate that general internal medicine faculty were always ready to tackle difficult issues.

By 1984, the meeting had grown to a full-day meeting with 20 presentations and four workshops representing 13 medical schools in the southern region. In the years that followed, there was an average of 40 abstract submissions annually with a 100% acceptance rate. The idea was to encourage GIM research and experience in presenting to a professional peer audience. Founding members recognized that such presentations were important for promotion. At these early meetings, there were no clinical vignettes or mentoring sessions, and few if any students and residents.

Program chairs often roped folks into coming by putting them on the program one way or another. Panel discussions were a wonderful venue for this purpose. The most memorable reluctant early attendee was Dr. Richard "Rick" Davidson (University of Florida) who feared flying and decided to ride the Amtrak train from Florida to New Orleans. SSGIM leaders had no idea he would not fly when they "pressured him" to give a presentation.

Association with other Southern academic societies was important to the early success of SREPCIM and later SGIM in the Southern region. The early hopes and expectations for SSGIM had been accomplished and exceeded. SSGIM continues to provide structure for members in the region and has been a continuing positive influence on the growth of academic generalists.

FROM THE EDITOR *(continued from page 5)*

Active early members of Southern SREPCIM/SSGIM have subsequently become Presidents of SGIM, Deans of Medical Schools, Chairs of Departments of Medicine, Presidents of the American College of Physicians and the American Society of Internal Medicine, Editors of the *Annals of Internal Medicine*, National Directors of Veterans Administration Research activities, Director of the Agency for Healthcare Research and Quality (AHRQ), or Chairs of influential local and national academic committees. Most importantly, SSGIM members have positively impacted the quality of clinical education of a generation of medical students, internal medicine residents, and fellows.

Presidents, Southern SGIM

In the early years, the Program Chairs also served as regional Presidents as there were no official Southern SREPCIM officers. Bylaws and a more formal regional organizational structure followed in 1985. Carolyn Clancy, then at the Medical College of Virginia and later Director of AHRQ, was elected as the first official president in 1988. Subsequently, a distinguished group of presidents has presided over SSGIM:

Southern SGIM Presidents	
1981*	Stephen Miller, University of Tennessee, Memphis
1982*	Eugene Boisaubin, Baylor College of Medicine
1983*	Eugene Boisaubin, Baylor College of Medicine
1984*	Eugene Boisaubin. Baylor College of Medicine, and Henry Perkins, University of Texas-San Antonio
1985*	Jack McCue, Bowman Gray School of Medicine
1986*	Jack McCue, Bowman Gray School of Medicine
1987*	Richard Bauer, University of Texas-San Antonio
1988	Carolyn Clancy, Medical College of Virginia
1989	David Matchar, Duke University
1990	Peter Robie, Bowman Gray School of Medicine
1991	Jacqueline Pugh, University of Texas-San Antonio
1992	Michael Lichtenstein, University of Texas-San Antonio
1993	Carol Ashton, Baylor College of Medicine
1994	David Simel, Duke University
1995	John Williams, University of Texas-San Antonio
1996	Don Holleman, University of Kentucky
1997	James Wagner, University of Texas-Southwestern
1998	Wally Smith, Medical College of Virginia
1999	Mary O'Keefe, University of Texas–San Antonio
2000	Samuel Cykert, Moses Cone Hospital/University of North Carolina
2001	Jane Geraci, Baylor College of Medicine
2002	Carlos Estrada, East Carolina University
2003	Donald Brady, Emory University
2004	Elisha Brownfield, Medical University of South Carolina
2005	Erica Brownfield, Emory University
2006	Karen DeSalvo, Tulane University
2007	Anderson Spickard III, Vanderbilt University
2008	Michael Landry, Tulane University
2009	Lisa Willett, University of Alabama at Birmingham
2010	Eric Rosenberg, University of Florida
2011	Jane O'Rorke, University of Texas–San Antonio
2012	Yvette Cua, University of Louisville
2013	Jason Morris, University of Alabama at Birmingham
2014	Bennett Lee, Medical College of Virginia
2015	Erin Snyder, University of Alabama at Birmingham
2016	Shelly Ann Fluker, Emory University
2017	Deepa Bhatnagar, Tulane University
2018	Brad Keith, Medical University of South Carolina College of Medicine
2019	Reena Hemrajani, Grady Health System
2020	Amanda Mixon, Vanderbilt University
2021	Winter Williams, University of Alabama at Birmingham
2022	Blake Barker, University of Texas-Southwestern
2023	Sarah Turbow, Emory University
2024	Lubna Khawaja, Baylor College of Medicine
2025	Jennifer Cowart, Mayo Clinic, Florida
2026	Meghan Black, University of Alabama at Birmingham

*During the initial years, the annual meeting chair fulfilled the role of president.

Southern SGIM Clinician Educator Award

In 1994, SSGIM designed recognition for younger general internists who had made significant contributions to clinical education. The SSGIM Clinical Educator Awardees have become local, regional, and national leaders, and include the following:

Southern SGIM Clinician Educator Awardees	
1995	Steven Haist, University of Kentucky
1996	Mary O'Keefe, University of Texas-San Antonio
1998	Debra Hunt, University of Texas-San Antonio
1999	Charles "Chipper" Griffith, University of Kentucky
2000	Anderson Spickard III, Vanderbilt University
2001	Pat Wathen, University of Texas-San Antonio
2002	Donald Brady, Emory University
2003	Paul Haidet, Baylor College of Medicine

FROM THE EDITOR *(continued from page 6)*

Southern SGIM Clinician Educator Awardees (continued)	
2004	Erica Brownfield, Emory University
2005	Jane O'Rorke, University of Texas-San Antonio
2006	Lisa Willett, University of Alabama at Birmingham
2007	Ian Chen, Eastern Virginia University
2008	Andrew Hoellein, University of Kentucky
2009	Analia Castiglioni, University of Alabama at Birmingham
2010	Eboni Price-Haywood, Tulane University
2011	Chad Miller, Tulane University
2012	Mary Poston, University of South Carolina
2013	Margaret Lo, University of Florida
2014	Danielle Jones, Emory University
2015	Dominique Cosco, Emory University
2016	David Ecker, University of South Florida
2017	Eva Rimler, Emory University
2018	Deepa Bhatnagar, Tulane University
2019	Starr Steinhilber, University of Alabama at Birmingham
2020	Erin Contratto, University of Alabama at Birmingham
2021	Julie Machen, University of Texas-Austin
2022	Aliza Norwood, University of Texas-Austin
2023	David Giovannini, University of South Carolina
2024	Shivani Desai, University of Texas-Southwestern
2025	Jennifer Caputo-Seidler, Mayo Clinic, Florida
2026	Britt Marshall, Emory University

Southern Leader and Mentor in GIM Award

In 2008, SSGIM recognized the increasing numbers of established members who demonstrated long-standing commitments and service to the Southern region and its members. These senior members served as exceptional role models, mentors, and colleagues who demonstrated the ideals of Generalists in Internal Medicine. The Southern region was the first SGIM region to present this award. The Southern Leader and Mentor in GIM award has been awarded to the following recipients:

Southern SGIM Leader and Mentor Awardees	
2009	Stephen Miller, University of Tennessee, Memphis
2010	Andy Diehl, University of Texas-San Antonio
2011	Robert Centor, University of Alabama at Birmingham
2012	John Feussner, University of South Carolina
2013	Steven Haist, University of Kentucky
2014	Carlos Estrada, University of Alabama at Birmingham
2015	Lisa Willett, University of Alabama at Birmingham
2016	William Moran, University of South Carolina
2017	Timothy Caudill, University of Kentucky
2018	Michael Landry, Tulane University
2019	Elisha Brownfield, Medical University of South Carolina
2020	Gregg Talente, University of South Carolina
2021	Daniel Hunt, Emory University
2022	Erin Snyder, University of Alabama at Birmingham
2023	Shelly-Ann Fluker, Emory University
2024	Blake Barker, University of Texas-Southwestern
2025	Lubna Khawaja, Baylor College of Medicine
2026	Meghan Black, University of Alabama at Birmingham

Leadership Development Award

In 2016, SSGIM implemented this award to support early career faculty in enhancing their leadership skills and fostering a deeper connection with SSGIM. Awardees attend and participate in the Southern SGIM Regional Meeting. Awardees gain further leadership development opportunities by serving on the planning committee for the SSGIM meeting.

Southern SGIM Leader Development Awardees	
2016	Andrew Sides, University of South Carolina
2017	Starr Steinhilber, University of Alabama at Birmingham
2021	Heather Wainstein, University of Texas-Southwestern
2023	Brandon Altillo, University of Texas-Austin
2024	Caroline Sloan, Duke University
2026	Reema Dbouk, Emory University

The Advocacy and Community Service Award

The Advocacy and Community Service Award was first awarded in 2024. This award is designed to honor members of the Southern SGIM Region who have notably contributed to enhancing the health of their community through advocacy and/or community service. This award can be conferred for a variety of achievements.

Advocacy and Community Service Awardees	
2024	Khaalisha Ajala, Emory University
2025	Mark Spencer, Emory University
2026	Sarah Koumtouzoua, Emory University

SSGIM has been an integral part of the development of academic general internal medicine. The early meetings of SSGIM were sessions of enthusiasm and uncertainty. Enthusiasm came with the recognition that academic general internal medicine was filling a fundamental need in clinical education. Uncertainty was found because

FROM THE EDITOR *(continued from page 7)*

generalists were pursuing a course that had not led to traditional academic success. Leadership, networks, and mentorship were needed from those who were committed to that course and could articulate its benefits. SSGIM met those needs.

Southern SGIM now provides sessions filled with enthusiasm for solid research, cogent clinical vignettes, and educational advances. Uncertainty may still creep into our discussions concerning funding and policies, but the educational and academic relevance of general internal medicine is firmly established. Southern SREPCIM and SSGIM contributed to that confirmation.

Conclusion

History is worth preserving. Times change. People change. But underlying principles important to GIM remain the same. Topics important in the 1980s are still important today. We owe a debt of gratitude to the early founders of the Southern region of SGIM. As Mahatma Ghandi says "A small body of determined spirits fired by an unquenchable faith in their mission can alter the course of history."[2]

Note: The listing of SGIM members' institutions was based upon their institution of record upon the receipt of their award.

References

1. Machiavelli N. Quotes: Niccolo Machiavelli. *AZ Quotes*. https://www.azquotes.com/quote/524633. Accessed April 15, 2026.
2. Ghandi M. Quotes: Mahatma Gandhi. *BrainyQuote*. https://www.brainyquote.com/quotes/mahatma_gandhi_160841?src=t_history. Accessed April 15, 2026.

SGIM

PRESIDENT'S COLUMN

WHY WE GATHER—AND WHY IT MATTERS

Mark D. Schwartz, MD
President, SGIM

"The future of general internal medicine will not be set by any single leader or meeting—it will be shaped by the choices we make, together."

As we prepare to gather again this May, it is worth pausing to ask "*Why do we meet?*"

The SGIM Annual Meeting is a fixture in many of our professional lives. Each year, SGIM members plan programs, book flights, and block calendars well before spring. But routine is not purpose. As notable author and strategic facilitator Priya Parker says "*Meetings lose power when their purpose is assumed, not articulated. When we stop asking why, gatherings risk becoming habits, not acts of intention*"."[1]

So why do we gather? We do not gather because we always have nor simply to sustain our organization. The easy answers like these fall short:

- *"We meet to serve our members."*
- *"We meet to support professional development and scholarship."*
- *"We meet to maintain Society membership and remain financially solvent."*
- *"We meet to fulfill the mission of the Society."*

Each of these answers is true. Each reason matters. And yet, none of them is sufficient on their own to explain why thousands of clinicians, educators, researchers, and advocates choose repeatedly to step away from their daily lives and come together. If the reason to meet is organizational survival, then we have set our sights too low.

PRESIDENT'S COLUMN *(continued from page 8)*

SGIM's vision is a just system of care in which all people can achieve optimal health.[2] Our core values include to advance excellence in general internal medicine, promote health equity, cultivate scholarship that improves care, and advocate for systems that better serve patients and communities.[2] We live out these commitments in our choices, our daily work, and our lives.

Why do members gather? We meet annually to share accomplishments and challenges, recharge our creative energies, and learn from each other.

What Is This Meeting For?

The SGIM Annual Meeting exists to strengthen the people who carry general internal medicine forward, so that we can do work that none of us could do alone. We gather to grow as professionals, not just by adding lines to our curriculum vitae, but to refine our craft, sharpen our thinking, and reconnect with why we chose this work. We gather to share ideas, present scholarship, and test new approaches in a community that understands both the rigor and the real-world constraints of generalist practice.

We gather to build relationships and deepen our sense of belonging. Across institutions, disciplines, generations, and career stages, the meeting builds collaborations, mentorship, sponsorship, and friendship. SGIM's values of inclusivity, respect, and commitment to diversity and health equity are experienced at the Annual Meeting. At our meeting, members often feel a sense of belonging to a professional community larger than their own practice, lab, classroom, or institution.

We also gather to replenish our wells. The work of general internal medicine, whether in patient care, education, research, or advocacy, can be exhausting *and* deeply meaningful. The meeting offers renewal through learning, reconnection, shared purpose, and the simple pleasure of being together. We gather not out of obligation, but out of necessity. We gather because excellence, equity, and integrity in general internal medicine require community. This is why we meet.

The 2026 Annual Meeting

The 2026 meeting theme of "Individual Voices, Collective Impact: Advocating for Excellence in Academic Medicine"[3] reminds us that our task in academic general internal medicine is not quiet work. It is work that asks us to speak, to stand, and at times to push.

- We speak for our patients when systems fail them.
- We speak for our trainees when they seek purpose and direction.
- We speak for science when evidence is ignored or distorted.
- We speak for our profession when the value of generalist care is overlooked.

Each voice alone may seem small. But when those voices join, they carry weight. That is how change happens in medicine, in universities, and in the public square.

The Annual Meeting gives us a place to hear one another's voices and a chance to sharpen our ideas and test our arguments. It gives us space to find courage in numbers. When we leave, we return to our institutions, clinics, classrooms, and communities inspired and stronger than when we arrived. That is collective impact.

Advocacy in academic medicine does not always look like lobbying or public campaigns. Often it is quieter and closer to home, as noted in the artfully crafted SGIM Forum article by this year's Meeting Program Committee Chairs Amanda Mixon and Eric Yudelevich.[4] It happens when we defend time for teaching. When we insist that primary care matters. When we ask challenging questions about how care is paid for and who has access to it. When we mentor a trainee who wonders if there is still a place for them in general internal medicine.

In these moments we use our voices, not only for ourselves but also for the people and principles we serve. Our Annual Meeting helps us do that work better.

For many members, this meeting is where ideas first take shape. A conversation after a session becomes a study. A hallway debate becomes a policy brief. A mentor's encouragement becomes a career.

I come to this meeting with deep gratitude for the Society that shaped my own career. Like many of you, I first came to SGIM as a trainee trying to find my footing. I still remember my first meeting as a general internal medicine fellow. I felt overwhelmed and uncertain, intimidated by the people whose papers I had read and whose work I admired from afar. Standing at my poster, I worried about methodological critiques and whether my work was important enough. What I experienced instead was warmth, curiosity, and encouragement from future colleagues. I had found my people.

Over time, this community became a place where I learned, found mentors, met collaborators, and built lasting friendships. SGIM helped shape the physician, teacher, and leader I became.

As I step into the role of SGIM President, I do so with humility and a simple goal: I want this Society to remain the place where academic general internists come to grow, lead, and make a difference. In the year ahead, we will continue the work that defines SGIM:

- Defend the value of generalist care.
- Support the next generation of scholars and teachers.
- Advocate for policies that strengthen primary care and improve health for all people.
- Continue to strengthen the community that makes this work possible.

PRESIDENT'S COLUMN *(continued from page 9)*

None of us does this work alone. We do it together, across institutions, across disciplines, and across generations. That work begins again when we gather.

Conclusion: An Invitation to Gather and to Shape What Comes Next

In May 2026, let's arrive at the Annual Meeting with intention. The Meeting is not simply a place to present our work or attend sessions. It is a moment to pause our individual routines and step into a shared professional space. What we make of that space, and of the year ahead, depends on us.

I invite you to listen generously, share openly, and engage across differences in experience, role, discipline, and perspective. I invite you to seek out new colleagues as well as reconnect with longtime friends, to mentor and to be mentored, and to bring your full professional self, including your questions, concerns, ideas, and hopes for the future of general internal medicine.

The challenges in our field are real, but so is our collective capacity to shape what comes next. The future of general internal medicine will not be set by any single leader or meeting. It will be shaped by the choices we make, together.

We gather not because it is tradition, but because this work requires community. We gather to strengthen one another, and to renew our commitment to patients and learners. We gather to remind ourselves that the values at the heart of general internal medicine still matter, now and in the years ahead.

I look forward to gathering with you, and to shaping our future together!

References

1. Parker P. *The Art of Gathering: How We Meet and Why It Matters*. New York: Riverhead Books, 2018.
2. SGIM Vision and Values. *SGIM*. https://www.sgim.org/about-sgim/vision-and-values/. Accessed April 15, 2026.
3. SGIM Annual Meeting 2026. *SGIM*. https://annual-meeting.sgim.org. Accessed April 15, 2026.
4. Mixon AS, Blumrosen EY. Beyond the marble steps: Redefining advocacy at the 2026 SGIM Annual Meeting. SGIM Forum. https://www.sgim.org/article/beyond-the-marble-steps-redefining-advocacy-at-the-2026-sgim-annual-meeting/. Published February 2026. Accessed April 15, 2026.

SGIM

FROM THE SOCIETY

Q & A ON SGIM'S PRIMARY CARE PRIORITIES

Eric B. Bass, MD, MPH; Michael Fischer, MD, MS; Anders Chen, MD, MHS; Celeste Newby, MD, PhD; Mark D. Schwartz, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Fischer (michael.fischer@bmc.org) is a Professor of Medicine at Boston University. Dr. Chen (andersch@uw.edu) is an Associate Professor of Medicine at the University of Washington. Dr. Newby (celeste.newby@gmail.com) is an Assistant Professor of Medicine at Tulane University. Dr. Schwartz (Mark.Schwartz@nyulangone.org) is the incoming President of SGIM.

In 2024, the National Academies of Sciences, Engineering, and Medicine (NASEM) created a standing committee of experts in primary care delivery, research, and policy to inform federal primary care policy.[1] Recently, the Standing Committee on Primary Care invited SGIM to give a presentation to the committee about the following questions:

- What are your current organizational primary care priorities?
- Where do you envision them in the next 3 to 5 years?
- What implications do these priorities have on the work of the committee?

SGIM was invited to present because we are one of 14 organizations sponsoring the work of the Standing Committee. The other sponsors include the American Academy of Family Physicians, American Academy of Nursing, American Board of Family Medicine, American College of Physicians, American Geriatrics Society, Arnold Ventures, California Health Care Foundation, Commonwealth Fund, Healing Works Foundation,

FROM THE SOCIETY *(continued from page 10)*

Milbank Memorial Fund, National League for Nursing, New York State Health Foundation, and Samueli Foundation. In this column, I share thoughts about how our health policy team plans to answer the questions posed by the committee.

EB: Mike, as Chair of the Health Policy Committee, you oversee how the organization sets priorities for SGIM's advocacy efforts. What do you see as SGIM's most important priorities for strengthening primary care?
MF: Every year, the Health Policy Committee establishes an agenda approved by SGIM's Council that identifies top priorities for active advocacy. Our priorities include advocating for:

1. Payment and delivery models that ensure high-quality, equitable primary care.
2. Appropriate reimbursement for primary care and cognitive care visits.
3. Federal support for primary care research.
4. Changes in Graduate Medical Education (GME) funding that will help to improve the supply and distribution of primary care physicians.

Based on these priorities, we joined the Primary Care Collaborative (PCC) in advocating for changes in federal physician payment policies that will include hybrid payment models and more appropriate reimbursement for primary care services. We also joined PCC in advocating for policies to increase investment in primary care.

Consistent with these priorities, we strongly support recommendations contained in the Standing Committee's report on Building a Workforce to Develop and Sustain Interprofessional Primary Care Teams.[2] The recommendations include calls for better payment for functions of high-quality primary care, accountability for enhanced primary care payment, prioritization of interprofessional primary care team training, and increased investment in research that advances primary care. These recommendations are important, but we are concerned that insufficient attention will be given to the needs for primary care research if the proposed reorganization of the Department of Health and Human Services proceeds without preservation of the Agency for Healthcare Research and Quality and its National Center for Excellence in Primary Care Research.

EB: Anders, as the Co-Chair of the Health Policy Committee who will be stepping into the Chair position, how do you envision our primary care priorities evolving in the next five years?
AC: Although I am optimistic about seeing progress in achieving greater use of hybrid payment models to strengthen primary care, I realize there will be much resistance to changing the fee-for-service physician payment system that is at the root of the problems with primary care in this country.[3] Furthermore, hybrid and many other alternative payment models are built on the old fee-for-service architecture. Thus, we need to continue advocating for changes in the pricing of physician services that increase incentives to deliver high-quality primary care involving prevention and treatment in a whole-person health approach. That approach will require fundamental reassessment of the methods used

SGIM Forum

Editor In Chief
Michael Landry, MD, MSc, FACP
SGIMForumEditor@gmail.com

Managing Editor
Frank Darmstadt
frank.darmstadt@ymail.com

Past Editor In Chief
Tiffany I. Leung, MD, MPH, FACP, FAMIA
tiffany.leung@jmir.org

Editorial Board
Yousaf Ali, MD, MS
Yousaf_Ali@URMC.Rochester.edu
Seki Balogun, MD, FACP
sab2s@virginia.edu
Cory Bhowmik, BS, MEd
abhowmik1@pride.hofstra.edu
Lauren Block, MD, MPH
lblock2@northwell.edu
Alfred Burger, MD, MS
aburger.md@gmail.com
Claire Ciarkowskiz, MD
claire.ciarkowski@hsc.utah.edu
Elaine B. Cruz, DO
exc406@case.edu
Jillian M. Gann
gannj@sgim.org
Shanu Gupta, MD, FACP
shanugupta@usf.edu
Tracey L. Henry, MD, MPH, MS
tlhenry@emory.edu
Vishnu Ilineni, MD
VishnuKarthikIlineni@texashealth.org
Christopher D. Jackson, MD, FSSCI
christopherjackson@usf.edu
Lubna Khawaja, MD, FHM
khawaja@bcm.edu
Michael Klein, MD
michael-klein@uiowa.edu
Jennifer L. Michener, MD
jennifer.michener@cuanschutz.edu
Susana Morales, MD
srm2001@med.cornell.edu
Amirala Pasha, DO, JD, FACP
pasha.amirala@mayo.edu
Janani Raveendran, MD, MEd
janani01@hotmail.com
Gaetan Sgro, MD
gaetan.sgro@va.gov
Nikhil Sood, MD
nikhil.sood@bannerhealth.com
Taylor Smith, MPS
smitht@sgim.org

The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.

FROM THE SOCIETY (continued from page 11)

to assign value to physician services, which is why SGIM strongly recommends that Congress pass legislation to create a technical advisory committee to reassess methods for valuing physician services. The proposed panel would help the Centers for Medicare & Medicaid Services (CMS) obtain better information to guide decisions about relative pricing of physician services.

I am also worried that any progress toward supporting primary care achieved by changing physician payment policy will be undermined by expected effects of new federal policies that reduce patients' access to health care. For that reason, SGIM will need to become even more active in working with other professional societies and patient advocacy organizations to promote policies consistent with SGIM's vision of a just system of care in which all people can achieve optimal health.

EB: Celeste, as Chair of the Clinical Practice Subcommittee of the Health Policy Committee, what do you think are the most important implications of our primary care priorities for the charge given to the Standing Committee on Primary Care?

CN: Our priorities are directly relevant to the charge given to the Standing Committee. Indeed, we appreciate that the committee has already published a report on Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule.[4] We were particularly pleased to see the committee's recommendations for CMS to consider a range of objective data sources and stronger methods to assign value to physician services, and to invite experts and technical advisory organizations beyond the Relative Value Scale Update Committee to contribute to the valuation process. We strongly favor establishment of an independent panel of experts to advise CMS on options for strengthening the evidence used to inform decisions about valuation of physician services.

SGIM members at Harvard Medical School's Center for Primary Care recently co-authored an Investment Guide that details how policymakers, employers, provider organizations, and health plans can assess, plan, and prioritize investments in team-based primary care services.[5] The Guide explains how primary care can improve outcomes and reduce costs using team-based services, including behavioral health integration, embedded clinical pharmacists, care management for patients with complex needs, population health programs, initiatives focused on social determinants of health, and E-consults to facilitate specialist input. This evidence-based Investment Guide reinforces the importance of our top priorities for strengthening primary care.

EB: Mark, as you prepare to serve as President of SGIM after your long service on the Health Policy Committee, what do you see as the best opportunities for SGIM to make a difference in advocating for primary care in the next year?

MS: For many years, SGIM has been a leader in advocating for changes in payment for primary care. We must continue to focus on this issue because forces seem to be aligning in a way that holds promise for real change in physician payment policy. If we want a stronger health system, we must build it on stronger primary care. That requires aligning payment, workforce policy, and research investment around the work primary care actually does. This work should focus on three "**P**s": **P**ayment (how to pay for primary care), **P**ractice (how to organize and support primary care practice), and **P**ipeline (how to build and sustain the primary care workforce).

Because SGIM's mission includes cultivating innovative educators and researchers in academic medicine, SGIM has a unique role in advocating for better support of primary care training and research. Recently, Congress has shown interest in increasing support for GME to address shortages in the physician workforce, as evidenced by the proposed Resident Physician Shortage Reduction Act.[6] SGIM will continue to lobby for passage of this bill.

SGIM also has consistently advocated for federal funding of primary care research. That realm of research is threatened by recent changes in federal policy. Yet, research is greatly needed to address the following types of questions related to the three **P**s.

1. **What payment models best support high-quality primary care?** For example: Which combinations of fee-for-service, prospective payment, capitation, or hybrid models improve access, continuity, comprehensiveness, team-based care, and outcomes, especially for patients with complex needs and for underserved communities?
2. **What practice designs and team-based care models improve patient outcomes, clinician experience, and value?** For example: Which staffing models, workflows, and supports strengthen primary care capacity, reduce burnout, and improve quality and equity?
3. **Which policies and training strategies are most effective in building, distributing, and retaining the primary care workforce?** For example: What is the impact of GME expansion, debt relief, community-based training, interprofessional education, and targeted recruitment strategies on entry into primary care, practice in underserved areas, and long-term retention?

We plan to continue working with the North American Primary Care Research Group, Academy Health, and other stakeholders to advocate for appropriate investment in primary care research.

FROM THE SOCIETY *(continued from page 12)*

EB: Overall, SGIM is pleased to have this unique opportunity to present our priorities to the Standing Committee on Primary Care.

References

1. National Academies of Sciences, Engineering, and Medicine. Standing Committee on Primary Care. *NAS*. https://www.nationalacademies.org/units/HMD-HCS-22-08. Accessed April 15, 2026.
2. National Academies of Sciences, Engineering, and Medicine. *Building a Workforce to Develop and Sustain Interprofessional Primary Care Teams*. Washington, DC: The National Academies Press, 2025. https://doi.org/10.17226/29226.
3. Goodson J. Payment for physician services in the United States: Has a reckoning begun? *Ann Intern Med*. 2025 Dec;178(12):1796-1797. doi:10.7326/ANNALS-25-03525. Epub 2025 Sep 30.
4. National Academies of Sciences, Engineering, and Medicine. *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule*. Washington, DC: The National Academies Press, 2025. https://doi.org/10.17226/29069.
5. Pollack AA, Ricci DA, Song Z, et al. The Primary Care Investment Guide. *Primary Care Collaborative*. https://thepcc.org/wp-content/uploads/2026/01/REPORT-Primary-Care-Investment-Guide-2025.pdf. Published December 18, 2025. Accessed April 15, 2026.
6. H.R.3890. Resident Physician Shortage Reduction Act of 2025. *Congress.gov*. https://www.congress.gov/bill/119th-congress/house-bill/3890/text/ih. Accessed April 15, 2026.

SGIM

SIGN OF THE TIMES

CULTIVATING JOY AND MEANING IN HOSPITAL MEDICINE: A QUALITATIVE STUDY OF HOSPITALISTS' EXPERIENCES

John Msaddi; James Austin Follett, MD; Shanu Gupta, MD, SFHM

Mr. Msaddi (jmsaddi@usf.edu) is a third-year medical student at the University of South Florida (USF) Morsani College of Medicine. Dr. Follett (jfollett@usf.edu) is an Assistant Professor of Medicine at USF and the Division Director of Hospital Medicine. Dr. Gupta (shanugupta@usf.edu) is an Associate Professor of Medicine at USF and Assistant Dean of Faculty Development at the Morsani College of Medicine.

Introduction

Hospital Medicine physicians often find themselves in liminal spaces, between admission and discharge, between night and day, between recovery and death. Over the last 10 years, burnout among hospitalists has increased with reported rates exceeding 50%, with a prominence in depersonalization and reduced personal accomplishment.[1] Factors including heavy workloads, non-traditional working hours, frequent interruptions, interdepartmental conflicts, and feeling undervalued by leadership have been cited as barriers to physician well-being.[2]

Hospitalist satisfaction, conversely, is rooted in delivering high-quality care and strengthening interprofessional relationships. Research suggests that organizational climate, quality of care, organizational fairness, personal time, relationships with administration, compensation, and patient relationships predict job satisfaction for hospitalists.[3]

In this pilot study, we explore how hospitalists' joyful experiences drive meaning-making. By analyzing qualitative interviews of hospital medicine practitioners, we identified themes and mechanisms through which meaning and purpose emerge in their work.

Methods

Hospital Medicine providers, including residents, attending physicians and advanced practice providers, were recruited at the annual University of South Florida hospital medicine conference in March 2025. The conference serves hospital medicine practitioners from across the Tampa Bay region. In addition to demographic questions regarding gender, practice type, and years of practice,

 (continued from page 13)

participants were asked "*the last time you were on clinical service, what was something that brought you joy at work?*" Interviews were audio recorded and transcribed verbatim using Otter.ai. De-identified responses were analyzed for themes. Two investigators independently coded transcripts, identified themes, reconciled coding, and generated higher-order thematic categories. Given the exploratory nature of the study, the goal was depth of meaning rather than generalizability.

Qualitative methods are particularly suited for exploring constructs such as joy and meaning because they allow physicians to narrate their lived experiences, attribute significance, and reflect on how context, relationships, identity, and purpose converge in their work.

Results

Forty individuals participated, with 37 eligible responses included in the analysis. Of the responses, 26 contained one theme, with the remaining 11 responses covering multiple themes. Through qualitative analysis, several distinct sources of joy were identified. Responses clustered around five major themes:

1. **Patient Gratitude (12 responses):** Experiencing direct expressions of gratitude from patients or their families emerged as a distinct source of joy. One hospitalist reflected "*She asked me, did anybody tell you that they loved you today? And she told me that she did love me for the work that we were doing and that brought me a lot of joy there.*"
2. **Building Rapport with Patients (11 responses):** Participants described joy in moments when they could connect meaningfully with patients, especially across cultural or language barriers. Several recalled communicating directly with Spanish speaking patients, which deepened connection and mutual respect. Others reflected on conversations about what mattered most to patients, especially "*what brings them joy and their life perspectives.*" These moments of authentic rapport went beyond clinical accuracy; they humanized the encounter and strengthened the patient-physician relationship. One participant recalled a patient remarking "*Do you have a practice outside? Can we come and see you?*" To them, this was "*the most reward I can have, because that tells me that they were extremely happy, and they really want to see me as an outpatient physician.*" These moments of relational connection anchored meaning in the work.
3. **Camaraderie (10 responses):** Joy frequently emerged when providers felt part of a high-functioning and supportive team that openly communicated, valued each other, and fostered reflection. One participant remarked "*joy at work was the camaraderie with my colleagues putting our thoughts together regarding medically complex patients.*"
4. **Clinical Satisfaction (9 responses):** Many participants described moments when they felt they made a real difference for a patient, especially when witnessing recovery or reconciliation. One responder finds joy when they "*absorb new information that kind of adds in a new puzzle piece to the framework that I had previously been working with that makes me understand things a little bit better.*"
5. **Mentorship (6 responses):** Witnessing growth of mentees was another source of joy. One participant described a learner making a career decision: "*{I} learned that one of the medical students had picked Internal Medicine as a career path based on their experience on the wards.*" Such responses suggested that mentorship reinforces a sense of contribution beyond immediate clinical tasks and supports a sense of professional purpose. We have identified this as a mode to strengthen professional growth amongst our physicians, which strengthens connection and retention in an academic medical setting.

Taken together, these themes illustrate that joy in hospital medicine is rooted in patient relationships, collegial support, clinical achievement, and mentorship. They underscore how meaningful connections are central to professional fulfillment and resilience among hospitalists.

Discussion

Current research focuses on reducing and preventing burnout by addressing occupational hurdles that are discordant with career goals, as physicians often respond to these hurdles by retreating from work through decreased hours, reducing their scope of practice, or retirement.[2,3] Career satisfaction and work engagement are closely tied to the amount of time individuals dedicate to work they classify as "meaningful."[4]

The responses in our study suggest that positive patient interactions are the largest source of joy for hospitalists, highlighting how patient-provider relationships foster fulfillment. Interactions with colleagues and other team members are frequently mentioned, indicating the importance of a collaborative and reflective work environment. Achieving positive patient outcomes was another common theme, suggesting that a rewarding career is a joyful one. This study demonstrates alignment with known hospitalist-controlled factors that support job satisfaction: a personal connection with patients and interprofessional teams, and the joy of seeing critical thinking fully realized at bedside.

Crucially, *meaning-making* is a term that describes not just an individual internal event but a relational and systemic phenomenon: it requires organizational

SIGN OF THE TIMES (continued from page 14)

conditions that permit clinicians to do what matters, connect with others, teach, learn, reflect, and be recognized. Cultivating joy demands institutional policies and leadership commitment that embed opportunities for meaning-making. This requires translating these qualitative insights into actionable strategies: regular reflection forums, protecting teaching time, redesigning workflow to reduce administrative burdens, publicly celebrating meaningful clinician work, measuring joy, and iteratively improving the provider's experience.

Although limited in scope, this study is helpful in identifying organizational levers to foster meaning and support joy in hospital medicine. We propose organizational policies that address provider wellbeing through a diverse lens. Resources—such as scheduled reflections and storytelling forums for providers to express meaning-making, as self-focused and other-focused gratitude journaling—are a simple, cost-effective method to improve well-being.[5] In addition, tracking joy beyond traditional hospital medicine metrics (i.e., Relative Value Units and length-of-stay) would provide holistic feedback on organizational health and well-being.

Conclusion

In this qualitative pilot study of hospital medicine providers, we found that satisfaction in work was closely tied to meaning-making: the sense of connection, contribution, and growth. These findings echo broader literature across healthcare professions, demonstrating meaning is central to joy, satisfaction, resilience, and professional fulfilment.

SGIM members are uniquely positioned to champion initiatives, such as regular reflection forums and storytelling sessions. These initiatives cultivate joy and meaning in clinical practice and help create a just system of care. By aligning daily work with SGIM's core values of professionalism, integrity, and patient-centeredness, SGIM members can build a workforce that not only mitigates burnout, but also inspires the next generation of healthcare providers, strengthens teams, and delivers compassionate, high-quality care to all patients.

References

1. Park KM, Kim J, Kyong T, et al. Prevalence, risk and protective factors of burnout among Korean hospitalists. *PLoS One*. 2025 Apr 28;20(4):e0320128. doi:10.1371/journal.pone.0320128. eCollection 2025.
2. Ghaseminejad F, Rich K, Rosenbaum D, et al. Organisational factors associated with burnout among emergency and internal medicine physicians: A qualitative study. *BMJ Open*. 2025 Jan 28;15(1):e085973. doi:10.1136/bmjopen-2024-085973.
3. Hinami K, Whelan CT, Wolosin RJ, et al. Worklife and satisfaction of hospitalists: Toward flourishing careers. *J Gen Intern Med*. 2012 Jan;27(1):28-36. doi:10.1007/s11606-011-1780-z. Epub 2011 Jul 20. PMID: 21773849; PMCID: PMC3250553.
4. Shanafelt TD, West CP, Sloan JA, et al. Career fit and burnout among academic faculty. *Arch Intern Med*. 2009 May 25;169(10):990-5. doi:10.1001/archinternmed.2009.70. PMID: 19468093.
5. Adair KC, Rodriguez-Homs LG, Masoud S, et al. Gratitude at work: Prospective cohort study of a web-based, single-exposure well-being intervention for health care workers. *J Med Internet Res*. 2020 May 14;22(5):e15562. doi:10.2196/15562. PMID: 32406864; PMCID: PMC7256751.

SGIM

BEST PRACTICES

THE HUMAN ONE-LINER: RECLAIMING JOY IN PATIENT CARE

Luisa Paredes Acosta, MD

Dr. Paredes Acosta (Luisa.ParedesAcosta@wfusm.edu) is an Assistant Professor of Medicine at Wake Forest University School of Medicine.

Introduction

On the inpatient medicine service, the team worked through the normal clinical diagnoses: pyelonephritis, failure to thrive, community-acquired pneumonia, soft tissue infections, and the usual tangle of consults and care coordination. Medically, there was nothing extraordinary about the cases. But something was different that week—we were piloting an innovation called the *Human One-Liner*. In this article, I review that innovation as a strategy for being intentional in knowing our patients

BEST PRACTICES *(continued from page 15)*

beyond their clinical conditions and highlight the positive impact it had on a team's morale.

The Human One-Liner exercise was born from my personal boredom with long, repetitive lists of patients represented solely by their ages and diseases. How many old men with acute kidney injury and heart failure exacerbations could there possibly be?

My previous experience as a trainee with the My Life My Story (MLMS) program was the inspiration behind the Human One-Liner. MLMS is a narrative medicine initiative that collects patient life stories through dedicated interviews and integrates them into the electronic health record for the entire healthcare team to view.[1] A positive impact was demonstrated with healthcare staff participating in the program strongly agreeing that learning about their patients' stories was a good use of clinical time and improved the care they delivered.[2] Furthermore, MLMS programs help pharmacy students and residents show care and compassion by improving their ability to view patients as whole persons.[3] For medical students, a similar narrative medicine program led to increased perceptions of medicine as rewarding, meaningful, and worthwhile.[4]

Determined to change how we viewed our patients, my team embarked on our CliffsNotes version of the MLMS initiative.

The Human One-Liner Innovation

I challenged the residents and medical students on the team to include a humanizing fact about each patient in their standard one-liner presentation; they were asked to present something beyond the patient's medical history or social barriers to care. At first, it felt awkward. Physicians are trained to distill patients into efficient summaries, and time is always tight. But we kept at it.

Before long, our patient list went from a monotonous inventory of clinical conditions to "a 92-year-old lady with pneumonia excited for her granddaughter's wedding," "a 35-year-old hairdresser with pyelonephritis," "a frustrated 65-year-old architect, who lives by the river, with a painful rash," and other patients each with their own unique one-liner observations. These small additions changed everything.

During pre-rounding, trainees began asking patients personal questions: "*So what do you enjoy doing when you're not in the hospital?,*" "*Nice balloons, who gave them to you?,*" and "*How cute! Is that your dog?*" that opened a window into their lives we couldn't have imagined. Although the motivation for asking these questions was to complete my assignment, it quickly turned into genuine curiosity and something the entire team looked forward to sharing during rounds. We monitored the usual labs, cultures, and pathology reports, but, along the way, we also learned about our patients' courage, humor, and heartbreak.

The impact of this exercise on our team was almost immediate. There was more laughter on rounds, more eye contact with patients, more joy in the smallest clinical victories. When we finally discharged our 92-year-old grandma, it felt triumphant—not only because we cured her pneumonia but also she was leaving in time to attend her granddaughter's wedding. That discharge mattered.

Discussion

The Human One-Liner became my practice of intentionally learning and sharing something small but meaningful about each patient during every interaction. It is a simpler, more attainable approach than MLMS, with similar benefits to the patient-physician relationship and to physician morale. The concept is so simple that physicians might believe we do this naturally; yet it is not until we find ourselves on the spot, in front of a team *expecting* to hear something "interesting" in the one-liner patient presentation, that we realize how often we fail at knowing our patients beyond their diagnoses. The Human One-Liner pushes physicians to be intentional about integrating brief, meaningful moments of getting to know patients as people and use this information to change clinical practice.

SGIM members often talk about humanism in medicine as a lofty ideal, something intangible that one can witness or experience but not impose or "do" on command. This exercise made humanism practical and ubiquitous in our service. Knowing and sharing something personal with every clinical presentation was a requirement, not just for the team members with the most time or empathy, but for everyone. The fact that it was required eventually became irrelevant. Learning about our patients' lives became a desired and enjoyable part of everyone's job. Ironically, humanizing our patients reminds us of our own humanity, and of how similar (and fragile) we all are at the end of the day.

SGIM members practice medicine in healthcare systems that often emphasize efficiency over empathy, where hospitals are constantly full, consultants overwhelmed, and trainees bogged down by the impossible balance of service, learning, and administrative demands. Now, more than ever, we *need* to be reminded of why we chose to do this work. As physicians, we want to heal, but also to know patients as people, to bear witness to their stories, and make them feel seen. Losing sight of the fact that our work impacts real people, with stories, joys, and struggles like our own, can make our work feel boring, even meaningless. Afterall, prescribing ointments for a painful rash isn't as satisfying as seeing Paul the architect starting to draw (and smile) again!

Conclusion

This article does not suggest that SGIM members abandon clinical precision for sentimental anecdotes or draft

BEST PRACTICES (continued from page 16)

a life-story narrative on every patient. We *should* dare to be intentional, to learn and share something small and personal about each patient, and to remind the healthcare team who the patients are and why our work is important. All it takes is a single question.

If SGIM members implement the Human One-Liner, they might learn something that changes the course of their patient's care. SGIM members might even remember why this work is worth doing in the first place.

References

1. Tummala M, McNicoll L. Using life stories to support patient-centered care: A narrative review of implementation and impact. *J Gen Intern Med*. 2026 Jan;41(1):187-196. doi:10.1007/s11606-025-09746-6. Epub 2025 Aug 4. PMID: 40760374; PMCID: PMC12855627.
2. Roberts TJ, Ringler T, Krahn D, et al. The My Life, My Story program: Sustained impact of veterans' personal narratives on healthcare providers 5 years after implementation. *Health Commun*. 2021 Jun;36(7):829-836. doi:10.1080/10410236.2020.1719316. Epub 2020 Jan 30. PMID: 31999933.
3. Nathan S, Woolley AB, Finlay L, et al. Teaching pharmacy students and residents patient-centered care through interviewing veterans. *Am J Pharm Educ*. 2021 Sep;85(8):8384. doi:10.5688/ajpe8384. Epub 2021 Apr 23. PMID: 34615622; PMCID: PMC8500284.
4. Yao J, Hunter C, Chehayeb R, et al. A medical school curriculum to foster the physician-patient relationship through narrative medicine. *J Clin Oncol*. https://ascopubs.org/doi/10.1200/JCO.2024.42.16_suppl.e21015. Published May 29, 2024. Accessed April 15, 2026.
5. Larson EB, Yao X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA*. 2005 Mar 2;293(9):1100-6. doi:10.1001/jama.293.9.1100. PMID: 15741532.

SGIM

PERSPECTIVE

GO AND LISTEN TO THE PEOPLE: A CASE FOR "NARRATIVE STREET MEDICINE"

Brina Ratangee, MA; Suha Arshad, BA; Vaishnavi Tetali, BS; Jaya Khullar; Divya Tase

Ms. Ratangee (brr248@pitt.edu) is a medical student at the University of Pittsburgh School of Medicine. Ms. Arshad (suha.arshad@vanderbilt.edu) is a recent graduate of Vanderbilt University. Ms. Tetali (vaishnavitetali@my.unthsc.edu) is a medical student at the Texas College of Osteopathic Medicine. Ms. Khullar (jaya.khullar@vanderbilt.edu) is an undergraduate at Vanderbilt University. Ms. Tase (dst43@pitt.edu) is an undergraduate at the University of Pittsburgh.

Introduction to "Narrative Street Medicine"

From brick-and-mortar offices to multi-story glass megaliths, clinicians often understand their patients through the medical gaze.[1] In room one sits a 65-year-old male with history of coronary artery disease and hypertension presenting today with a chief complaint of dizziness. But at the wharf downtown, our Street Medicine team encounters the same patient differently. He's not defined by his age, gender, diagnoses, or family history. To us, he's "John." John, who used to be a cook, John who cares for the city's stray cats, John who loves the color green. Our team knows him through the stories he shares, dizzy not from any fault of his own, but because the city recently swept his encampment—and with it, his food, water, and lisinopril prescription—leaving him with nothing to fend off the 100 degree-and-climbing temperatures. In the clinic, his medical conditions are diagnoses to be managed; but, on the street, these conditions unfold as direct consequences of poverty, forced displacement, and structural discrimination.

This is what "Narrative Street Medicine" empowers: it shapes what we as learners notice, what questions we ask, and which interventions we dream possible when we encounter patients on the street. For John, it enabled us to identify his friends on the street with a safe nook to reestablish camp, provide him with the only flavor of Gatorade we knew he would drink, and coordinate his visit to our town's free clinic on a day he'd have time for the two bus rides. In Narrative Street Medicine, listening to patients' stories isn't secondary to care—it *is* the care.

PERSPECTIVE *(continued from page 17)*

In this article, we present a novel framework for Narrative Street Medicine which we argue can and should be applied more broadly to medical education and clinical practice. By contextualizing disease within lived experience of unsheltered homelessness, this approach offers a way of teaching medicine that invites medical students to truly engage with patients. These patients, in turn, emerge not as collections of diagnoses but as human beings with complex social realities navigating their health across an often-unnavigable healthcare system.

Narrative Medicine as a Hallmark of Street Medicine

In the late 1990s, Dr. Rita Charon and her colleagues at Columbia University recognized the potential of narratives to uniquely enrich the physician-patient relationship. They created the field of Narrative Medicine which asks physicians and physicians-in-training to see patients not as their physiological conditions, but as the collection of patients' contexts and lived experience.[2] Healthcare professionals who practice narrative medicine can improve the diagnostic accuracy and quality of care they provide, fostering trust and recognition between themselves and their patients.

Underlying the philosophy of Street Medicine, as embraced by the Street Medicine Institute,[3] is the tenet "go to the people."[4] Street Medicine embodies a model of care in which health professionals provide medical and social services to individuals experiencing unsheltered homelessness in their own environment—down alleyways, under bridges, near abandoned buildings, and in encampments. Street Medicine recognizes how a complex combination of institutional harm, trauma, financial barriers, and mobility constraints can restrict access to traditional healthcare settings.[5] Like Narrative Medicine, Street Medicine aims to foster patient-clinician trust and the delivery of high-quality care tailored to patients' unique circumstances.

While Narrative Medicine asks healthcare professionals and trainees to defer to patients as the experts of their own stories, Street Medicine demands it. Medical practitioners cannot know the specific set of circumstances that led their patients to homelessness, nor how these patients contend with and interpret this experience. As student volunteers and trainees, our ability to help is limited; oftentimes, the only thing we can give them beyond food and supplies is an open ear. But in a healthcare system that does not want to hear these vulnerable patients, a listening ear is as vital as medicine. To hear these patients is to empathize with and understand them. To be heard is to have one's presence acknowledged and dignity respected.

Framework for Narrative Street Medicine

In practice, we propose conceptualizing Narrative Street Medicine into the following framework:

1. **Self-reflection:** Street Medicine teams have begun to employ Narrative Street Medicine. The University of Pittsburgh's student-run Street Medicine organization asks volunteers at the end of weekly street rounds to share one word that defines that shift's experience for them. Other volunteers and advocates in Street Medicine have written reflections on particularly poignant patient encounters, describing not just what happened but, importantly, how they felt and what they hope can be different going forward. Reflection grounds clinicians and trainees in empathy and humanity, offering a compelling counter to fatigue and feeling overwhelmed. It forces the medical field to contend with the complex factors shaping a person's access to and interactions with the healthcare system. When put into dialogue with others' experiences, reflection can teach how to address these complexities in practice.
2. **Discussion and community-building:** compounding the educational value of this self-reflection is having the space and community to share one's thoughts and experiences with others. The grassroots nature of Street Medicine requires that students and professionals continue to learn from one another, tailoring proven approaches to the unique circumstances of their neighbors and cities. Imbuing street rounds with narrative allows for an even stronger sense of community and even deeper extent of reflection, paving the way toward novel approaches to addressing challenges within Street Medicine.
3. **Radical imagination:** the individuals who participate in Street Medicine often operate outside of the typical healthcare establishment. Reflection and community-building are critical to continue the radical, adaptive nature of Street Medicine, fueling the imaginations of those within it to care for patients with complex situations. This can look like launching mobile vans that bring resources directly to encampments, coordinating documents for housing and Medicaid applications, and establishing microbusinesses that employ—and empower—individuals with lived experience of unsheltered homelessness.

Taken together, these three pillars support the delivery of high-quality care to vulnerable populations, strengthen interprofessional education and community, and equip current and future health professionals with strategies to combat burnout and advocate for change.

Looking beyond the Streets

Creating a distinct space for Narrative Street Medicine combines the two inherently related fields of Street Medicine and Narrative Medicine into one whose nuances can be labeled, defined, and explored. Street

PERSPECTIVE *(continued from page 18)*

Medicine, in many ways, already embodies the tenets of Narrative Medicine. Explicitly drawing this connection forges the path toward a future that sustains those committed to serving folks experiencing homelessness while also fighting for a future where homelessness is obsolete. There is perhaps no medical field for which Narrative Medicine is more salient than Street Medicine, in which storytelling makes visible the experiences of patients who often go unseen and efforts of providers which can be dismissed as too transient for meaningful impact.

This intersection also holds implications beyond care for individuals experiencing unsheltered homelessness. Narrative Street Medicine opens new avenues of thinking that traditional modes of medical education silo, instead emphasizing ambiguity, compassion, and creativity over heuristical categorization. It encourages trainees to reflect on their encounters with humility, become comfortable discussing uncertainties, and collaborate to devise innovative solutions.

This framework not only may benefit SGIM members and patients across a broad range of fields but also offers new ways of thinking about the meaning of the patient-physician relationship. Next time a patient like John is in front of you, take a moment to re-center him as a person, first. Let his narrative guide your lines of questioning and clinical decision-making. Reflect on the factors that shape his lived experience and create space for your trainees to do the same. By going and listening to the people, SGIM professionals and students can help redesign medical care to be accountable to the structural conditions that shape patients' realities.

Acknowledgments: The authors would like to acknowledge Ms. Sophia Vogel for creating spaces for Narrative Street Medicine to flourish, as well as for her guidance throughout the editing process.

References

1. Foucault M. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Tavistock Publications, 1973.
2. Charon R. The patient-physician relationship. Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA*. 2001 Oct 17;286(15):1897-902. doi:10.1001/jama.286.15.1897.
3. Street Medicine Institute. https://www.streetmedicine.org/. Accessed April 15, 2026.
4. Withers J, Kohl D. Bringing health professions education to patients on the streets. *AMA J Ethics*. 2021;23(11):E858-863. doi:10.1001/amajethics.2021.858.
5. Doohan NC, Mishori R. Street Medicine: Creating a "classroom without walls" for teaching population health. *Med Sci Educ*. 2019 Nov 1;30(1):513-521. doi:10.1007/s40670-019-00849-4. eCollection 2020 Mar. PMID: 34457695 PMCID: PMC8368862. SGIM

IMPROVING CARE

REIMAGINING CARDIOVASCULAR CARE FOR YOUNG BLACK ADULTS IN THE AGE OF ARTIFICIAL INTELLIGENCE

Tracey Brascom, MD, MS

Dr. Brascom (traceybrascom@umm.edu) is a second-year internal medicine resident in the University of Maryland Capital Region Health Internal Medicine Residency Program.

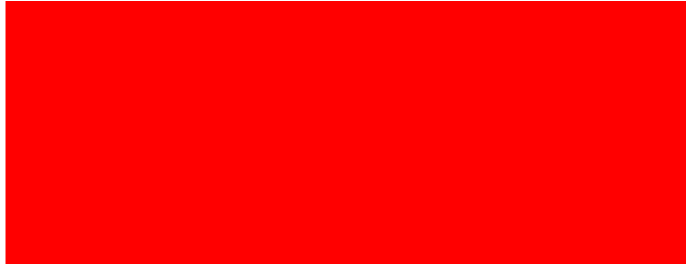
As a resident, I have had to confront the devastating reality of too many young Black adults presenting with advanced congestive heart failure (CHF). In this article, I highlight why the notion that CHF is exclusively a disease of the elderly is outdated and explore how artificial intelligence (AI)-driven tools can support internists in improving care for these patients.

CHF prevalence is increasing among young adults, especially Black adults. Black adults in the United States have higher rates of hospitalization for acute decompensated CHF, longer lengths of hospital stay, and higher in-hospital mortality compared with their White and Hispanic counterparts.[1-3] Internists are now managing end-stage cardiovascular disease in patients who have

 (continued from page 19)

barely begun adulthood.[1,2] Recently, I ordered a wearable defibrillator for a 28-year-old woman with a severely reduced ejection fraction, consulted palliative care for a 30-year-old man admitted for his *fifth* CHF hospitalization in two months, and explained to countless patients in their twenties that their heart is failing. I did not imagine having these conversations so early in these patients' lives.

One recurring challenge I encounter is that cardiovascular care is shaped not only by variables such as healthcare access and cost but also by factors like identity and stigma. One patient in his late twenties admitted that he stopped taking his CHF medications before a group trip because he did not want to be "*the guy with a bag full of pills*." For many young adults, pill boxes symbolize aging and chronic disease management feels incompatible with their lives.



Often as the first point of contact for patients, internists are uniquely positioned to lead the reframing of cardiovascular care that is relevant to today's young adults. Counseling a 25-year-old about salt intake or daily medication requires a "different language" than counseling a 75-year-old. It also requires acknowledgment of social pressures, economic realities, and the psychological burden of chronic illness in early life.[1,2] Nonetheless, a cultural shift may not be enough.

A Potential Path Forward: Employing Artificial Intelligence (AI)

Internists are practicing medicine in an era of rapidly evolving Artificial Intelligence (AI). AI is being used to enhance diagnostic accuracy and improve resource utilization in cardiovascular care, though studies evaluating its impact in this context are limited.[4] Imagine leveraging AI within electronic health records to identify patients under 35 with risk factors such as poorly controlled hypertension, rising hemoglobin A1c levels, repeated emergency visits, early left ventricular remodeling on imaging, or subtle electrocardiogram changes predictive of cardiomyopathy. This AI-based risk stratification system could be paired with structured patient education and navigation programs.

For example, patients who meet high-risk criteria could be referred automatically to a dedicated heart failure educator to discuss culturally tailored heart-healthy diets, physical activity, medication indications, and side effects, as well as early recognition of CHF symptoms. However, education alone is not sufficient; continued engagement through follow-up messages, remote monitoring, and telehealth visits is critical to reinforce adherence to care while respecting patients' personal autonomy. If thoughtfully implemented, AI could standardize early identification and management of heart failure and prompt intervention in populations historically underserved by preventive cardiology.

Guardrails and Ethical Considerations

Enthusiasm for AI must be balanced with caution. Some important limitations to consider include the following:

1. Algorithms reflect their embedded data and assumptions and thus must be designed and validated using diverse datasets.[4] Algorithms trained on biased or incomplete data could perpetuate disparities rather than mitigate them.
2. If internists deploy predictive tools, they must also address structural barriers to care such as insurance issues, food insecurity, transportation gaps, and pharmacy access. Otherwise, this might label patients as "high-risk" without providing them meaningful pathways to lower their risk.
3. AI cannot replace the therapeutic alliance that exists between physicians and patients. A predictive alert may identify a 27-year-old man with escalating blood pressure, but this alert will not uncover the patient's reluctance to take medication because it conflicts with his sense of identity.

By recognizing these limits, internists can better balance patient-centered care with technological innovation.

Hope amid Reality

Internists are being trained at the intersection of two revolutions: one demographic, one technological. CHF in young adults (in particular, young Black adults) is not disappearing. Simultaneously, digital tools are reshaping disease evaluation and management. Earlier detection, culturally responsive education, and sustained outpatient engagement, potentially augmented by AI—offer one path forward. By centering the personal experiences of young patients living with chronic disease and combining innovation with intentionality, SGIM members can change the future of cardiovascular care. For the young adults I care for—and the trainees learning alongside me—that future cannot come soon enough.

References

1. Minhas AMK, Talha KM, Abramov D, et al. Racial and ethnic disparities in cardiovascular disease -

IMPROVING CARE *(continued from page 20)*

Analysis across major US national databases. *J Natl Med Assoc*. 2024;116(3):258-270. doi:10.1016/j.jnma.2024.01.022. Epub 2024 Feb 10.

2. Miller, T, Carter SV, Smith BA. Disparities in acute decompensated heart failure. *Curr Opin Cardiol*. 2021 May 1;36(3):335-339. doi:10.1097/HCO.0000000000000856.
3. Talha KM, Almas T, Minhas AMK, et al. Disparities in heart failure between White, Black, and Hispanic young adults: Insights from the National Health and Nutrition Examination Survey. *Ther Adv Cardiovasc* Dis. 2024;18:17539447241239814. doi:10.1177/17539447241239814. PMID: 38523335 PMCID: PMC10962029.
4. Hadida Barzilai D, Sudri K, Goshen G, et al. Randomized controlled trials evaluating artificial intelligence in cardiovascular care: A systematic review. *JACC Adv*. 2025 Nov;4(11 Pt 1):102152. doi:10.1016/j.jacadv.2025.102152. Epub 2025 Sep 24.

SGIM

MORNING REPORT

CLINICAL REASONING FOR GASTROINTESTINAL BLEEDING: CONSIDER GI AMYLOIDOSIS WHEN YOU SEE THE ATYPICAL

Robert Ledford, MD, FACP; Charles Cavalaris, MD; Riley Ostdiek, MD; Shreya Narayanan, MD

Dr. Ledford (ledfordr@usf.edu) is a Hospitalist and Co-Director of the Internal Medicine Clerkship at the University of South Florida. Dr. Cavalaris (charlescavalaris@usf.edu) is a Fellow in Gastroenterology at the University of South Florida. Dr. Ostdiek (rileyostdiek@usf.edu) is an Internal Medicine Resident at the University of South Florida. Dr. Narayanan (snarayanan@usf.edu) is a Gastroenterologist and GI Fellowship Director at the University of South Florida.

Gastrointestinal bleeding is one of the most encountered chief complaints in Internal Medicine. When the common etiologies have been ruled out, physicians need to consider more rare conditions. This article highlights the diagnostic approach to this commonly encountered problem in the fields of General Internal Medicine and Gastroenterology.

A 71-year-old man with a history of JAK2 V617F-positive polycythemia vera initially presented with intermittent episodes of nausea, hematemesis, and melena over several months. His polycythemia had been managed with regular phlebotomy and intermittent hydroxyurea, with a baseline hemoglobin around 16 g/dL. Upon presentation with his GI symptoms, his hemoglobin declined to 12 g/dL. Given these presenting symptoms, he underwent a standard workup for gastrointestinal bleeding. Coagulopathy and thrombocytopenia were ruled out as a systemic cause of bleeding. An evaluation for localized causes, such as gastric ulcers, gastritis, variceal bleeding related to portal hypertension, esophagitis, arteriovenous malformations, tumors, and diverticula, was accomplished with bidirectional endoscopy.

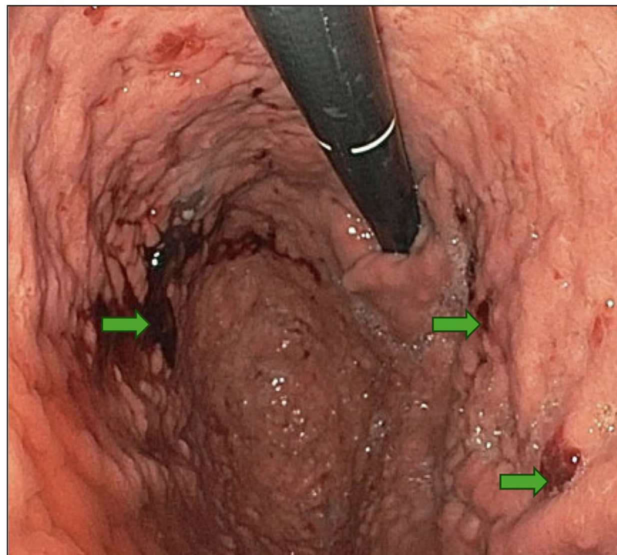
While the colonoscopy was unremarkable, esophagogastroduodenoscopy (EGD) revealed diffuse gastric inflammation with hemorrhage. Antral biopsies showed foveolar hyperplasia, moderate chronic inflammation, and deposition of pink amorphous material, but no evidence of Helicobacter pylori. Despite these findings, the etiology of his bleeding remained unclear.

More detailed radiographic evaluation was pursued at this point to look for other signs of localized or diffuse abdominal processes that might reveal the underlying cause. Magnetic resonance enterography (MRE) demonstrated wall thickening from the cardia to the proximal body of the stomach, along with focal areas of mid-wall thickening and enhancement in parts of the jejunum and ileum. He was referred to the University of South Florida Medical Center.

MORNING REPORT *(continued from page 21)*

When a patient is referred to an academic medical center Gastroenterology practice, physicians start with a broad differential diagnosis. The thickening seen on MRE and bleeding anchor the Gastroenterologist's diagnosis to an inflammatory condition. Inflammatory bowel disease (IBD) is a strong consideration as one of the most common inflammatory conditions of the gastrointestinal (GI) tract. Disorders of the small intestine alone rarely present with hematemesis. However, Crohn's Disease can certainly have patchy involvement in the stomach and esophagus which can result in hematemesis. Other considerations would be infiltrating conditions of the GI tract, such as eosinophilic gastroenteritis, mastocytosis, and amyloidosis. The patient's history of a myeloproliferative disorder increases the consideration for malignant processes which may be infiltrating the GI tract, or thrombosis of the portal system could result in gastric bleeding and vascular congestion from portal hypertension.

Based on the radiographic abnormalities appreciated on MRE and no clear etiology on the previously completed EGD, the patient was scheduled for antegrade single balloon enteroscopy. However, upon insertion of the enteroscope, the stomach was found to be diffusely congested with areas of friable, spontaneously bleeding tissue in the gastric fundus and body, as well as irregular and thickened gastric folds (see photo). Antegrade single balloon enteroscopy involves use of an overtube to allow for deeper intubation of the GI tract. The overtube can increase the diameter of the scope by as much as 50% as well as the rigidity of the entire scope. Based on the degree of inflammation, enteroscopy with overtube was aborted in favor of standard EGD to avoid traumatic injury to the gastric mucosa. Biopsies revealed chronic and active gastritis, and histopathological examination using Congo red staining confirmed the presence of subepithelial amyloid deposition. Liquid chromatography-tandem mass spectrometry of peptides extracted from Congo red-positive areas confirmed the diagnosis of AL (kappa)-type amyloidosis.



Retroflexed view of stomach
Areas of spontaneous hemorrhage (green arrows)
Remainder of mucosa has diffuse thickening and nodularity
Photo courtesy of Dr. Narayanan and Dr. Cavalaris

Amyloidosis is a rare disorder with an incidence of 9.7-14.0 cases per million person-years,[1] which results in the deposition of abnormally folded amyloid fibrils in organs of the body. There are three types of amyloidosis based on the precursor protein that forms the fibrils. Because these proteins can infiltrate into any organ, amyloidosis has a diverse and protean manifestation. A myriad of chief complaints can lead to differential diagnoses that include amyloidosis. AL amyloidosis (also known as primary amyloidosis) is caused by the deposition of misfolded light chain immunoglobulin proteins.[1] Involvement of the gastrointestinal tract is rare, with one study reporting 76 out of 2,334 patients with amyloidosis over a 13-year period having biopsy-proven amyloid involvement of the gastrointestinal tract.[2] When amyloidosis does involve the gastrointestinal tract, AL amyloidosis is the most common.[2, 3] Patients may present with weight loss, diarrhea, early satiety, or bleeding.[2] The diagnosis of gastrointestinal amyloidosis is often delayed for several reasons including: nonspecific endoscopic findings, histological involvement with subclinical presentation,[4] or a lack of familiarity with the disease amongst physicians.[5] Treatment of amyloidosis with gastrointestinal involvement is also difficult, as myeloablative chemotherapy is often avoided due to risk of life-threatening hemorrhage.[2]

Given the amyloidosis identified in gastric biopsies, the patient was referred to Cardiology and Hematology. Further investigations were conducted to determine the extent of his amyloidosis. Echocardiogram demonstrated normal systolic function. However, cardiac MRI revealed abnormal late subendocardial gadolinium enhancement in the left ventricular myocardium, consistent with cardiac amyloidosis. A bone marrow biopsy demonstrated hypercellular marrow with increase in all cell lines, atypical megakaryocyte hyperplasia, and no excess blasts. The biopsy did not demonstrate amyloidosis in the bone marrow as Congo red stain was negative. In addition to the previously diagnosed amyloidosis elsewhere, bone marrow findings suggested that the patient also had polycythemia vera-chronic myelomonocytic leukemia (PV-CMML) overlap syndrome. Genetic sequencing demonstrated several mutations in addition to JAK2 mutation which are likely associated with a PV-CMML overlap. Subsequent positron emission

MORNING REPORT *(continued from page 22)*

tomography (PET) CT scan demonstrated heterogenous activity throughout the bone marrow, consistent with CMML. There were no lytic skeletal lesions suggestive of amyloid involvement of bone.

It's important to recognize that the diagnosis could have been made during the original endoscopy. The appearance of the stomach was notably unusual in its congestion, friability, and diffused slow bleeding. There were also areas of nodularity that were visualized. Together, these findings strongly suggested the presence of an infiltrating disorder. Although these conditions are not common in the general population, in this instance, they should be high on the differential.

The physician (either the Internist who referred the patient or the Gastroenterologist performing the EGD) should ensure the pathologist is aware of the concern for an infiltrating disease. This would prompt the use of Congo red staining. Detailed differential diagnoses and communication to the entire treatment team are often the key to solving more unusual cases. The significance of the nodularity to the gastroenterologist who already was considering amyloidosis imparted increased importance to the finding and led to the correct diagnosis.

With the confirmation of systemic amyloidosis, treatment was initiated with daratumumab, bortezomib, and dexamethasone (DVd regimen). Cyclophosphamide, another commonly utilized agent in treating AL amyloidosis, was deferred due to risk of CMML transformation into acute myeloid leukemia (AML). Treatment of PV-CMML crossover syndrome was initially managed with routine phlebotomy alone and cytotoxic agents were eventually added. Unfortunately, this patient experienced multiple significant adverse events related to chemotherapeutic agents and subsequently expired.

This case highlights important learning points for SGIM members. Amyloidosis can affect any part of the GI tract, and signs of infiltrative disease, especially in a patient with other hematologic disorders, should raise suspicion. If there is concern for gastrointestinal amyloid, work closely with your gastroenterologist and pathologist to ensure the necessary testing and staining are performed. Finally, amyloidosis is often diagnosed late in the disease course; however, therapeutic advances can significantly change prognosis if the disease is identified early.

References

1. Sanchorawala V. Systemic Light Chain Amyloidosis. *N Engl J Med*. 2024 Jun 27;390(24):2295-2307. doi:10.1056/NEJMra2304088.
2. Cowan AJ, Skinner M, Seldin DC, et al. Amyloidosis of the gastrointestinal tract: A 13-year, single-center, referral experience. *Haematologica*. 2013 Jan;98(1):141-6. doi:10.3324/haematol.2012.068155. Epub 2012 Jun 24.
3. Said SM, Grogg KL, Smyrk TC. Gastric amyloidosis: Clinicopathological correlations in 79 cases from a single institution. *Hum Pathol*. 2015 Apr;46(4):491-8. doi:10.1016/j.humpath.2014.12.009. Epub 2015 Jan 7.
4. Sattianayagam PT, Hawkins PN, Gillmore JD. Systemic amyloidosis and the gastrointestinal tract. *Nat Rev Gastroenterol & Hepatol*. 2009 Oct;6(10):608-17. doi:10.1038/nrgastro.2009.147. Epub 2009 Sep 1.
5. McCausland KL, White MK, Guthrie SD, et al. Light Chain (AL) Amyloidosis: The journey to diagnosis. *Patient*. 2018 Apr;11(2):207-216. doi:10.1007/s40271-017-0273-5.

SGIM