JUNE 2026 V49, NO. 6

SGIM FORUM

IN THIS ISSUE:

MEDICAL EDUCATION: ARTICLE I

EVOLVING PROFESSIONAL ROLE IDENTITY AND HEALTH SYSTEM SCIENCE FOR PRIMARY CARE TRAINEES: A MULTI-INSTITUTIONAL QUALITATIVE STUDY

Deepa Rani Nandiwada, MD, MSME; Erik X. Tan, MD; Zoe Barbati, MD; Jennifer Kogan, MD

Dr. Nandiwada (rani.nandiwada@pennmedicine.upenn.edu) is an Associate Professor of Clinical Medicine at the University of Pennsylvania Perelman School of Medicine. Dr. Tan (Erik.tan@pennmedicine.upenn.edu) is an Assistant Professor of Clinical Medicine at the University of Pennsylvania Perelman School of Medicine. Dr. Barbati (zoe.barbati@pennmedicine.upenn.edu) is a resident in the University of Pennsylvania Primary Care Residency Program. Dr. Kogan (Jennifer.kogan2@pennmedicine.upenn.edu) is a Professor of Medicine at the University of Pennsylvania Perelman School of Medicine.

Background

Trainees going into primary care today may have a discordant understanding of the different roles that shift once graduation occurs and attending life starts. *Health systems science* (HSS) is an umbrella term for the system skills needed to provide evidence-based, high quality health care.[1,2] Within HSS skill domains, technology and electronic health record (EHR)-based skills (including telehealth, remote monitoring, and patient messaging) are now required for practicing primary care physicians (PCPs).

Since many residents are shielded from the realities of health system's needs, many trainees do not have the adaptive expertise to acclimate effectively. Education focused on HSS skills and concepts is often disconnected from direct clinical care, creating the impression that this is a supplementary skill rather than a core component of PCP practice.[3-5] As primary care training programs work to attract and keep more trainees in primary care, identifying their relationship with these aspects of the PCP role is vital to upskill trainees and create jobs that reduce burnout. In this article, we describe a qualitative study that seeks to better understand how trainees came to conceptualize the professional identity of the PCP as well as the opportunities and challenges of HSS components that are integrated into their future careers. This data

MEDICAL EDUCATION: ARTICLE I *(continued from page 1)*

will allow primary care educators to understand the gaps in HSS professional role identify formation and create curricula and training experiences to develop adaptive expertise for these future PCPs.

Design

We performed a mixed-method, multi-institutional study at four large academic internal medicine residency programs with either a primary care track, generalist track, or general medicine fellowship in the Mid-Atlantic Region (University of Pennsylvania, Johns Hopkins Bayview, University of Pittsburgh, and New York University). A total of 17 interviews and post interview surveys were conducted from May 2020-December 2021. This study was approved by the University of Pennsylvania's institutional review board.

Results

Seventeen participants completed semi-structured interviews, with 16 participants completing the online survey. Participants were between the ages of 25 to 35, 14 (82%) were women, and they represented 13 different medical schools across the country. Via a free response question, participants indicated that ideal job components would include protected time for professional passions, including teaching/curriculum development, serving underserved patients, caring for specific vulnerable patient populations, time for research/quality improvement projects, and work-life balance.

Overarching Themes

Three major themes were generated from our focus groups centering on professional identity challenges, balancing the joy of direct patient care, and HSS roles feeling like additional uncompensated workload:

- **Theme 1: Challenges of embracing future HSS roles into traditional primary care professional role identities developed in training.**
  Trainees embrace the role of a PCP in longitudinally leading and coordinating patients' care. Moving forward, trainees see primary care as an opportunity to be a leader within medicine, since the PCP is often the first touchpoint for patients in healthcare systems. Trainees noted a lack of mentorship or role modeling regarding how HSS components are part of the attendings' work life. Additionally, there were concerns about increased demands from PCPs by the healthcare system with little protection of their time. In the end, patient relationships (especially in-person clinical care) were defined as a major driver for joy in the work of being a PCP.

  "…the primary care doctor is one of the only providers that people can expect to have for multiple years…I think that really is a great opportunity for me to be a coach for people to help figure out what's important to a patient and then how to help them achieve their goals."

  "I talked to a bunch of the other primary care doctors in our clinic and none of them are doing panel management…A lot of them have been practicing for a good five plus years as a PCP and it just hasn't been something that has been pushed on them yet…it's not part of their culture yet."

- **Theme 2: Trainees are excited by, but concerned with, how healthcare systems will integrate HSS into the PCP's roles in the future.**
  Overall, trainees found satisfaction when participating in aspects of HSS, such as quality improvement (QI) projects and population health to improve patient outcomes but noticed challenges in integrating this into their workflow. Trainees felt population health and QI projects were add-on work and expressed concern about institutional support for such work counting towards patient care.

  "… there's no funding that's going to reimburse my work on panel management. I also don't think I'm going to be necessarily rewarded in terms of my job or advancement for my work with this kind of stuff."

  "[non-patient facing care] requires its own time…I hope that…it's given actual time for clinical practice [so] things can be done well instead of just getting them done…squeezed in whenever possible."

- **Theme 3: Tensions exist between HSS skills that improve patient care but create more distance from longitudinal relationships with patients.**
  Participants defined that connections and longitudinal relationships are the core components of the PCPs' role identity. Tensions are created with some HSS components (such as population health technology and interdisciplinary care teams) as they make more space between the provider and patients. However, they also acknowledged these components provide for more comprehensive care.

  "Every person is so unique and faced with such incredible challenges that it's very valuable to have that data and to have an overall sense of your panel …"

  "…one of the most challenging things about being a resident is multitasking, prioritizing, and then making sure things don't fall behind. Two hours later, if you open up your in-basket again, there's five more messages just waiting for you. Even with your dedicated admin time, it just expands…It's just never ending."

MEDICAL EDUCATION: ARTICLE I *(continued from page 2)*

In this study, participants describe an unconscious hidden curriculum driven by institutional culture and faculty. Study participants felt that HSS roles are not part of the role identity of the PCP due to the lack of protected time, financial alignment, and faculty/role model acceptance of these roles. Many of these feelings also resonate with attending faculty.

Discussion

There are several challenges to incorporate HSS education into residency training that encourage integration with professional identity. First, faculty may feel uncomfortable with HSS topics, leading to decreased informal teaching (i.e., "How can I teach what I am just trying to pick up myself?") or even a counterproductive unconscious hidden curriculum, manifested by devaluing HSS-related aspects of physician work. Second, it is inherently difficult to create a clinical learning experience for an evolving role, especially with ongoing technology changes and innovations. Earlier and more deliberate exposure to these domains during training could help create a stronger foundation for adaptive expertise. This leads to multiple opportunities to embed HSS roles into professional role identities including developing more undergraduate medical education (UME) and graduate medical education (GME) primary tracks, protecting labeled clinical time during training for HSS activities, and nationally advocating for reimbursement policies that include HSS skills as clinical patient care.

Conclusion

Recruiting trainees into primary care is challenging at baseline. SGIM members must create space that visibly values new health system work and create time for individual healthcare passions. This effort will create sources of professional identity and fulfillment and to promote career vitality.

Acknowledgements: We would like to acknowledge our external institutional co-authors/collaborators—Dr. Paul O'Rourke, Dr, Jennifer Adams, and Dr. Amar Kohli. We offer great thanks to the Williams foundation, Caitlin Clancy MD, and the mixed method lab team Andrea Bilger and Zoe Belardo for supporting this work.

References

1. Gonzalo J, Haidet P, Papp KK, et al. Educating for the 21st-century health care system: An interdependent framework of basic, clinical, and system sciences. *Acad Med*. 2017 Jan;92(1):35-39. doi:10.1097/ACM.0000000000000951.
2. Skochelak SE, Hawkins RE. *AMA Education Consortium. Health Systems Science*. 2nd Ed. St. Louis, MO: Elsevier, 2020.
3. Gonzalo JD, Chang A, Dekhtyar M, et al. Health systems science in medical education: Unifying the components to catalyze transformation. *Acad Med*. 2020;95(9):1362-1372. doi:10.1097/acm.0000000000003400.
4. Borkan JM, Hammoud MM, Nelson E, et al. Health systems science education: The new post-Flexner professionalism for the 21st century. *Med Teach*. 2021 Jul;43(sup2):S25-S31. doi:10.1080/014215 9X.2021.1924366.
5. Sawatsky AP, Matchett CL, Hafferty FW, et al. Professional identity struggle and ideology: A qualitative study of residents' experiences. *Med Educ*. 2023 Nov;57(11):1092-1101. doi:10.1111/medu.15142. Epub 2023 Jun 3.

SGIM

HORSESHOE OR MAGNET? OUTSTANDING LEADERS ARE BETTER MAGNETS

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

"Effective leaders are always on the lookout for good people… who you get is not determined by what you want. It is determined by who you are."[1]

As a child, I remember playing with two favorite toys residing in the toybox tucked away in the corner of my bedroom. Both were prized possessions obtained by means unremembered at this stage of my career. Back then, both had similar physical appearances. Only later did I realize that they were metaphors for different leaders I encountered during my career. In this article, I share the symbolism on how my childhood toys influence my leadership style.

My horseshoe and horseshoe magnet both had a crescent shape with their solid bottom tapering into two extended arms. They were often found together in the bottom of the toybox with the steel horseshoe stuck to the end of the magnet. The old, cold steel horseshoe often left behind a red stain on my hand from the flaking red-brown paint worn thin and the rust that had settled in where the paint had long worn away. The nicks and divots along the surface showed a lifetime of dedicated purpose and hard use.

However, my magnet was new and shiny—its surface was smooth without dings and the color was an unblemished black. My magnet was powerful as I used it to attract ferromagnetic materials throughout the house and backyard. I was excited when I got new magnets and learned that magnets attract other magnets when they are oriented in the same direction. Direction of the poles mattered because otherwise they would repel each other. Sure, I could force the ends together but there was no electromagnetic attraction and once the force pushing them together was removed, they would separate. But, when they were aligned correctly, the sudden snap of a solid connection was instantaneous and inseparable.

Leadership Development

As I transitioned into leadership positions, I observed leaders around me and studied their behavior, conversations, and interactions. I adopted a similar mindset to residency where I would learn as much from a bad attending physician as a great attending physician. The behaviors I observed in residency were as much about the style and actions of bad attendings that I would not incorporate into my future attending rounds contrasted with the behaviors I would emulate from attendings whom I admired. Learning from good and bad examples of leaders followed a similar tract.

An early mentor had referred me to several books by noted author John Maxwell during my leadership development. Maxwell's writing style was easy to read and contained real world examples to illustrate learning points. One book, *The 21 Irrefutable Laws of Leadership*, stood out to me.[1] His 21 laws made sense to my still developing style and I committed to implementing these laws into my blossoming leadership roles.

Law of Magnetism

In 2017, I was still developing my leadership skills as my team, and I opened the newly built, state-of-the-art post-Hurricane Katrina replacement Veterans Affairs medical center. Along the way, we needed to recruit physicians to deliver care and staff the hospital as we moved from a system of post-hurricane community clinics to a full-service hospital. During this time, one of Maxwell's law became highly relevant to my daily work: The Law of Magnetism (Law #9) that stated, "Who you are is who you attract."[1] Ahead of us was a tremendous opportunity to build a team and a culture from the ground up. Recruitment and later retention hinged upon getting Law #9 right.

Maxwell described several key concepts that were essential to understanding what I needed to do as a leader to define the culture and recruit the necessary staff:

1. *"Who you get is not determined by what you want. It's determined by who you are."*[1] Effective leaders possess core qualities and characteristics that are identifiable and relatable to others. Leaders who are transparent and able to state what is important to them allow followers to identify with shared visions.

FROM THE EDITOR (continued from page 4)

"To create power is like a magnet, this is true because this creative power operates like a magnet. Give it a strong clear picture of what you want and this creative power starts to work magnetizing conditions about you—attracting to you things, resources, opportunities, circumstances and even the people you need, to help bring to pass in your outer life what you have pictured."[2] I learned to effectively describe my visions and plans for how my service would operate in the new facility.

2. *"It is possible for a leader to go out and recruit people unlike himself, but those are not the people he will naturally attract."*[1]
   Leaders will create a culture whereby individuals are attracted to qualities and characteristics possessed by the leader. This does not mean that those attracted to the leader are identical to the leader. But there are often shared qualities, visions, and attitudes. There are significant benefits to aligning these qualities, but diversity also adds to workplace value. To better understand who is attracted and why, Maxwell states that the leader needs to understand the common areas most likely to lead to shared magnetism: Attitude, Generations/Age, Background, Values, Life Experiences, and Leadership Ability. It is only by understanding these shared characteristics that leaders can look to attract others that are different in these areas to add diversity to their team. I came to understand what colleagues would work within the developing culture, who could fill missing gaps and who would not be a fit.

3. *"The better leader you are, the better leaders you will attract."*[1]
   I knew we were building a strong team dedicated to improving the health care of Veterans. I knew I needed strong leaders. But I also knew that if we were not continuing to get better, we would get worse. There is no staying the same in health care. My focus on Law #9 was influenced by Maxwell's Law #7: The Law of Respect—people naturally follow leaders stronger than themselves. I had to continue learning and adapting. I needed to improve myself. If my leadership style was only above average, I was likely to attract only average leaders. I needed to up my game to become an outstanding leader to attract excellent leaders. This realization led me to continuously analyze my leadership style and deliverables as I invest in my leaders, so they attract the next generation of leaders.

By recognizing these specific attributes in my leadership style, I have worked to become a better leader.

Horseshoes versus Magnets

As I continue my leadership journey, I often recount the varied leadership concepts I have learned that I now incorporate into my leadership style. Teaching and mentoring others in leadership leads to analogies pulled from my childhood memories. The horseshoe and the magnet became symbols of leadership styles I wanted to avoid and adopt, respectively.

Memories of my horseshoe were that it was old, cold, and steely. There was hope that it would invite good luck, but it lacked the power of attraction. My old horseshoe left negative reminders of our interactions, including the rust-colored stains on my hands. It had the nicks and scrapes of a lifetime of hard work; but, if not on the foot of a horse, the horseshoe had lost its purpose. This became emblematic of the leadership style I chose to avoid.

On the other hand, I remember my magnet as shiny and new—it actively attracted items and even attracted other magnets. At times, it might repel other magnets; but with reorientation, the connection was strong and solid once aligned in the correct direction. My magnet provided me with happy memories and came to symbolize the leader I wanted to become.

Conclusion

Leadership is not a *status quo* event. Becoming a leader is only the first step in the leadership journey. Continuous self-improvement is a must. Excellent leaders attract added resources, better people, and more leaders. SGIM members must analyze their leadership style. If the people you are trying to recruit and retain are not where you want them to be, perhaps the answer lies within.

As SGIM members continue to lead in health care, leaders need to ask themselves: Do you want to be the old horseshoe waiting for good luck to happen or do you want to be the best damn magnet you can be? As the award-winning musician Carlos Santana says, *"Your mind is a magnet. You don't attract what you need or what you want; you attract who you are. And I love who I am!"*[3]

Personally, I want to be a better magnet.

References

1. Maxwell JC. *The 21 Irrefutable Laws of Leadership.* 25th Anniversary Ed. New York: HarperCollins Leadership, 2022.
2. Bristol C. Quote: Claude M. Bristol. *AZ Quotes.* https://www.azquotes.com/quote/1015909?ref=magnet. Accessed May 15, 2026.
3. Santana C. Quote: Carlos Santana. *AZ Quotes.* https://www.azquotes.com/quote/258664?ref=magnet. Accessed May 15, 2026.

SGIM

MY PAST AND THE YEAR AHEAD: OUR JOURNEY TOGETHER

Mark D. Schwartz, MD
President, SGIM

"SGIM is the thread that ties my past and our future together. It is more than a professional home. My goal is to sustain and strengthen that home, widen the door, and ensure that when people enter, they find respect, purpose, and belonging."

As I begin my term as President of SGIM during its golden anniversary year, I would like to first introduce myself to members by sharing my personal and professional history. Then I will highlight the unique opportunities that lie ahead for SGIM.

My Journey into Medicine

I am the grandson of Jewish immigrants from Lithuania and Ukraine who came to the United States before the Second World War and the Holocaust. Others in my family were not as lucky. I grew up in middle class Brooklyn in the 1970s, riding my bike, with the New York Mets on the radio, and jazz in my ears. I studied biology at Brooklyn College, where I fell in love with science and learned how hard it is to do it well.

When I applied to medical school, I was rejected everywhere. Thirty schools, 30 thin envelopes. I was shaken. For a time, I was not sure what came next. I found work as a medical assistant in a busy clinic in central Brooklyn, New York. Because I was a tall white man who said he wanted to be a doctor, I was entrusted by the physicians I worked for with tasks I had no right doing. I loved the interactions with patients, and that experience deepened my commitment to pursue my dream of becoming a physician.

After being accepted to medical school in Guadalajara, I moved to Mexico where I studied medicine in a foreign language and a different culture. I learned to care for patients where resources were scarce, but needs were great. In a mountain village, a handful of trainees and one resident were the only doctors for miles. The clinic was the only building with electricity. We made house calls to dirt-floor homes with chickens underfoot. Those years shaped me. They taught me that medicine is local, patient-centered, and challenging; in such settings care is often improvised.

I transferred into the clerkship year at Cornell University College of Medicine (now Weill Cornell Medical School) in New York City just as HIV had begun to reshape our lives. I cared for patients who were isolated by public fear as much as by their illness. I observed starkly different worlds of care across public and private settings. These differences taught me how health and health care are tied to power and money.

I completed my residency training at Bellevue Hospital and NYU Medical Center. It is here where I met my July co-intern Adina Kalet, who became my life partner. We cared for patients who were poor; many were immigrants, marginalized, and often unseen. In those early days of the AIDS epidemic, our patients were often our age. Many were dying. Caring for this group of patients taught us the impact and limits of doctoring. We learned that our work is not only to treat disease but also to sit and comfort patients when a cure is not possible.

My career took many turns over the subsequent years. I became a general internist, a researcher, a teacher, and a leader. I found purpose in building programs, mentoring others, and asking larger questions, *"Why we get sick?"* and *"How might we do better?"* Over time, I came to see that what happens in the clinic is shaped as much by policy as by physiology. That pivotal realization drew me into health policy and advocacy, and deeper into SGIM.

SGIM invited me in as a learner. It gave me teachers, colleagues, and a place to grow into a professional. SGIM showed me that our work does not stop at the clinic door, and that our voice, when joined with others, can shape the conditions in which we provide care, teach, and discover.

I still remember my first SGIM meeting, the 1989 Southern Regional meeting in New Orleans, Louisiana. I felt small. I wondered if I belonged. Many of you know that feeling. Some of you may feel it now. SGIM makes stories like mine possible. Our task now is to ensure it can do so for the next generation.

PRESIDENT'S COLUMN *(continued from page 6)*

Our Journey Together

As President, I assume the role with deep gratitude, and a clear sense of my place within a larger story. As part of SGIM's ongoing effort to broaden who leads and belongs in our organization, I recognize that I am the first white male to serve as President in nearly a decade as well as one of the oldest to serve in this role.

I come to this role as a Jew at a time of deep strain for my people and the world. The events of the past few years have touched many of us, directly and indirectly. Many in our SGIM community carry grief, anger, fear, and diverse world views. I will not be able to resolve these tensions, but I will not ignore them. Like many of you, I carry both pride in identity and concern for how my identity is viewed at this moment. I see my task as creating space for respectful dialogue, caring for patients and communities without bias, and remaining grounded in our shared commitment to human dignity.

We are in a political crisis that threatens our mission. Federal policies and proposals currently reduce research funding, strain our training programs, and limit access to health care for the patients we serve. These forces shape our engagement with trainees, our research, and the care we deliver to our patients.

In these times, silence is *not* an option. Our voice matters. Our responsibility is to speak clearly, grounded in evidence, and in our lived experience as clinicians, educators, and scholars. We must sustain a strong, collective voice for our patients, our learners, and our profession.

The Year Ahead

Primary care is under strain. The workforce is thinned. Models for payment, practice, and our pipeline lag the needs of patients and clinicians. Yet, the demand for what we do has never been greater.

SGIM is well positioned to lead, but we cannot do this alone. We will work with partners across medicine, including our colleagues in internal medicine, family medicine, and pediatrics, as well as organizations focused on education, research, and patient advocacy. We will seek alignment where possible. But SGIM will bring forward the distinct and trusted voice of general internal medicine where we must.

Over this year, we will celebrate SGIM's 50th anniversary with the theme of our 2027 annual meeting: *SGIM@50 Honoring Our Legacy, Shaping the Future of GIM*. I will work with SGIM's Council to shape an agenda built around the following three aims that are essential for our future:

- Shape a bold and actionable vision for the future of general internal medicine and primary care, with clear policy targets and partners.
- Strengthen our collective voice through coordinated advocacy—from the grass roots (members) to the grass tops (leaders) of SGIM—that is timely, credible, and effective.
- Invest in the professional home of SGIM and our pipeline by supporting trainees, early career members,

PRESIDENT'S COLUMN *(continued from page 7)*

and our staff, advancing mentorship and sponsorship, and sustaining SGIM across the career span.

Together, these aims connect vision, advocacy, and community to move SGIM, and our field forward.

Conclusion

I enter this year with energy and humility. However, I may fall short at times. I might forget to thank people who deserve it. I will send an e-mail when I should have made a call. I will move too quickly in some moments and too slowly in others. When that happens, I ask for your patience and forgiveness. I promise to listen and learn from these opportunities.

No one does this work alone. SGIM is blessed with a phenomenal professional staff, led by Eric Bass, MD, MPH, and Kay Ovington, CAE. I will lean on their guidance throughout the year. My career is shaped by teachers who asked tough questions, mentors and sponsors who advised and opened doors, colleagues who stood with me, learners who let me touch the future, and patients who trusted me. These experiences will guide me as we face the journey together.

SGIM is the thread that ties my past and our future together. It is more than a professional home. My goal is to sustain and strengthen that home, widen the door, and ensure that when people enter, they find respect, purpose, and belonging.

Thank you for the chance to serve and the work we will do together this coming year!

SGIM

FROM THE SOCIETY

Q & A WITH SGIM'S CEO AND PRESIDENT ON THE SOCIETY'S ACHIEVEMENTS OF 2025-26

Eric B. Bass, MD, MPH; Carlos Estrada, MD, MS, FACP

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Estrada (cestrada@uabmc.edu) was the President of SGIM in 2025-26.

Dr. Estrada served as SGIM's 48th President in 2025-26. In his initial SGIM Forum column as SGIM's President, he declared his commitment to continuing to build SGIM as a community of like-minded members who must support each other amidst many threats to the mission of academic medicine.[1] As another challenging year reaches an end, I asked Dr. Estrada to share his reflections on the Society's achievements of the past year.[2]

EB: Looking back on your year as SGIM's President, what activities contributed the most to building up our community?

CE: I believe our Annual Meeting and regional meetings have been extremely successful in nurturing a strong sense of community among members. From my own experience in attending multiple regional meetings in addition to the Annual Meeting, I have witnessed how members cherish time together, inspire each other, and welcome new members and trainees into the SGIM community. Meeting registration data confirms that the meetings continue to support growth of the SGIM community. Of the 1,026 registrants at regional meetings in the last year, 64% were not previously members, most of whom were trainees. I had an aspirational goal of 2,074 attendees for the 2026 Annual Meeting (the year 2026 + 48th President = 2,074). Thanks to our members, the goal was exceeded!

The ACLGIM Summit in December enriched our community by bringing together 114 general internal medicine (GIM) leaders around the theme of "Unlocking Our GIM Superpowers."[3] For the first time, the summit included healthcare administration business and operations partners from many GIM divisions.

Thanks to the Membership Committee, SGIM welcomed 92 new members from two institutions that participated in a pilot institutional membership program for divisions that previously had limited engagement with SGIM. The Membership Committee also gave complimentary "Investing in GIM" memberships to 33 first-year

FROM THE SOCIETY (continued from page 8)

fellows and 32 chief residents and presented "National Young Scholar" awards to 41 medical residents and 29 medical students to cover the cost of attending our national meeting.

Thanks to the Leadership Pathway Program Workgroup,[4] SGIM developed a new online resource to help members identify volunteer opportunities within the organization. This will enhance the inclusiveness of our community by making it easier for members to engage in leadership development opportunities regardless of their institutional footprint size within SGIM.

I greatly appreciate the efforts of these groups that helped to build up the SGIM community by recruiting new members, engaging new members in our meetings, and promoting leadership development of members.

EB: What else stands out to you about the achievements of SGIM's committees and commissions during the last year?
CE: I am deeply grateful for the work done by our members during a stressful year in which all aspects of the academic mission have been disrupted. The Health Policy Committee addressed the threats to clinical practice, medical education, and research by signing on to or submitting more than 110 letters to governmental leaders on policy issues. Yes, *110 letters*! Each letter aligned with SGIM's core values and mission:

- Clinical issues focused on Medicare and Medicaid policies with an emphasis on advocating for access to care and better support of primary care and telehealth.
- Educational issues focused on graduate medical education and primary care training programs funded by the Health Resources and Services Administration.
- Research advocacy focused on funding for the National Institutes of Health, Veterans Affairs, and Agency for Healthcare Research (AHRQ).

The committee also sent timely action alerts to members and provided educational sessions for members at the Annual Meeting.

To support the work of the Health Policy Committee and strengthen our advocacy voice, SGIM's leadership nurtured relationships with organizations having similar priorities.[5] SGIM partnered with the North American Primary Care Research Group and the Public Citizen Litigation Group to file suit against the U.S. Department of Health and Human Services about the impoundment of funding appropriated by Congress for AHRQ. SGIM also worked closely with leaders of AcademyHealth to advocate for preservation of federal support for health services research and primary care research. As a member of the Primary Care Collaborative (PCC), SGIM supported PCC's advocacy for increased investment in primary care, hybrid primary care payment plans, and integration of behavioral health and primary care. To support suits filed by other societies concerning reproductive care and vaccination policies, SGIM signed *amicus* briefs (a legal document submitted to a court by non-parties with expertise in the area).

Although advocacy efforts required significant attention from SGIM leadership, other core committees continued to support the organizational goals by promoting scholarship in person-centered and population-oriented approaches to improving health as well as fostering the development of GIM leaders. The Clinical Practice Committee prepared a position paper on deregulating primary care, a webinar on improving care for patients with non-English language preference in clinical settings, a GIMLearn module on "getting to code," and 10 Evidence-Based Medicine Bottom Line Summaries published in JGIM.[2] The Education Committee established a new award for "Best Innovation in Medical Education Oral Abstract," published a paper in *JGIM* on "The Primary Care Exception Rule in Internal Medicine Residency Clinics," and gave multiple presentations nationally on "Building an Educator Portfolio."[2] The Research Committee organized a pre-course for GIM fellows at the Annual Meeting and completed a comprehensive update of the Secondary Database Compendium for researchers.[2] Of course, the Annual Meeting Program Committee did a great job planning the Annual Meeting focused on the theme of "Individual Voices, Collective Impact: Advocating for Excellence in Academic Medicine." The meeting was designed to inspire members to be advocates in their work as clinicians, educators, and researchers.[6]

SGIM's commissions continue to foster collaboration with core committees, interest groups, and other entities on specific parts of our mission. Members of the Academic Hospitalist Commission worked with members of the Society of Hospital Medicine to prepare new content for the Academic Hospitalist Academy held in September 2025. The Health Equity Commission continued to provide outstanding equity-focused content for the Annual Meeting and regional meetings and made plans for a special issue of JGIM on the theme of health equity. The Women and Medicine Commission expanded content for SGIM's regional meetings and continued to recruit new sponsees and sponsors to promote career advancement in GIM.

EB: What did you enjoy most during your year as SGIM's President?
CE: Overcoming "impostor" syndrome and feeling comfortable in my shoes! Meeting members at regional and national meetings, and at times visiting their academic institutions. Getting to know, working with, and learn-

FROM THE SOCIETY *(continued from page 9)*

ing from SGIM Staff—they work *hard*! Also, working with members of Council, the Annual Meeting Planning Committee, Philanthropy Committee, Academic Hospitalist Commission, and Artificial Intelligence Task Force. I mentioned these specific groups because I was the Council liaison or involved as part of a new strategic initiative. In one word, members!

EB: On behalf of SGIM's Council, Carlos and I want to thank all members who volunteered their time to support the community-building work of the committees, commissions, task forces, workgroups, and interest groups to advance our mission!

Disclosures. The opinions expressed in this article are those of the authors alone and do not reflect the views of any of their employers.

References

1. Estrada C. Starting a new chapter, building community, and moving forward. SGIM Forum. https://www.sgim.org/article/starting-a-new-chapter-building-community-and-moving-forward/. Published May 2025. Accessed May 15, 2026.
2. SGIM's Annual Reports: Notable Achievements in 2025-26. *SGIM*. https://www.sgim.org/about-sgim/reports/annual-reports/. Accessed May 15, 2026.
3. Pirraglia P, Chander G, Gann J. Unlocking our general internal medicine superpowers: Highlights from the 2025 ACLGIM Summit. SGIM Forum. https://www.sgim.org/article/unlocking-our-general-internal-medicine-superpowers-highlights-from-the-2025-aclgim-summit/. Published March 2026. Accessed May 15, 2026.
4. Bussey-Jones J. Unlocking leadership: Developing a transparent leadership pathway program to empower SGIM's future. SGIM Forum. https://www.sgim.org/article/unlocking-leadership-developing-a-transparent-leadership-pathway-program-to-empower-sgims-future/. Published December 2024. Accessed May 15, 2026.
5. Bass EB, Bussey-Jones J. Q & A with SGIM's CEO and President about the importance of SGIM's external relations in disruptive times. SGIM Forum. https://www.sgim.org/article/q-a-with-sgims-ceo-and-president-about-the-importance-of-sgims-external-relations-in-disruptive-times/. Published February 2025. Accessed May 15, 2026.
6. 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 May 15, 2026. SGIM

LEADERSHIP AND HEALTHCARE ADMINISTRATION

PIVOT WITH PURPOSE: ACHIEVING GOALS AMID UNCERTAINTY

Claire Ciarkowski, MD, SFHM; Eve A. Kerr, MD, MPH, MACP; Cynthia Chuang, MD, MSc

Dr. Ciarkowski (claire.ciarkowski@hsc.utah.edu) is an Associate Professor and Hospitalist at the University of Utah. Dr. Kerr (ekerr@umich.edu) is the Kutsche Memorial Professor in Internal Medicine, Chief, Division of General Medicine at University of Michigan Medical School, and Research Scientist at the Center for Clinical Management Research, VA Ann Arbor Healthcare System. Dr. Chuang (cchuang@pennstatehealth.psu.edu) is a Professor of Medicine and Public Health Sciences at Penn State Health and previous Chief of the Division of General Internal Medicine at Penn State College of Medicine and Penn State Health Milton S. Hershey Medical Center. Drs. Kerr and Chuang were featured speakers at the 2025 ACLGIM Winter Summit.

Introduction

Change and uncertainty are core concepts to any Internal Medicine physician when it comes to patient care; yet, when these concepts are applied to the foundation of academic medical centers, they elicit fear and anxiety. Emotions are high as a new administration brought rapid policy changes, shook the foundation of medicine, and disbanded grant funding. These changes have forced many SGIM members to refocus on our own missions to stay true to ourselves and support our colleagues. During the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) Winter Summit, Drs. Kerr and Chuang spoke about their experiences during a panel session, "Pivot with Purpose, Achieving

LEADERSHIP AND HEALTHCARE ADMINISTRATION (continued from page 10)

Goals amid Uncertainty." The presenters gave both institutional and personal examples of how they kept their footing while supporting themselves and their departments and provided recommendations to the attendees on their personal pivots. In this article, Drs. Kerr and Chuang reflect on advice they offer faculty during this unprecedented time of uncertainty.

Profound Uncertainty: Eve A. Kerr, MD, MPH, MACP

During periods of profound uncertainty—such as those experienced in academia in 2025—listening carefully and responding with empathy, support, and reassurance are among the most important contributions leaders make. These skills can be challenging, as leaders themselves face uncertainty about the best courses of action and are not always able to be fully transparent. In this context, the messaging and calls to action from the Society of General Internal Medicine[1] and the American College of Physicians[2] were especially valuable, enabling me to share guidance with faculty and staff that reflected the collective voice of our professional societies.

In working to support our faculty and staff, I came to recognize the importance of first addressing my own reactions to the national environment, particularly related to scientific funding and federal employment. As one faculty member aptly noted, what we were experiencing was "not normal"; for researchers, this was not a typical "down cycle." Effective pivoting required acknowledging the emotional impact—both my own and that of others—and then identifying constructive ways to move forward to achieve our goals.

At the University of Michigan, our division undertook several concrete actions, particularly in response to research funding challenges. We convened a research retreat focused on portfolio diversification and mutual support and implemented a grant review process to provide rapid feedback (JIFFY—Just-In-Time Feedback for You) for faculty preparing submissions. These disruptions have been especially challenging for early-career faculty and those approaching promotion. We continue to grapple with the constraints of fixed promotion processes. In parallel, we are exploring more flexible and sustainable career paths for research faculty—ones that integrate research and clinical work in ways that are productive, fulfilling, and impactful. These transitions are not easy. They require acknowledging that prior models may no longer be realistic and partnering closely with the Dean's and Provost's offices to design research career paths that are viable for the future.

The early months of 2025 were particularly difficult for our VA faculty and staff. Messages suggesting that they (and I, as a VA physician for nearly 30 years) consider more "productive" employment in the private sector were demoralizing for individuals who have devoted their careers to the Veterans Health Administration. In the face of such messaging, it was critical that leaders affirm that their employee's work does matter—that their research has meaningfully improved the health and healthcare of Veterans—and that this mission remains essential.

In times such as these, professional networks are especially vital. Whether through national VA and professional society connections or through local relationships, SGIM and ACLGIM members must rely on one another for moral support, shared learning, and collective problem-solving as we navigate ongoing uncertainty.

On Pivoting: Cynthia Chuang, MD, MSc

For many years, I had a steady effort allocation distribution with equal parts of my time spent in primary care clinic, administrative duties as division chief, and as a health services researcher primarily through the Agency of Healthcare Research and Quality (AHRQ). Although deciding to step down as division chief was carefully planned, it was still accompanied by uncomfortable decisions about how I would re-allocate my time. While external research funding is obviously never guaranteed, I did not anticipate the collapse of the agency that I depend on for possible grant funding.

Although my day-to-day schedule looks different these days, my work's purpose is the same. The following are my four suggestions for others facing uncertainty to consider how to pivot.

1. **Revisit your professional mission.** Ensure you stay true to your mission (or get more aligned with it). For me, that was remembering that I am a proud general internist passionate about women's health care who seeks to understand how U.S. health policies affect reproductive health wellness and equity.
2. **Assess your willingness to pivot.** I considered my willingness to do more patient care (e.g., started a new menopause clinic), seek new funding sources (foundations), ask different research questions (collaborating with new teams), and to go part-time (currently 75% FTE).
3. **Recognize facilitators that can help you with your pivot.** The focus of the 2025 ACLGIM Summit was "Unlocking your GIM Superpower,"[3] referring to the broad array of clinical, teaching, research, and administrative skills we accumulate to be invaluable in many arenas. For me, I pursued new clinical opportunities outside of traditional primary care. To make this successful, I turned my relationships with research mentees in OB-GYN and cardiology into bi-directional advising relationships that have assisted me in developing clinical expertise for a new menopause clinic.

LEADERSHIP AND HEALTHCARE ADMINISTRATION (continued from page 11)

4. **Recognize that pivoting is not leaping.** At the Summit, ACLGIM President Mitch Feldman reminded us that pivoting changes your direction, but you still have one foot firmly planted in the same place where you started. With intention and reflection, that shift may gradually move you closer to work that feels more aligned and sustainable.

While the path may look different than originally planned, intentional pivots can sustain both our professional identities and our sense of purpose.

Conclusion

Change is inevitable. As leaders in Internal Medicine, we have many superpowers and pivoting is one of them. As we reflect on the year behind us and plan for the year ahead, SGIM members can keep our feet solidly beneath us, acknowledge the emotions around us and find our path to keep pushing forward.

References

1. Advocacy and Policy. *SGIM*. https://www.sgim.org/advocacy-policy/. Accessed May 15, 2026.
2. ACP. ACP 2026 Advocacy Priorities. *ACP Online*. https://www.acponline.org/advocacy/where-we-stand/acp-2026-advocacy-priorities. Accessed May 15, 2026.
3. Pirraglia P, Chander G, Gann J. Unlocking our general internal medicine superpowers: Highlights from the 2025 ACLGIM Summit. SGIM Forum. https://www.sgim.org/article/unlocking-our-general-internal-medicine-superpowers-highlights-from-the-2025-aclgim-summit/. Published March 2026. Accessed May 15, 2026.

SGIM

SIGN OF THE TIMES

IMPROVING CLINICAL FACULTY MENTORING: BUILDING A MENTORSHIP CULTURE IN ACADEMIC GIM

Lauren P. Wallner, PhD, MPH; Charmaine B. Prichard; Jeffrey T. Kullgren, MD, MPH, MS; Eve A. Kerr, MD, MPH; Jennifer R. Lukela, MD

Dr. Wallner (lwallner@umich.edu) is an Associate Professor of Internal Medicine and Assistant Chief for Faculty Development and Mentoring. Mrs. Prichard (cprichar@umich.edu) is the Business and Program Manager. Dr. Kullgren (jkullgre@umich.edu) is an Associate Professor of Internal Medicine and Vice Chief for Research and Innovation. Dr. Kerr (ekerr@umich.edu) is the Kutsche Memorial Professor of Internal Medicine and Division Chief. Dr. Lukela (jlreilly@umich.edu) is a Clinical Associate Professor of Internal Medicine and Vice Chief of Clinical Strategy and Community Engagement. All authors are members of the Division of General Medicine, Department of Internal Medicine, University of Michigan, Ann Arbor, MI.

Introduction

Inadequate mentoring is a well-established barrier to career development and success in academic medicine. As burnout and career dissatisfaction remain significant challenges for general internists, supporting career development through mentorship is increasingly important. Structured mentoring programs support individual career satisfaction, enhance recruitment and retention, promote equity, develop future leaders, and foster collaboration amongst colleagues.[1]

However, mentoring programs in many academic general internal medicine (GIM) divisions have historically focused on supporting physician-researchers, emphasizing extramural research grants and scholarly productivity. As a result, clinician-educators, often lack sufficient mentoring and career development support.[2] Implementing structured mentoring programs for clinical faculty has been difficult due to notable barriers, including limited time amid clinical productivity demands, insufficient infrastructure, limited mentor availability, cultural and institutional barriers, sustainability challenges, and equity issues.[3]

In this article, we describe the development and implementation of mentoring initiatives within our division to support clinical faculty, with a broad goal of fostering a culture of mentorship. Like many divisions, our division at the University of Michigan lacked robust

SIGN OF THE TIMES (continued from page 12)

mentorship for clinical faculty. Over the past three years, we developed and launched structured mentoring programs for approximately 100 clinical GIM faculty. We systematically assessed the mentoring needs of individual clinicians and sought to connect them with our new mentoring programs. We then established an evaluation process to support continuous improvement.

Identifying Mentoring Needs

Part of our annual evaluation process is to assess the ongoing mentoring experiences of our clinical faculty and identify their mentoring needs. Questions include information about their current mentor network (mentors, peer mentors, and mentees) and whether they would like additional mentoring support in specific areas. Our GIM leadership team reviews this data; faculty who express interest in additional mentoring support are connected to one of the mentoring initiatives, as detailed below. In addition, early-career faculty—fewer than 5 years on faculty—are given an updated individualized mentoring plan (IMP) annually. This plan summarizes their current professional goals and mentoring support as well as areas for enhanced mentorship and further development. Tailored recommendations from division leadership for participation in mentoring initiatives, connections with mentors, and/or institutional faculty development programs are also included in the IMP.

Mentoring Initiatives

We developed the following four new mentoring initiatives specifically for clinical faculty: two geared toward early career faculty, one for mid-career faculty, and one for all clinical faculty:

- **Peer mentoring groups for new faculty:** All new faculty members are invited to join a peer mentoring group to foster connection and community and support them to launch their careers in academic medicine. Each group consists of 5-8 new faculty members based on their date of orientation. A pre-meeting survey is distributed to collect topics of interest. These topics are discussed over quarterly meetings for a year, the first of which is a division-sponsored dinner. Faculty are asked to rotate in the role of meeting facilitator. All participants are sent guidance ahead of participating in the program, including program expectations and key components of successful peer mentoring groups. Since launching 2.5 years ago, 38 new faculty have engaged in this program.
- **Mentor-matching program:** To address gaps in mentoring for early and mid-career clinical faculty members, we designed and implemented a mentor-matching program utilizing emeritus and recently retired clinical faculty as mentors. Clinical faculty members who express a desire for additional mentoring are matched to a traditional mentorship dyad based on the topic area they identified. The dyads meet twice over the course of 6-9 months, with encouragement to continue their mentee/mentor relationship beyond that if a productive relationship develops. All participants are sent guidance ahead of their first meeting, including key components of successful mentor/mentee relationships. To date, 20 early- and mid-career faculty have been matched with mentors as part of this program, and new cohorts are matched annually.
- **Boost teams for mid-career faculty:** The goals of the boost team are to help mid-career faculty identify career objectives, map an individualized trajectory to achieve these goals, expand their professional networks, and ensure equitable opportunities for advancement. Each participating faculty member is paired with a team of 4–5 mentors, at least one from GIM and others from within or outside the institution. These mentors represent diverse perspectives and mentoring roles such as sponsor, connector, and coach. Boost teams are guided by a chair who collaborates with the mentee to set agendas and track progress toward goals like leadership development, work-life integration, and skill-building during quarterly meetings over the year. To date, two mid-career clinical faculty have participated in this program.
- **Topic-focused peer mentoring groups:** Responding to clinical faculty requests to connect with colleagues around clinical topics of interest, we launched several new topic-focused peer mentoring groups in Fall 2025. For this year, the groups focused on medical education and obesity medicine. A survey was sent to all clinical faculty ascertaining interest in participating. More than a third of our faculty responded and expressed interest. Two groups of up to 10 faculty were then created for each topic area, with two volunteer facilitators with expertise in the specific topic areas assigned to each group. The groups attended a division-sponsored kick-off dinner and are scheduled to meet quarterly for one year. This initiative has specifically expanded our mentoring program reach to mid and senior level faculty, with 33 faculty across all career stages participating.

Collectively, these initiatives established structured, scalable mentoring support that spans career stages, integrates peer and traditional mentorship models, and responds to evolving faculty needs.

Participation and Evaluation

Overall, 66% of our clinical faculty—100% of early-career faculty, 40% of mid-career faculty, and 19% of senior faculty—participated in at least one mentoring

SIGN OF THE TIMES *(continued from page 13)*

program as a mentee. Notably, 39% of our early-career faculty are participating in more than one program. Lower engagement amongst senior and mid-career faculty may be due to participation in other institutional career development opportunities targeting mid- and senior-career faculty.

Electronic surveys are sent post-participation in each of our pilot programs. Participants are asked about their program participation, program acceptability, overall satisfaction with the program, barriers and facilitators to participation, and to what extent the program met their mentoring needs. Early evaluation data from two cohorts of our mentor-matching program and two new faculty peer mentoring groups (see table) not only demonstrate strong program satisfaction and high acceptability but also highlight notable barriers to participation including child care, competing demands on time, and clinic schedules.

Early Evaluation Data from Clinical Faculty Mentoring Programs	
	Mentor-Matching Program*
Eligible for survey (N)	28
Survey respondents N (response rate)	15 (54%)
Average times met mean (max 2)	2
Acceptability mean (max 5):	
Useful way to spend my time: *mentee*	4.25
Useful way to spend my time: *mentor*	4.625
Program was a positive experience: *mentor*	4.5
Overall satisfaction with program mean (max 6)	4.9
Program met mentoring needs *mentee* mean (max 5)	4.75
	New Faculty Peer Mentoring Group
Eligible for survey (N)	13
Survey respondents (N, response rate)	7 (54%)
Average times met mean (max 4)	2.5
Acceptability mean (max 5):	
Useful way to spend my time	4
Improved connection with colleagues	3.83
Made me feel more supported in my role	3.83
Overall satisfaction with program mean (max 5)	3.6
Barriers to participation (%):	
Time	28%
Clinic schedule	28%
Child Care	14%
	Mid-Career Boost Teams**
Eligible for survey N	12
Survey respondents N (response rate)	9 (79%)
Average times met mean (max 5)	4
Acceptability mean (max 5)	
Effective use of my time	4.5
Sufficient time allotted for meetings	4.8
Helped me set and achieve my career goals *mentee*	4.5
Overall satisfaction with program mean (max 5)	4.23

*Both mentors (N=14) and mentees (N=14) were surveyed; 9 mentors and 6 mentees responded
**Both mentors (N=10) and mentees (N=2) were surveyed; 7 mentors and 2 mentees responded

SIGN OF THE TIMES *(continued from page 14)*

Future Opportunities

We have primarily leveraged emeritus and recently retired faculty as mentors for our clinical track faculty due to limited time and bandwidth of senior faculty. However, a key opportunity and future focus is engaging more senior clinical track faculty in mentoring initiatives. In addition, we are expanding support geared toward mid-career faculty. This includes connecting mid- and senior-faculty with coaches and established coaching programs and developing new initiatives of interest to faculty at these career stages. We have seen strong uptake of our topic-focused peer mentoring groups amongst mid- and senior-faculty, and plan to expand these groups to additional clinical topics of interest. We also plan to scale our boost team initiative to reach more mid-career faculty members.

Conclusion

To address the diverse mentoring needs of clinical faculty in a large academic GIM division, we designed and implemented four new mentoring programs over a three-year period, with strong reach and positive faculty engagement. Future work will focus on expanding our reach to mid- and senior-career faculty, optimizing our program evaluations, and supporting scalability of the programs. We hope our programs can serve as models for SGIM members to help enhance mentorship for clinical faculty at their institutions.

References

1. Mylona E, Brubaker L, Williams VN, et al. Does formal mentoring for faculty members matter? A survey of clinical faculty members. *Med Educ*. 2016 Jun;50(6):670-81. doi:10.1111/medu.12972. PMID: 27170085.
2. Chew LD, Watanabe JM, Buchwald D, et al. Junior faculty's perspectives on mentoring. *Acad Med*. 2003 Jun;78(6):652. doi:10.1097/00001888-200306000-00022. PMID: 12805052.
3. Crites GE, Ward WL, Archuleta P, et al. A Scoping Review of health care faculty mentorship programs in academia: Implications for program design, implementation, and outcome evaluation. *J Contin Educ Health Prof*. 2023 Jan 1;43(1):42-51. doi:10.1097/CEH.0000000000000459. Epub 2022 Oct 5. PMID: 36215162.

SGIM

PERSPECTIVE

IMPROVING THE CARE OF DEAFBLIND ADULTS: INTEGRATING PATIENT AND FAMILY PERSPECTIVES

Sharon Kelmar, MD; Amy Courtney, DO; Rebekah Gardner, MD

Dr. Kelmar (skelmar@brownhealth.org) is a third-year Internal Medicine Resident at Brown University. Dr. Courtney (Amy.Courtney@mainehealth.org) is an Internal Medicine Chief Resident at Maine Medical Center. Dr. Gardner (rgardner@brownhealth.org) is a Professor of Medicine at the Warren Alpert Medical School of Brown University and practicing internist at Rhode Island Hospital.

Introduction

In this article, we highlight the experience of a patient with complete deafblindness who was hospitalized for bacteremia. We use this case and a discussion with the patient's wife and caregiver to underscore several challenges faced by deafblind adults in the hospital setting.

Case

You are an 80-year-old man with a history of Usher syndrome (a genetic condition which has left you completely deaf and blind since age 11). After suffering a fall at home, you are taken to the hospital. You sit in your hospital bed, disoriented. You have no sense of how much time has passed as you do not have your tactile watch. Without warning, a cold object is placed on your bare chest. You reach your hands up to sign, but no one reaches out in return.

After what feels like an eternity, your hands are met by someone who "speaks your language." You have a chance to ask a few questions and are introduced to the hands of three doctors, but none of them know tactile

PERSPECTIVE *(continued from page 15)*

American Sign Language (ASL). You are told you have "bacteria in your blood," but they do not yet know the source. The interpreter spells the name of the medicine they are treating you with, but it is just a jumble of letters and added confusion. These newly familiar hands then leave. These hands were your only connection to those caring for you. Your wife sits with you for a while, but then she eventually leaves as well. You wait in silence until your hands are picked up tomorrow.

Discussion

This patient's hospitalization was complicated by multiple delays in care due to inadequate communication. One discharge to a skilled nursing facility resulted in an immediate readmission after the patient and family were told interpretation services would not be regularly available. After two months in the hospital, this patient returned home. A year later, he had not returned to his prior level of cognitive or physical function. This was likely exacerbated by prolonged stretches in the hospital without adequate reorientation strategies. This case generated a review into the ways that we care for deafblind patients and how we can improve their healthcare experience.

Deafblindness is a condition defined by combined visual and hearing impairments and affects approximately 40,000 adults in the United States.[1] This number is likely much higher when including individuals with age-related dual sensory loss. Despite its prevalence, physicians have few published guidelines to treat deafblind patients equitably in hospitals or outpatient settings. Several societies, such as the American Association for the Deaf Blind and Helen Keller services, have published general guidelines for healthcare workers, but the medical literature offers little formal data to augment this guidance.[2] Guidelines for treating patients who are visually impaired often do not apply to those with dual sensory loss.[3] For example, the suggestion to introduce all team members every time you enter the room (commonly included in guidelines for the visually impaired) can be cumbersome in tactile ASL and is unnecessary for team members the patient will not interact with. This gap in management guidelines for patients with sensory loss often misses deafblind individuals and underscores the need for additional research to better care for this vulnerable population.

Caregiver Perspectives

To better understand how we could have improved the care of our patient, we interviewed his wife several months after his hospitalization. She is not deafblind herself but has worked for many years as a tactile ASL interpreter and advocate for the deafblind community. Her perspectives highlight several aspects of her husband's care that she felt could be improved:

- *"It was clear when interpreters were familiar with patients like my husband or not."*
  She described the importance of using interpreters experienced in working with deafblind patients. On multiple occasions, interpreter scheduling challenges meant the only tactile ASL interpreter available did not themselves speak English. This situation then required a separate ASL video interpreter to translate between the tactile ASL interpreter and the clinicians. This added additional opportunity for miscommunication and significantly slowed down conversations. In the hospital setting, this can make it challenging to obtain a proper history and result in delays in care.
- *"I did not always feel like I could ask questions because of how long the interpretation was taking."*
  The patient's wife felt that updates could have been tailored to her husband's experience to help decrease time spent on unnecessary updates. For example, spending 10 minutes on introductions of everyone in the room was overwhelming and distracted him from what information was most important. She also noted the importance of incorporating his intact senses into explanations. For her husband, a model of a set of teeth that he could feel would have helped him understand his planned tooth extraction much faster than discussing the plan in words using multiple interpreters.
- *"There was good communication with the big things, but small things, like the fact that he does not like orange juice and was given one every morning, had no place."*
  While interpreters were readily available for bigger updates with the medical team and procedures, her husband could not communicate with staff about smaller but still important aspects of daily care throughout the day. She and her husband did not want to waste valuable time with the interpreter to discuss these things, but they did have a large impact on the overall patient experience.
- *"How was he supposed to use a call button?"*
  She noted that usual mechanisms for expressing needs in the hospital, such as a call button, are not accessible for deafblind patients. Even if he pressed the button to call help into the room, staff often could not meet his needs without an interpreter who was not immediately available. She suggested some physical communication tools that, when available, can help to bridge this gap. These strategies have been studied as tools to improve patient orientation.[4] Options for this could include typed and printable braille devices which are commercially available and raised stickers applied to the bed control buttons to allow patients to control their position more easily.

PERSPECTIVE *(continued from page 16)*

- *"Every patient's experience will be different."* The patient's wife highlighted the importance of clinicians taking thorough histories surrounding each patient's unique visual and hearing impairments. A patient born deafblind may have a very different knowledge set than those who lost senses later in life. Histories should include thorough details about specific deficits, abilities at baseline, and what support this patient has at home. There are some published tools for obtaining detailed histories around functional abilities in deafblind adults.[5] Attempts should be made to allow the patient to continue to do as many of their normal day-to-day activities as possible to create a sense of normalcy and prevent the functional loss seen with our patient.

At the end of our conversation, the patient's wife noted that she and her husband (who was unable to join in this conversation due to ongoing confusion) hoped her perspective would improve the care of other deafblind patients in the future.

Conclusion

This case and caregiver perspectives highlight challenges faced by deafblind adults in the hospital setting. Strategies to improve the patient's experience include the following:

1. Involve care team members experienced with deafblind patients whenever possible.
2. Use physical communication tools to fill in the gaps when interpreters are not available.
3. Take thorough histories to tailor patient care to their specific impairments.

Deafblind patients benefit from advocates, whether this is a family member, as was the case for our patient, or care team members with specific experience with the deafblind community. We hope this case provides SGIM members with tools to better treat and advocate for their deafblind patients.

References

1. National Center on Deaf-Blindness. The 2019 National Deaf-Blind Child Count Report. *NCDB*. https://www.nationaldb.org/media/doc/2019_National_Deaf-Blind_Child_Count_Report_FINAL_a.pdf. Published December 2020. Accessed May 15, 2026.
2. Brooks P. Deafblindness and health advocacy. *Amer Nurse J*. https://www.myamericannurse.com/deaf-blindness-and-health-advocacy/. Published September 8, 2023. Accessed May 15, 2026.
3. Hamadah K, Velagapudi M, Navarro JJ, et al. Best practices for treating blind and visually impaired patients in the emergency department: A Scoping Review. *West J Emerg Med*. 2024 May;25(3):350-357. doi:10.5811/westjem.61686.
4. Warnicke C, Wahlqvist M, Anderzén-Carlsson A, et al. Interventions for adults with deafblindness - An integrative review. *BMC Health Serv Res*. 2022 Dec 30;22(1):1594. doi:10.1186/s12913-022-08958-4.
5. Guthrie DM, Pitman R, Stolee P, et al. Reliability of standardized assessment for adults who are deafblind. *J Rehabil Res Dev*. 2011;48(5):545-54. doi:10.1682/jrrd.2010.09.0175.

SGIM

TEACHING IDD AND NEURODIVERSITY: IMPLEMENTATION STRATEGY AND LESSONS LEARNED

Emily Nations Bufkin, MD; Olivia Fox; Ashley Smith, MD; Debra Caudy, MD; Kylie Cullinan, MD

Dr. Bufkin (emily.bufkin@utsouthwestern.edu) is an Assistant Professor of Internal Medicine and Pediatrics at the University of Texas (UT), Southwestern Medical Center. Ms. Fox (livyrfox@gmail.com) is a premedical student at the UT at Austin and the proud sister of Leonard Fox. Dr. Smith (ashley.smith2@utsouthwestern.edu) is a first-year resident in the Pediatrics residency program at UT Southwestern Medical Center. Dr. Caudy (debra@29acres.org) is the Executive Director for 29 Acres. Dr. Cullinan (kylie.cullinan@utsouthwestern.edu) is an Assistant Professor of Internal Medicine and Pediatrics at the UT Southwestern Medical Center.

Clinical Vignette

An adult with intellectual and developmental disability (IDD) was admitted to the ICU with multiple ulcers and small intestinal perforations. In the ICU, he had complications including sepsis and gastrointestinal bleeding. As he recovered and nutrition became an issue, an ICU team member told his parents, "A G tube wouldn't really make a difference for him," (given his IDD). At that moment, it became clear that the biggest threat to his health was a condition the ICU did not need to fix at all: his IDD.

"People with disabilities must be included in the development of disability-focused medical education so that curricula are grounded in lived experience."

Introduction

With training and education, internists are equipped to treat complex patients. Yet, when a patient's chart includes IDD, there is little formal education or clinical guidelines to direct care—leaving space for assumptions and unconscious ableism to shape care plans. This patient was Olivia's brother, Leonard. Many clinicians equated Leonard's IDD with complete dependence and assumed he couldn't speak or walk independently, thus shaping their medical decision-making. When the doctor discussed feeding tube placement, he minimized its significance because Leonard "already lived with disabilities." Sharing meals with friends and family is one of Leonard's greatest joys. With better training and exposure to the spectrum of IDD, Leonard could have received more individualized, compassionate care. In this article, we describe the development and implementation of a mandatory undergraduate medical education (UME) curriculum in IDD and neurodiversity to educate future physicians in providing person-centered care for these patients.

Leonard's experience is not an isolated incident. Nationally, disability-focused training is limited: only 34.6% of internal medicine and family medicine residents report any disability-specific instruction in medical school and just 11.2% report such training during residency.[1] In one survey of practicing physicians, only 40% report confidence in providing equal-quality care to people with disabilities and only 55% would welcome patients with disabilities into their practice.[2]

The National Institutes of Health has designated people with disabilities as a population experiencing significant health disparities, and a systematic review of adult IDD wellness visits and screening identified limited clinician training as the most common barrier.[3] We developed a required Undergraduate Medical Education (UME) IDD curriculum to address this gap. We share our first-year lessons and a practical roadmap for educators piloting similar efforts.

Evaluation

Over the first 12 months of academic year 2024–25, the standard ambulatory clerkship evaluation showed that 98.9% of 188 learners responded *"Agree/Strongly Agree"* that the session met learning needs and provided information they could use to improve patient care.

Representative feedback from the survey included the following:

- *"I gained several key techniques that I have already used in the clinic."*
- *"Thanks for including someone from the IDD community to come and speak about their perspectives."*
- *"[I] Believe this presentation filled a gap in our medical education—I have found myself on clerkships taking care of patients with IDD and/or who are neurodiverse. I found this presentation really helpful in learning how best to take care of these patients!"*

MEDICAL EDUCATION: ARTICLE II *(continued from page 18)*

These results support high learner-perceived value and impact during the first year of curricular implementation.

Four Steps to Develop a Disability Curriculum

Drawing on the data from our first year implementing a UME curriculum in IDD and neurodiversity, we present the following four steps to guide educators in developing similar efforts:

1. **Partner Meaningfully with Your Community:** A central principle of the disability rights movement is "Nothing About Us Without Us." People with disabilities must be included in the development of disability-focused medical education so that curricula are grounded in lived experience. Identify community organizations that support people with disabilities and invite them to serve as co-designers of the curriculum. We partnered with the Down Syndrome Guild of Dallas, Special Olympics Texas, and 29 Acres, an inclusive living community supporting autistic adults' independence and employment.
2. **Assess the Baseline Using a Three-Prong Approach:** Before building new content, begin with a baseline assessment across three domains: community, curriculum, and clinical environment.
   - **Community:** Assess community priorities to ensure the curriculum reflects lived experiences and real-world needs. After establishing community partnerships, we recruited self-advocates (individuals with IDD and/or neurodiversity) and support people (family members or caregivers) for a needs assessment using a brief survey and focus groups. Thematic analysis directly informed learning objectives and highlighted practical barriers and helpful clinical accommodation.
   - **Curriculum:** To fill gaps without duplicating existing content, define the current state of your UME curriculum related to IDD and neurodiversity. Our review identified two preclinical didactics and potential learning opportunities in Pediatrics and Psychiatry clerkships that provided some exposure to IDD. However, the content was pediatric focused, with minimal attention to adult IDD/neurodiversity care. There was limited emphasis on practical skills such as disability etiquette, communication accommodations, and sensory-friendly examination techniques.
   - **Clinical Environment:** Map your clinical ecosystem to identify stakeholders already providing care to patients with IDD and neurodiversity and recruit clinical champions who can support teaching and experiential learning. Our baseline assessment identified partners across Internal Medicine, Pediatrics, Psychiatry, Physical Medicine and Rehabilitation, and Neurology. These multi-specialty relationships expanded the range of clinical perspectives represented in the curriculum.

Together, these steps defined the needs, the resources, and the partners foundational to our curricular implementation.

3. **Identify Support and Synergy:** Avoid reinventing the wheel. Participating in professional societies, such as the American Academy of Developmental Medicine & Dentistry (AADMD), and engaging with the SGIM interest group Adults with Complex Conditions Originating in Childhood can connect educators with peers building similar curricula. We identified a regional partner through Project ECHO and collaborated with the University of Houston–Clear Lake Autism Center's Behavioral Analysis for Informed Physical Exams. Leverage local talent by recruiting medical students and trainees with an interest in disability health as implementation partners. They can help coordinate community outreach, support evaluation efforts, and provide a learner perspective in curriculum design. When available, modest funding can support implementation by covering core resources. As a NICHE-MED Medical School Partner,[4] we received financial and administrative support, as well as access to standardized assessment tools to measure learner attitudes, knowledge, and skills related to IDD care.
4. **Build a Multimodal Skills-Based Curriculum:** The next task is to embed the curriculum where learners already are. Because people with IDD and neurodiversity receive care across many specialties, identify existing curricular "real estate" where all learners participate—ideally within a required clinical rotation. Our multimodal curriculum is embedded in the ambulatory clerkship, a rotation all medical students complete at our institution.

   Our curriculum includes a two-hour, case-anchored, interactive workshop that integrates community voice and skills practice. The session includes communication accommodation, sensory-friendly care, and an inclusive physical exam framework. A self-advocate and support person share their stories, including positive and negative health care experiences, and what they wish every clinician understood about IDD and/or neurodiversity.

   Learners then complete the required four-hour clinical application experience in a clinic that cares for people with IDD and/or neurodiversity to apply these

MEDICAL EDUCATION: ARTICLE II *(continued from page 19)*

skills in real patient care. We also offer an optional community engagement component to reinforce strengths-based, person-centered perspectives on disability.

These four steps provide a practical approach to implementing an IDD and neurodiversity curriculum. Together, these steps keep the work grounded in lived experience while making it feasible to reach all learners beyond elective experiences.

Conclusion

Embedding a required, skills-based IDD and neurodiversity curriculum within a mandatory clerkship was feasible and highly valued over the first year. In their written feedback, learners consistently described the workshop as practical, responsive to a gap in the curriculum, and strengthened by the inclusion of lived-experience voices. For SGIM members starting similar work, we recommend anchoring in a required curricular space, co-designing with self-advocates, and pairing workshop teaching with required clinical application. This approach shifts bedside decisions from ableist assumptions to person-centered care—care that Leonard and others with IDD and/or neurodiversity deserve.

References

1. Stillman MD, Ankam N, Mallow M, et al. A survey of internal and family medicine residents: Assessment of disability-specific education and knowledge. *Disabil Health J*.2021;14(2):101011. doi:10.1016/j.dhjo.2020.101011. Epub 2020 Oct 7.
2. Lagu T, Haywood C, Reimold K, et al. "I am not the doctor for you": Physicians' attitudes about caring for people with disabilities. *Health Aff (Millwood)*. 2022;41(10):1387-1395. doi:10.1377/hlthaff.2022.00475.
3. Sonderlund AL, Baygi F, Soendergaard J, et al. Advancing health equity for populations with intellectual disabilities: A systematic review of facilitators and barriers to the implementation of health checks and screening. *SSM Health Syst*. 2024;2:100009. doi:10.1016/j.ssmhs.2024.100009.
4. IDD Curriculum Initiative. *NICHE-MED*. https://www.nichecurriculum.org/niche-med. Accessed May 15, 2026.

SGIM

BEST PRACTICES

STATIN INITIATION IN HIV-POSITIVE PATIENTS: UTILITY OF THE REPRIEVE TRIAL

Aprotim C. Bhowmik, MD, MPH, EdM

Dr. Bhowmik (aprotim.bhowmik@yale.edu) is a first-year internal medicine resident physician at Yale New Haven Health.

As a resident physician in Yale's HIV training track, I care for and learn from people living with HIV (PLWH). Most of my continuity clinic patients seen at the Yale Center for Infectious Diseases (YCID) include PLWH. Because these patients present for HIV-related care as well as primary care, our role is a hybrid between that of an infectious disease specialist and a primary care physician. These visits focus on comprehensive issues of clinical and social factors that influence the quality of life of our patients. Typical visits consist of discussions regarding antiretroviral therapy (ART), sexual health, vaccinations, blood pressure control, diabetes management, and others. One topic that warrants special attention in PLWH is statin initiation for atherosclerotic cardiovascular disease (ASCVD) prevention. In this article, I highlight the risk of ASCVD in PLWH, the role of statins in reducing ASCVD risk, and the shared decision-making that should govern the recommendation of statins to PLWH.

ASCVD Risk in People Living with HIV (PLWH)

Well-known risk factors for ASCVD include hypertension, diabetes, and high levels of low-density lipoproteins (LDLs). Less recognized (and less emphasized) is the role that chronic inflammation plays in the development of ASCVD. HIV is a pathogen that increases inflammatory

BEST PRACTICES *(continued from page 20)*

markers and thereby increases the likelihood of cardiovascular plaque buildup. This plaque formation occurs even in PLWH who are virally suppressed on ART. PLWH have been shown to have approximately *double* the risk of ASCVD relative to people without HIV.[1] This difference is even greater in women relative to men.[1] With the increased risk of ASCVD in PLWH, the incidence of acute myocardial infarction (AMI) was found to be higher in patients with HIV, even when controlling for age, gender, hypertension, diabetes, and hyperlipidemia.[2]

Because of the increased ASCVD risk in PLWH, the use of statins is especially important in decreasing hyperlipidemia. A landmark study used as evidence for/against statin initiation in PLWH was published in 2023—the Randomized Trial to Prevent Vascular Events in HIV (REPRIEVE trial).[2]

Findings from the REPRIEVE Trial

ASCVD risk can be calculated based on the American College of Cardiology Pooled Cohort Equation risk calculator, which includes risk factors such as age, hypertension, and diabetes—but *not* HIV. Based on this calculation, a patient's risk can be categorized as low, moderate, or high. Initiating a statin in patients with *high* ASCVD risk is well-studied in those without HIV. In patients with *low to moderate* ASCVD risk, does the concomitant presence of HIV warrant statin use?

> **"PLWH have been shown to have approximately double the risk of ASCVD relative to people without HIV."**

To study the potential benefit of a statin in this low to moderate risk population, the REPRIEVE trial enrolled more than 7,000 people with a diagnosis of HIV, 40 to 75 years old, without reported statin use in the past 90 days. All participants received ART and counseling on lifestyle modifications. Participants were randomized to receive either pitavastatin 4mg each day or placebo, with a primary outcome measure of major adverse cardiovascular events (MACE). Most enrolled patients had an undetectable HIV viral load.

The primary outcome of MACE was lower in those taking pitavastatin relative to those taking placebo. The joint outcome of MACE or death was also less in those taking pitavastatin. Given that the direct target of pitavastatin therapy is LDL cholesterol, LDL levels decreased more in those taking pitavastatin relative to those taking placebo, as expected. These outcomes were all statistically significant.

Limitations and Need for Shared Decision-Making

The REPRIEVE trial used pitavastatin (a less commonly used medication for hyperlipidemia) in the treatment arm, because of its favorable side effect profile and low interaction profile with ART regimens. The efficacy of other statins, though likely to be similar given their common mechanisms, was not studied in this trial. Moreover, given the low-level viremia in study participants, this trial does not adequately capture the efficacy of statins in those with a higher viral load, though efficacy could be hypothesized to be equal/greater given the increased inflammation caused by a higher HIV burden. Patients with a high viral load with low adherence to ART may struggle with adherence to a statin, thus making it less clear whether all PLWH would benefit from statins.

Another limitation of this study is the use of LDL as a target for therapy. New research indicates the importance of measuring apolipoprotein B and/or Lp(a) in deciding to prescribe therapy for hyperlipidemia,[3] and these measures were not adequately explored in this trial. However, the primary outcome of MACE—the downstream effect of these multiple proteins—was still found to be improved with pitavastatin. In fact, studies like the REPRIEVE trial have resulted in the Infectious Disease Society of America (IDSA) recommending statins in *all* patients with HIV who are older than 40.[4]

Statins are commonly prescribed in patients with and without HIV for ASCVD risk modification. However, statins are not benign medications and can add to pill burden, especially in those already on ART and other medications. Although the REPRIEVE trial demonstrates that statin initiation would be beneficial in reducing MACE in patients with low to moderate ASCVD risk, the decision to start a statin should be negotiated with the patient. How does the patient feel about an additional pill each day? Does an ASCVD risk of 5% or 10% warrant a statin to the patient? Does the reduction in MACE over the 5-year follow-up period of the REPRIEVE trial convince the patient that this change in their daily regimen will be worth pursuing?

Just as any decision in medicine should be shared,[5] statin initiation in PLWH should include a conversation with the patient—understanding their concerns, communicating their risk, and centering on the patient's feelings and wishes.

Takeaways

As SGIM members, our patients come from diverse backgrounds with varying medical comorbidities. To adequately care for them, physicians must use appropriate evidence to substantiate recommended therapies. In PLWH with low to moderate ASCVD risk, SGIM members must acknowledge the increased risk of ASCVD at baseline,

BEST PRACTICES *(continued from page 21)*

even when patients are undetectable with ART. The initiation of a statin can be beneficial in reducing the incidence of MACE in these patients. Communicating to our HIV-positive patients about their cardiovascular risk and the potential benefits from starting a statin could be lifesaving.

References

1. Grinspoon SK, Fitch K, Zanni M, et al. Pitavastatin to prevent cardiovascular disease in HIV infection. *N Engl J Med*. 2023 Aug 24;389(8):687-699. doi:10.1056/NEJMoa2304146. Epub 2023 Jul 23.
2. Triant VA, Lee H, Hadigan C, et al. Increased acute myocardial infarction rates and cardiovascular risk factors among patients with human immunodeficiency virus disease. *J Clin Endocrinol Metab*. 2007 Jul;92(7):2506-12. doi:10.1210/jc.2006-2190. Epub 2007 Apr 24.
3. Alpert JS, Stone NJ. The importance of Apo B and Lipoprotein little a [Lp(a)]. *Am J Med*. 2024 Dec;137(12):1149-1150. doi:10.1016/j.amjmed.2024.02.025. Epub 2024 Feb 25.
4. Horberg M, Thompson M, Agwu A, et al. Primary care guidance for providers who care for persons with Human Immunodeficiency Virus: 2024 update by the HIV Medicine Association of the Infectious Diseases Society of America. *Clin Infect Dis*. 2024 Oct 12:ciae479. doi:10.1093/cid/ciae479. Online ahead of print. 2024; ciae479.
5. Montori VM, Ruissen MM, Hargraves IG, et al. Shared decision-making as a method of care. *BMJ Evid Based Med*. 2023 Aug;28(4):213-217. doi:10.1136/bmjebm-2022-112068. Epub 2022 Dec 2.

SGIM

IMPROVING CARE

RETHINKING PRIMARY CARE: ADVANCING HOLISTIC CARE THROUGH A DIABETES-FOCUSED CLINIC

Dheepa Sekar, MD; Anna Kho, MD

Dr. Sekar (dheepa.sekar@emory.edu) is an Assistant Professor of Medicine at Emory School of Medicine.
Dr. Kho (apham@emory.edu) is an Associate Professor of Medicine at Emory School of Medicine.

Introduction

Primary care physicians (PCPs) strive to provide prompt, comprehensive care to patients with diverse and often complex medical needs.[1] Time constraints in clinic can make delivering this level of care challenging, particularly when additional barriers, such as limited health literacy, language differences, or financial barriers to medication access, are present. Managing patients with multiple chronic conditions within these constraints can feel overwhelming, and achieving optimal disease control can seem out of reach. While holistic care remains the ideal, the pressure to address every medical condition and related care barrier during a single visit often creates gaps in patient education and preventative care.[2]

In this perspective, we explore the benefits of a physician-run, type 2 diabetes-focused clinic serving an urban, predominantly underserved patient population. We apply a model of comprehensive primary care (preventative care, disease education, disease management, and social determinants of health [SDOH]) to a single-condition visit (see figure).[1] We explore important benefits to the patient, the physician, and the system. This alternative primary care model creates the time and structure needed to focus holistically on the patient, addressing not only disease management but also education, preventative care, and management of comorbid conditions through dedicated, single-issue visits.

Benefits to the Patient

Restructuring the clinic visit around a single condition, such as diabetes, offers substantial benefits to patients by enabling more comprehensive, education-centered care.

IMPROVING CARE *(continued from page 22)*

This construct allows PCPs to address these barriers more effectively to treatment:

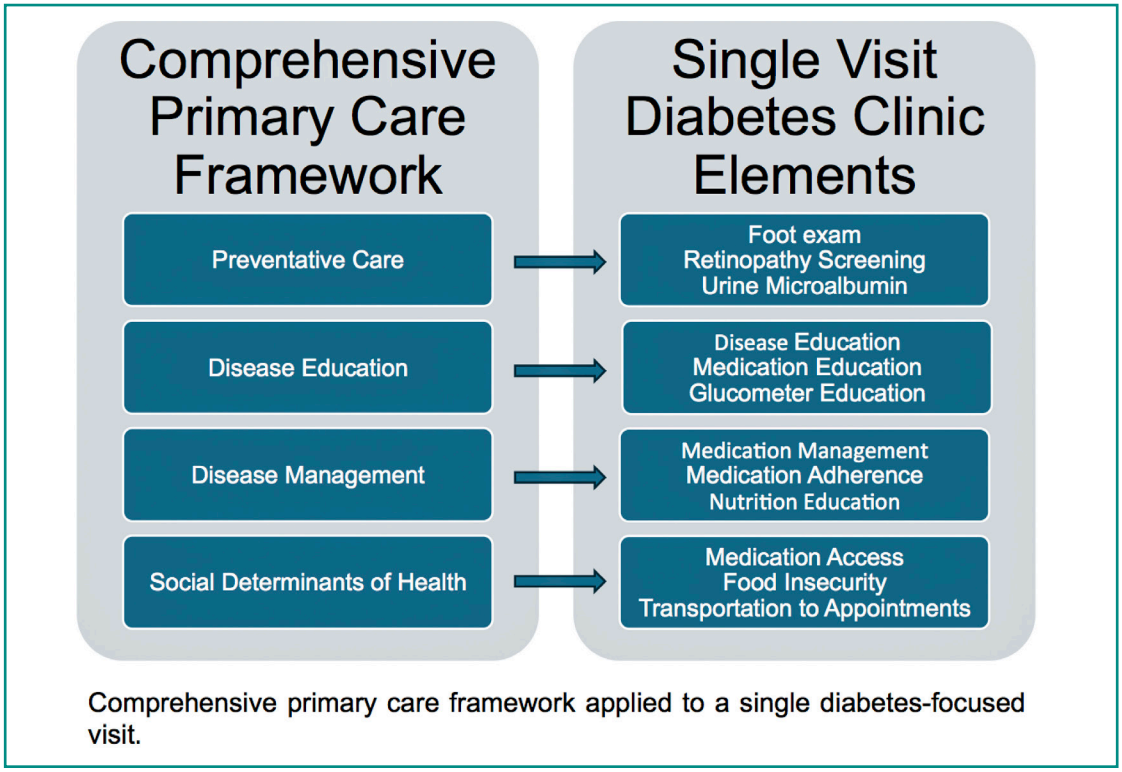
- **Education:** In a diabetes-focused visit, patients have the time to learn about their condition in meaningful depth—including how to administer medications, the role of lifestyle and dietary habits, how to properly use a glucometer or continuous glucose monitor (CGM), when to check their blood glucose, and what glycemic level to target.
- **Screening:** Diabetes-related screenings such as diabetic foot exams, retina screening, and screening for comorbid conditions, including nephropathy, hypertension, and metabolic-associated liver disease, can be more reliably addressed. While these are often the same tasks attempted in a full-primary care visit, providing a focused visit framework allows in depth coverage of the topic, especially related to preventative and comorbid screenings.
- **Social Factors:** Beyond clinical management, the PCP can explore social factors that affect a patient's diabetes control, such as food and housing insecurity, limited income, and lack of insurance.[3] For example, identifying consistent and healthy food resources can help improve diabetes management. Helping a patient navigate medication storage in the setting of housing insecurity can help improve medication adherence. Exploring financial barriers to medications can help triage which medications to use or explore more affordable formulary options.

By concentrating on diabetes and its related conditions, the PCP is better positioned to work with patients to dismantle the barriers standing between patients and better health—improving both disease control and patient understanding.

Benefits to the Physician

In today's clinical environment, hospital or clinic administrators closely track productivity, and visits are routinely compressed into 15–30 minutes. With these changes, it has become increasingly difficult to meaningfully address a complex condition like uncontrolled diabetes. A single problem-focused visit offers a more practical and sustainable approach. For the PCP, these potential benefits are significant:

- Improved efficiency and focus.
- Adequate time to address diabetes-related quality metrics, such as diabetic retinopathy screening, foot exams, and urine microalbumin testing.
- Improved appointment show rates, driven by a stronger established physician-patient relationship.
- Greater professional fulfillment from making tangible, measurable progress in a patient's diabetes management.



Comprehensive primary care framework applied to a single diabetes-focused visit.

IMPROVING CARE (continued from page 23)

Together, these benefits illustrate how refocusing the visit around one condition can simultaneously improve physician performance metrics and patient experience.

Benefits to the System

Dedicating a visit exclusively for type 2 diabetes care creates opportunities to close system-level gaps more efficiently.[4] In practice, this approach has allowed us to:

- Address deficiencies in diabetes foot exams, retinopathy screening, A1c monitoring, and SDOH screening at a population level on a consistent basis, improving clinic quality metrics.
- Refer patients to specialists earlier by systematically checking for diabetes-related complications during these focused visits, before conditions like diabetic foot ulcers or retinopathy progress, avoiding expensive hospitalizations or procedures, reducing significant downstream costs—particularly within a capitated payment model.
- Identify high-risk patients most likely to benefit from a single-condition visit utilizing population health data that further supports this model.
- Connect patients with limited income or inadequate insurance to social services, pharmacy resources, and community programs—helping them access medications through patient assistance programs, institutional discounts, government insurance enrollment, or local community resources.

While advanced practice providers play a significant role in focused subspecialty care, a physician-run clinic can provide care for patients that addresses comorbid diseases. Physicians can simultaneously address conditions such as chronic kidney disease, hypertension, and metabolic-associated liver disease that overlap with diabetes during this diabetes focused visit.[5] This comprehensive approach enables the physician to treat multiple conditions simultaneously if needed as well as recognize when a patient's overall clinical picture requires escalation of care, such as subspecialty referral. In a low-resource environment, a physician-run focused clinic is a practical solution to improving diabetes outcomes, where limitations exist for access to multi-disciplinary teams and services. Ultimately, better diabetes control and more consistent preventative screening can translate to fewer complications and hospitalizations, thus reducing downstream strain on the healthcare system.

Conclusion

Diabetes is frequently managed alongside a host of other conditions during a standard primary care visit. Hurried attention is allocated to diabetes as PCPs juggle competing priorities. A dedicated diabetes-focused visit within the primary care setting gives PCPs the space to focus on diabetes management, adjust medications thoughtfully, assess the full range of factors influencing a patient's care, and often still manage overlapping comorbid conditions. This dedicated approach strengthens the doctor-patient alliance around a single, shared goal, while appropriately reserving the most medically complex cases—severely uncontrolled type 2 diabetes or type 1 diabetes—for endocrinologists and multidisciplinary clinics. For a subset of patients, shifting the PCP's mindset toward single-disease visits might be the structural transformation needed to improve diabetes outcomes in complex, under-resourced primary care settings. Future directions include leveraging population health tools for internal referrals and expanding the disease-focused visit model to address other high-priority conditions within the local patient population.

References

1. Bodenheimer T, Ghorob A, Willard-Grace R, et al. The 10 building blocks of high-performing primary care. *Ann Fam Med*. Mar-Apr 2014;12(2):166-71. doi:10.1370/afm.1616.
2. Barnes CS, Ziemer DC, Miller CD, et al. Little time for diabetes management in the primary care setting. *Diabetes Educ*. Jan-Feb 2004;30(1):126-35. doi:10.1177/014572170403000120.
3. Rudisill AC, Eicken MGA, Gupta D, et al. Patient and care team perspectives on social determinants of health screening in primary care: A qualitative study. *JAMA Netw Open*. Nov 1 2023;6(11):e2345444. doi:10.1001/jamanetworkopen.2023.45444.
4. Peterson KA, Carlin C, Solberg LI, et al. Redesigning primary care to improve diabetes outcomes (the UNITED Study). *Diabetes Care*. Mar 2020;43(3):549-555. doi:10.2337/dc19-1140.
5. Virani SS, Akeroyd JM, Ramsey DJ, et al. Comparative effectiveness of outpatient cardiovascular disease and diabetes care delivery between advanced practice providers and physician providers in primary care: Implications for care under the Affordable Care Act. *Am Heart J*. 2016 Nov:181:74-82. doi:10.1016/j.ahj.2016.07.020. Epub 2016 Aug 28.

SGIM