



SGIM FORUM

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LEADERSHIP AND HEALTHCARE ADMINISTRATION

GROUNDING IN PURPOSE, FLOURISHING IN LEADERSHIP: REFLECTIONS ON THE 2026 ACLGIM LEON HESS MANAGEMENT TRAINING AND LEADERSHIP INSTITUTE

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Introduction

“What does it mean to lead well in medicine today?”

This question anchored the 2026 ACLGIM Leon Hess Management Training and Leadership Institute, held May 6, 2026, as a lead-in to the 2026 SGIM Annual Meeting. Under the theme “Grounding in Purpose and Care, Flourishing in Leadership,” the Institute convened division chiefs, hospital medicine directors, associate chiefs, section heads, and other leaders from general internal medicine and hospital medicine for a day of substantive dialogue, prac-

tical tools, and genuine community. In an era marked by institutional flux, mounting clinician burnout, and shifting healthcare economics, the Institute offered something increasingly rare: dedicated time and space to reflect on the foundations of effective, person-centered leadership.

This article summarizes the day’s programming and reflects on its core contributions to leadership development in academic general internal medicine. Our aim is to share insights that may benefit leaders who were unable to attend and to situate the Institute’s themes within the broader conversation about physician flourishing and organizational culture.



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Caring as a Leadership Imperative

The morning opened with a keynote from Joshua D. Hartzell, MD, MS-HPEd, FACP, FIDSA, a retired Army Colonel and certified executive coach whose career spanned battlefield medicine, graduate medical education, and leadership scholarship. Drawing on decades of experience—including a deployment to Afghanistan with the 82nd Airborne Division—and his book, *A Prescription for Caring in Healthcare Leadership: Building a Culture of Compassion and Excellence*, Dr. Hartzell challenged participants to examine how caring functions not as a soft skill in leadership but as a core tenet.¹ He argued that leaders who tend to their own well-being and model vulnerability create the psychological safety that allows teams to perform at their highest level. His session blended research on leadership effectiveness with candid stories from his career, affirming that optimizing personal well-being is not a luxury—it is a prerequisite for sustained, ethical leadership. Finally, attendees spent a few minutes addressing one of Dr. Hartzell's other keys to creating a high-performing culture, gratitude, by writing out thank you notes for team members.

Navigating Change and Challenge toward Flourishing

Kimara Ellefson, MBA, EdD, National Director of Strategy and Partnerships for the Kern National Network for Flourishing in Health, offered the Institute's conceptual centerpiece, flourishing in leadership, and built on many of the ideas offered in Dr. Hartzell's presentation. Grounded in relational theory and systems-level thinking, her session invited leaders to move beyond individual resilience—the implicit expectation that leaders simply “bounce back” from adversity—toward something more generative: ecosystem-wide flourishing.² According to the mathematician Dr. Francis Su, flourishing is defined as “a wholeness of being and doing, of realizing one's potential and helping others do the same.”³ Ms. Ellefson used personal vignettes to illustrate bringing one's whole self to a leadership journey and the importance of being rooted in core values. She opened personally and purposefully, sharing pictures of her life and what defined her. She described her work with healthcare institutions across the country to identify structural opportunities for reshaping organizational culture. She shared concrete tools and frameworks as tangible take-aways, grounding abstract concepts into daily practice. But perhaps her most pressing message was one of urgency: we cannot wait for a perfect environment to begin. Starting small, acting now, and trusting that momentum builds—this is how organizational culture shifts.

The Fiscal Frontier: Pragmatic Leadership in Academic Medicine

Sunil Sahai, MD, Professor of Medicine at UT MD Anderson and a former Division Chief of General

Medicine at UTMB Galveston, closed the morning with a session digging into the financial and operational realities that confront GIM leaders. His session, “The Fiscal Frontier: Reflections of a Past Division Chief in Academic Medicine,” offered candid lessons from years leading a clinical division through periods of resource constraint, organizational restructuring, and competing institutional priorities. Dr. Sahai's board certification in Medical Quality and graduate training in Health Care Management from Rice University enriched a session that was as useful as it was honest. He modeled the value of transparency around finances and operations—arguing that leaders who demystify the “fiscal black box” for their teams build trust and enable effective shared decision-making.

Breakout Sessions: Applied Skills for the Modern GIM Leader

The afternoon breakout sessions translated the day's themes into actionable items. Kara Alcegueire, MD (Johns Hopkins Bayview) and Chavon Onumah, MD, MPH, MED (George Washington University) co-led a workshop on community-anchored, trauma-informed strategies for medicine leaders. Their session provided tools for understanding how historical and systemic trauma affects teams and patients alike—and how leaders can respond with structural, not merely symptomatic, interventions.

Jeannine Z. Engel, MD, MACP, Associate Chair for Quality and Patient Safety at the University of Virginia School of Medicine, led a session on care management in academic GIM, covering strategy, infrastructure, and sustainable reimbursement. As healthcare systems increasingly recognize care management as central to value-based delivery, this session equipped leaders with practical frameworks for building programs that are both clinically effective and financially viable.

Eric Gascho, Vice President at CRD Associates, facilitated “Advocacy 101: Making Your Voice Count,” a session that met participants where many feel least prepared: the intersection of medicine and policy. Mr. Gascho offered a practical introduction to the mechanisms of health policy advocacy—how to identify leverage points, build relationships with policymakers, and translate clinical expertise into policy influence. The session affirmed that advocacy is itself a leadership competency, not a peripheral activity.

Conclusion

The 2026 Hess Institute affirmed a central premise: that leadership in academic general internal medicine is both a technical and a deeply human endeavor. The day's sessions collectively argued that leaders who are grounded in purpose, attentive to the cultures they inhabit, and honest



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about the structural realities of their roles are better positioned to help their teams—and themselves—flourish.

The Institute contributes to the literature on physician leadership development by modeling an integrative approach: one that holds well-being, fiscal stewardship, health equity, and advocacy, not as competing priorities, but as mutually reinforcing dimensions of effective leadership. As the field continues to grapple with burnout, workforce shortages, and institutional transformation, convenings like the Hess Institute offer a vital counterweight—a reminder that leadership is not only about managing complexity but also about cultivating meaning.

We are grateful to the speakers, participants, ACLGIM leadership, and SGIM staff whose commitment made this year's Institute possible. We hope these reflec-

tions serve as an invitation—to those who attended and those who did not—to continue this conversation about what it means to lead with clarity, compassion, and trust.

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FROM THE EDITOR

PLAYING THE LONG GAME: HELPING TRAINEES SEE THE JOYS OF A CAREER IN GENERAL INTERNAL MEDICINE

Megan McNamara, MD, MS

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In 2017, Atul Gawande, in his article “The Heroism of Incremental Care,” described his thought process in selecting surgery as his career path:

“Fields like primary-care medicine seemed, by comparison, squishy and uncertain. How often could you really achieve victories by inveigling patients to take their medicines when less than half really do; to lose weight when only a small fraction can keep it off; to quit smoking; to deal with their alcohol problem; to show up for their annual physical, which doesn’t seem to make that much difference anyway? I wanted to know I was doing work that would matter. I decided to go into surgery.”¹

Despite this impression, Dr. Gawande eventually set out to understand why patients with primary care physicians experienced better healthcare outcomes than those who did not. After observing dozens of internists taking

care of a myriad number of issues, he concluded that the physician-patient relationship formed the cornerstone of good medical care, especially in the setting of chronic disease management. He noted that few medical conditions get better after just one visit; clinical improvement often depends on making small changes in treatment over time.¹

I suspect that most internists think this is a fairly obvious conclusion. Many of us chose internal medicine as a career because we enjoy talking to patients, getting to know their families, and developing trusting relationships. The incremental care that we provide is a natural outcome of the essential principles that guide excellent primary care: first contact, comprehensiveness, coordination, and continuity (the 4 Cs).² As a clinician-educator, I try to demonstrate the joy that I feel in being the “point person,” and hearing a patient say “Doc, I trust you.”

Recently, a graduate from our internal medicine program joined our primary care practice. He was one



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of just a few residents who chose general internal medicine as a career, and the only one in his residency track who chose primary care. When I met him three years ago, he wanted to specialize in pulmonary/critical care and anticipated applying to fellowship. However, after spending three years with the physician preceptors in our VA clinic, he switched gears and instead decided to pursue primary care. I like to think that my colleagues and I here at the VA deserve at least part of the credit for this: we love our jobs, care deeply for our patients, and are intellectually stimulated by the medical illnesses that make up our “bread and butter.” I am excited to watch him become the “go to” person for his patients when they are sick, scared, and feeling vulnerable. Stepping into that role is both humbling and rewarding.

Like many of you, I would like to see more of our graduates pursue general internal medicine as a career. I have always thought that being a good role-model, and showing the joy I experience in my career, would be enough to spark a resident’s interest in this field.

However, I am now realizing that I need to be more intentional in achieving this goal. I need to articulate the satisfaction I feel when I help someone quit smoking, lose weight, or manage their blood pressure. I need to tell residents how worthwhile it is to help someone live a healthy life. I need to show trainees how internal medicine is all about playing the long game, and how fulfilling it is to be with your patient every step of the way.

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SGIM

PRESIDENT’S COLUMN

RUNNING TOWARD THE FIRE: THE SOUL OF GENERAL INTERNAL MEDICINE

Mark D. Schwartz, MD
President, SGIM

“Is there a doctor here?!”

“Patients rarely remember our titles, publications, or committee assignments. They remember who showed up. They remember who stayed.”



The voice came from the hallway outside the theater. Adina Kalet and I looked at each other and stood up almost at the same time.

We were at the Nitehawk Theater in Park Slope on a date night, watching *Project Hail Mary* (the book was much better than the film). But suddenly, the movie no longer mattered. A middle-aged man crouched at the top of a steep staircase in the hallway looking pale, frightened, and unsteady. He had just had coronary stents placed at NYU the day before. Now he felt weak, light-headed, and his heart was racing.

Adina walked with him slowly to the lobby while theater staff called 911. She stayed with him, gathered the story, kept her finger on his pulse, assessed what was happening, and helped keep him and his wife calm while everyone waited.

When EMS arrived, she convinced them to bring him back to NYU, where he had just received his care, even though it was not the closest emergency room. She knew that where he went mattered as much as how quickly he got there. Returning him to the team that had cared for him only the day before would avoid a fragmented hand-off and give his physicians immediate access to his story. In moments like this, continuity matters.



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The next day Adina got a handwritten note from the patient thanking her for staying with him and his wife and for being kind during this frightening episode. After reading it, she said something that has stayed with me. *"Of all the awards I have received, this may be the one I am most proud of."* Not the plaques. Not the professorships. Not the invited lectures. A "thank you" card from a stranger she helped.

Like firefighters and emergency workers, general internists run toward the fire because someone must step forward when the situation is uncertain and a patient needs help. And unlike firefighters, our work often begins after the immediate danger has passed.

We live in a time when medicine is increasingly organized around boundaries, protocols, and narrow domains of expertise. Much of this has brought real gains. We can now diagnose and treat diseases that once would have been hopeless. Subspecialists perform extraordinary work every day.

But patients do not experience an illness one organ system at a time. Patients experience fear, confusion, and symptoms that do not fit neatly into any box. They experience fragmented systems, disconnected records, long waits, mixed messages, and the quiet loneliness of trying to hold together a story that keeps coming apart.

And when things become unclear, patients are often bounced from one place to another.

"This is not really my area."

"You should probably ask someone else."

"Your tests look normal."

"It's not your X" (pick an organ system)

"Go back to your primary doctor."

Sometimes those statements are appropriate. No physician can manage everything. Expertise and boundaries matter. But someone must still take responsibility for helping patients through the maze. That work often falls to general internists.

We are the physicians who care for patients whose problems spill across categories. We care for patients with five subspecialists and no quarterback. We care for symptoms before diagnosis, worries after discharge, and suffering that does not fit an algorithm.

Much of our work involves uncertainty. A patient's fatigue may turn out to be heart failure, depression, medication toxicity, loneliness, cancer, sleep deprivation, hypothyroidism, financial stress, or several of those at once. A hospital discharge summary tells only part of the story. A medication list doesn't match what is in the patient's kitchen cabinet. A "simple" problem often turns out not to be simple at all.

General internal medicine has always required a tolerance for ambiguity and a willingness to stay pres-

ent while things unfold. That is part of what I love most about our work and our field.

We do not just diagnose disease. We absorb and integrate complexity. We do not simply execute protocols. We help patients find their way through systems that often overwhelm them. We do not walk away when the answer is not yet clear. We *stay*.

This ethic rarely makes headlines. It is quieter work than dramatic rescues or groundbreaking procedures. It often goes unseen. There are no billing codes for reassurance, accompaniment, or helping frightened people make sense of what is happening to them. Yet patients remember it.

That small moment in the theater reminded me that the deepest values of medicine are often revealed outside the formal walls of hospitals and clinics. In those moments, stripped of titles and institutional structures, what remains is something simple and old-fashioned: another human being needing help. And a physician deciding whether to step forward.

Adina did not perform a procedure that night. She did not make a difficult diagnosis. She did something both smaller and, in some ways, larger. She showed up. She remained calm. She helped coordinate care. She advocated for what was best for the patient and stayed until the situation was settled. That, too, is good medicine.

I think many SGIM members will recognize this instinct in themselves and their colleagues. It is part of the culture of general internal medicine. We are drawn not only to science and problem-solving but also to the human work of caring for people across time and settings.

That is why the future of academic primary care matters so deeply. The challenge before us is not simply to produce more internists, redesign payment, strengthen research, or improve practice models, important as those goals are. It is to preserve and pass on this culture of responsibility. We need health systems to reward physicians for staying with patients, not just seeing them. We need training programs to teach residents how to embrace uncertainty rather than flee it. We need payment models to recognize continuity, integration, and relationships as sources of value, not inefficiency.

Over the coming months, SGIM will launch a Task Force on the Future of Academic Primary Care Internal Medicine. We will develop and advocate for recommendations to strengthen the academic primary care internal medicine workforce, to improve primary care payment and practice, and to support research to provide the evidence for these goals. This work is urgent. But our deeper responsibility is to preserve the soul of general internal medicine. How do we build systems to make it easier for physicians to take responsibility for the whole patient? How do we train future internists not only to master



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diseases but also to stay with patients in their uncertainty and complexity? How do we build a healthcare system that makes it easier to run toward the fire?

The future of academic primary care will be measured not just by how many physicians we train or how we redesign payment, but by whether we preserve a profession that rewards physicians for stepping into uncertainty, taking responsibility, and staying with patients. That is the kind of future we should build. General internists cannot solve every problem. But we are often the people who stay at the scene long enough to make

sure the patient is not left alone in the confusion. The “thank-you” note from the patient still sits in our kitchen. It reminds me that patients rarely remember our titles, publications, or committee assignments. They remember who answered when they called. They remember who showed up. They remember who stayed.

If SGIM has a calling in this moment, it is to ensure that future generations of general internists continue to earn that kind of gratitude. Because medicine will always need physicians willing to run toward the fire.

SGIM

FROM THE SOCIETY

REFLECTIONS ON THE 2026 SGIM ANNUAL MEETING

Eric B. Bass, MD, MPH; Amanda S. Mixon, MD, MS, MSPH; Eric Yudelevich Blumrosen, MD, MS; Carlos Estrada, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Drs. Mixon (amanda.s.mixon@vumc.org) and Blumrosen (yudelee@ccf.org) were Chair and Co-Chair, respectively, of the 2026 Annual Meeting Program Committee. Dr. Estrada (cestrada@uabmc.edu) was President of SGIM at the time of the Annual Meeting.

S GIM held its 49th Annual Meeting on May 6-9, 2026, at the National Harbor in Maryland, on the outskirts of Washington, DC, the source of federal policies that continue to threaten many aspects of SGIM’s mission. Despite restrictions that many institutions have imposed on spending on travel and meetings, the meeting had 2,721 attendees from 544 institutions, representing 44 states and 13 countries. Attendance was the third highest in SGIM’s history. The program included 130 workshops, 16 clinical updates, 70 interest group meetings, and 1,563 posters. In recognition of the outstanding work that went into preparing and running the meeting, I would like to share some reflections from the leaders of the Annual Meeting.

EB: Carlos, why were you so excited when Amanda Mixon and Eric Yudelevich Blumrosen accepted your invitation to serve as Chairs of the Annual Meeting?

CE: I thought about people who are deeply involved and committed to SGIM. I also was interested in having a team that represented our membership of clinician-educators and researchers. I also wanted to represent hospital medicine and outpatient clinicians. Then, somebody who works at a Veterans Affairs hospital and a foreign medical graduate. When both Amanda and Eric agreed to

serve, I had my wish. A unicorn team. The rest is history; they truly rose to the moment!

EB: Amanda, what was your overall strategy for addressing the meeting’s theme of “Individual Voices, Collective Impact: Advocating for Excellence in Academic Medicine”?

AM: We took a broad view of advocacy, meaning all of us—trainees, researchers, leaders, clinicians, and educators—have unique roles in advocating in academic medicine. Hence, we kept the theme at the center of all we did: from choosing the plenary speakers to encouraging our Program Committee to review the submissions from all categories with an eye toward advocacy.

EB: Carlos, what was the significance of the song that was played when you took the stage for your plenary presentation?

CE: The song was “Sólo Le Pido a Dios (En Directo)” by Mercedes Sosa,¹ who challenged the military dictatorships that gripped Latin America during the 1960s, 1970s, and 1980s. She became known as the “voice of the voiceless ones” and her music was so influential that she was exiled from Argentina in 1979.² When someone in the audience lifted a phone with the light on, I honestly felt like a rock



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star in concert, which gave me an unplanned excuse to keep the phones out. The lyrics to the song include the following:

- “I only ask God (*Sólo le pido a Dios*)”
- “May the pain not be indifferent to me (*Que el dolor no me sea indiferente*)”
- “May dry death not find me (*Que la reseca muerte no me encuentre*)”
- “Empty and alone without having done enough (*Vacía y sola sin haber hecho lo suficiente*)”
- “I only ask God (*Sólo le pido a Dios*)”
- “May the unfair not be indifferent to me (*Que lo injusto no me sea indiferente*)”
- “Don’t slap me on the other cheek (*Que no me abofeeen la otra mejilla*)”
- “After a claw scratched me this luck (*Después que una garra me arañó esta suerte*)”
- “I only ask God (*Sólo le pido a Dios*)”
- “May war not be indifferent to me (*Que la guerra no me sea indiferente*)”
- “It’s a big monster and it stomps (*Es un monstruo grande y pisa Fuerte*)”
- “All the poor innocence of the people (*Toda la pobre inocencia de la gente*)”
- “It’s a big monster and it stomps (*Es un monstruo grande y pisa Fuerte*)”
- “All the poor innocence of the people (*Toda la pobre inocencia de la gente*)”
- “I only ask God (*Sólo le pido a Dios*)”
- “May deception not be indifferent to me (*Que el engaño no me sea indiferente*)”
- “If a traitor can do more than a few (*Si un traidor puede más que unos cuantos*)”
- “May those few not forget it easily (*Que esos cuantos no lo olviden fácilmente*)”
- “I only ask God (*Sólo le pido a Dios*)”
- “May the future not be indifferent to me (*Que el futuro no me sea indiferente*)”
- “He who has to leave is hopeless (*Desahuciado está el que tiene que marchar*)”
- “To live a different culture (*A vivir una cultura diferente*)”
- “I only ask God (*Sólo le pido a Dios*)”
- “May war not be indifferent to me (*Que la guerra no me sea indiferente*)”
- “It’s a big monster and it stomps (*Es un monstruo grande y pisa Fuerte*)”
- “All the poor innocence of the people (*Toda la pobre inocencia de la gente*).”¹

EB: Eric, what was the most powerful and inspiring memory of the meeting for you?

EYB: For me, the most powerful moment was seeing the months of dedicated work from Carlos, Judy Dalie, the staff, the Program Committee, Amanda, and myself finally come to life. Looking out into the audience and seeing the faces of mentors, colleagues, and friends

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genuinely enjoying the meeting we built together was an incredible, full-circle experience.

EB: Amanda and Eric, what do you appreciate most about your Program Committee members?

AM/EYB: We appreciated their energy, creativity, and thoroughness in helping us make the meeting fantastic. It was inspirational to see the passion each brought for the parts of General Internal Medicine that they championed.

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SGIM

PERSPECTIVE

RATIONAL MACHINES AND THE HUMAN HEART: WHAT THE ENLIGHTENMENT TEACHES US ABOUT ARTIFICIAL INTELLIGENCE (AI) IN MEDICINE

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Two and a half centuries ago, the Enlightenment promised to liberate medicine from superstition through pure rational analysis. In this article, I argue that understanding the Enlightenment’s transformation of medicine—its genuine triumphs and its eventual complications—teaches us how to navigate the current AI revolution. The answer lies not in choosing between algorithmic logic and clinical wisdom, but in integrating them.

A colleague was staring at her monitor with an expression I have come to recognize on people my own age and younger as we work through the AI rollout: half fascination, half dread. “*The algorithm flagged this chest film as 94 percent probability of pneumonia,*” she said, turning the screen toward me. “*But the patient does not look like pneumonia. The story does not fit. The exam does not fit. So, who do I trust, the algorithm or my clinical judgment?*”

Standing there, I had an uncomfortable thought. A young physician 250 years ago might have asked nearly the same question in a different vocabulary. The new rational system suggests a humoral imbalance, but the patient in front of me does not seem to fit. Do I trust the scientific method or my traditional understanding? Different century, same problem.

The more I have lived with our current AI rollout, the more I see echoes of the Enlightenment’s transformation of medicine, including both the promises and the perils. I think understanding these parallels matter because we are not the first generation of physicians to be told that a new rational system will free us from the messiness of human judgment. The pattern repeats with unsettling precision: a new system promises objectivity and rescue from fallible human judgment, delivers real gains, then collides with the same complexity it was supposed to transcend. The last time the field got that promise, the answer turned out to be more complicated than the marketing suggested.

The Seductive Promise of Rational Systems

The Enlightenment, spanning the 17th and 18th centuries, promised to liberate medicine from the tyranny of ancient authorities through empirical inquiry and logical reasoning. Hermann Boerhaave revolutionized medical education in the early 1700s by emphasizing systematic observation and evidence-based practice.¹ His approach represented a real shift from inherited wisdom to disciplined investigation, from authority to evidence.

Sound familiar? Today’s AI revolution makes nearly



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the same pitch. Machine learning can process datasets that no human can hold in working memory. It can identify patterns invisible to direct observation. It can offer “objective” recommendations that surpass individual clinical judgment.³ The marketing materials I read when our institution piloted an AI radiology tool last year used language that, with a few word substitutions, could have come from an 18th-century lecture hall.

The methodological parallel runs deeper than rhetoric. The Enlightenment emphasized standardized bedside instruction and reproducible diagnostic approaches. AI medicine promotes algorithmic standardization and protocol-driven care. Both movements promised to transform medicine from an art relying on individual intuition into something more dependable. Both promises were partially right. And both ran into the same problem.

When Rational Systems Meet Human Complexity

The Enlightenment approach, for all its eventual triumphs, initially struggled with medicine’s irreducible complexity. Early scientific medicine sometimes missed the contextual understanding that experienced practitioners carried in their bones. Standardization at first produced oversimplified models that could not capture what was happening at the bedside. It took generations to integrate the rigor of the new science with the wisdom of clinical experience.

I see the same pattern with AI currently in practice. Our sepsis alert algorithm, for example, fires constantly. It flags patients that no experienced clinician would call septic. Nurses develop alarm fatigue. Interventions get triggered that the patient did not need. The algorithm is following its logic perfectly. What it cannot do is hold the context that lets an experienced internist say, “*no, that lactate is from her bowel ischemia, the heart rate is from her pain, this is not sepsis.*”

One of our senior internists put it this way: “*The AI sees patterns in data. I see patterns in people.*” That distinction is older than it looks. It is the same one the Enlightenment eventually had to come to terms with, and it is the one we are working out again now.

The Persistence of Human Judgment

What strikes me about the Enlightenment parallel is how the best physicians of that era did not choose between the rational system and clinical wisdom. They integrated them. Boerhaave himself emphasized bedside manner and patient communication alongside his systematic methods. The clinicians who got the most out of the new science were not the ones who surrendered to it. They were the ones who kept their judgment intact while folding the new tools into it.

That is the integration challenge we face now.³ The most effective AI implementations I have witnessed do

not replace physician judgment. They augment it. When my colleague encountered her discordant AI reading, she did the right thing. She treated the algorithm as one data point among many. She kept examining the patient. She kept thinking. Further workup eventually revealed early heart failure with pulmonary edema mimicking the radiographic features of pneumonia. The algorithm caught a pattern. The diagnosis required someone willing to keep asking questions to contextualize the pattern.

Where This Leaves Us

The Enlightenment’s transformation of medicine took decades to fully realize, and even then, it required constant negotiation with clinical experience.⁴ Our AI rollout will follow a similar trajectory. Initial promise. Gradual implementation. Visible failures. Adjustments. Eventually, an uneasy integration into a medical practice that is neither purely rational nor purely intuitive, because medicine has never actually been either.

The patient, whom my colleague worried about, recovered fully. Her “pneumonia” was fluid retention from heart failure. The treatment that helped her was not one that the algorithm proposed. It came from a clinician who reviewed the algorithm’s output, determined it did not match the patient in the room, and continued working on the problem.⁵

As we work through this stretch of medical history, I keep coming back to one thought: *rational machines can process information at scales we cannot.* But only humans can care. The Enlightenment taught us to trust the methods of science while keeping our clinical judgment intact. The AI revolution will teach us the same lesson, if we are paying attention. Whether we learn it the easy way or the hard way is up to us.

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THE 2026 SGIM UPDATE IN MEDICAL EDUCATION: UNDERGRADUATE MEDICAL EDUCATION STUDIES TO GET YOU THINKING

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During the 2026 SGIM Annual Meeting, members of the Education Committee presented the Medical Education Update, highlighting nine innovative education articles from 2025. These articles were identified through a PubMed search of original medical education studies from 16 high-impact medical and education journals. Eligible studies included U.S. or Canadian learners and excluded reviews and editorials. Abstracts were independently screened for eligibility by two reviewers, followed by two independent full-text reviews to assess internal medicine (IM) relevance, medical education significance, generalizability, methodological rigor, innovativeness, and alignment with the 2026 SGIM meeting theme. Authors conducted a consensus meeting to select final articles. In this article, we provide a brief synopsis of those articles relevant to undergraduate medical education and conclude each section with a question in italics for you to consider. Among the innovations described are learners' trust in Artificial Intelligence (AI) and implementation of Entrustable Professional Activities (EPAs). We will review the innovative graduate medical education articles of 2025 in next month's issue of SGIM Forum.

Exploring Medical Student Trust in Generative Artificial Intelligence (ChatGPT) versus Peers in Team-Based Learning¹

Kirplani et al. studied how AI influences medical student decision-making during team-based learning. Forty first-year medical students at the end of their genitourinary systems block were given eight challenging clinical cases with multiple choice answers. They answered the cases independently, then revised their answers after reviewing AI responses to the cases, and again after peer discussion of the cases and the AI responses. In half of the cases, AI was incorrect. The primary out-

comes were the shift in answer choices and correction of misconceptions across the three phases. Across all three time points, the percentage of correct answers increased from 18.75% to 26.25% ($p = 0.118$). Although answers changed significantly at each stage, peer discussion failed to correct errors introduced by incorrect AI information. Limitations of this study include single center design and use of challenging cases with only a quarter of them being answered correctly. The authors conclude that AI can strongly influence student decision-making demonstrated by the shift in answers with AI information and that AI-driven misconceptions may persist despite group discussion.

How can we generate buy-in from students that expertise is valuable and that they must learn the knowledge themselves before incorporating technology like AI?

Bridging Early Medical Education and Health Systems Improvement: A Multi-Faceted Faculty Development Program to Enhance Engagement and Impact²

Lau et al. present a comprehensive evaluation of a longitudinal, multi-component faculty development program aimed at equipping physician educators to coach early medical students in health systems improvement (HSI) within clinical environments. Addressing a common gap in undergraduate medical education—limited faculty preparation to teach health systems science—the program integrates individual coaching, faculty development days, continuous improvement workshops, just-in-time learning resources, and communities of practice. Using the Kirkpatrick evaluation model, the authors demonstrate outcomes across all four levels, including high faculty satisfaction, demonstrable gains in HSI competence, sustained teaching behaviors, and meaningful organizational impact. Notably, the program trained 119 faculty across multiple departments and health systems, enabling



MEDICAL EDUCATION *(continued from page 10)*

more than 1,200 students to participate in experiential HSI learning. Level 4 outcomes included faculty promotion and retention, enhanced professional fulfillment, all students meeting curricular expectations, and completion of more than 240 student-led HSI projects aligned with health system priorities. The study offers a scalable, replicable model showing that workplace-embedded, longitudinal faculty development can align educational and clinical missions while generating system-level value.

How can we bring similar models of faculty development on Health Systems Improvement back to our home institutions?

Implementing Core Entrustable Professional Activities in Undergraduate Medical Education: A Psychometric Study³

The Association of American Medical Colleges (AAMC) developed the core EPAs to help define performance for entering residency. Violato et al. present a large-scale implementation of EPAs as a longitudinal assessment framework for undergraduate medical education and provides psychometric evidence supporting their use in these learners. Using more than 32,000 workplace-based EPA assessments across seven core clerkships, for the entire MS3 year at a single institution, the authors demonstrated that EPAs can reliably measure clinical competence and track learner growth over time.

The direct observations in this study were completed by a cadre of faculty, residents and “assessment and coaching experts” (ACEs). ACE groups consisted of 15 faculty trained in competency-based assessment and, specifically, in core EPA assessment. The ACEs also served

as faculty developers for the faculty and residents in EPA assessment. The requests for assessment were student driven, influencing why some of the EPAs had sparse data.

Notably, this study innovatively used learning curve theory to model student development. Rather than assuming linear progression, the study showed that EPA growth followed a negative exponential pattern with rapid early gains followed by slower progression as learners approached entrustment. Key takeaways include the feasibility of large-scale EPA implementation, the importance of repeated direct observation, and the recognition that some EPAs require curricular redesign or additional clinical opportunities to achieve entrustment consistently. Replication would require strong student buy-in and cyclic faculty development due to faculty and resident attrition.

How might your institution adopt a comparable longitudinal EPA assessment model?

Can AI Grade Like a Professor? Comparing Artificial Intelligence and Faculty Scoring of Medical Student Short-Answer Clinical Reasoning Exams⁴

Rajan et al. evaluated whether GPT-4o could grade short-answer clinical reasoning responses from medical students with accuracy, consistency, and fairness comparable to faculty graders. Using de-identified exam responses from one medical school, the authors prompted GPT-4o through OpenAI’s API to score each response using the same rubric and point values applied by faculty. AI and faculty scores were compared using bootstrapping, with equivalence defined as a mean difference within five percentage points. AI graded each question



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three times to assess consistency using intraclass correlation coefficients. Across 1,450 responses, AI scores closely matched faculty scores: 82.74% versus 83.32%, with a mean difference of -0.55%. AI scoring was highly consistent and performed best on Remembering, Applying, and Analyzing questions, but less well on Understanding and Evaluating items. The findings suggest AI may support efficient grading, though human oversight remains essential for complex, open-ended assessments.

How do we best train faculty to provide effective oversight on how quickly evolving large language models are used in short-answer assessment?

We hope you find these studies to be inspiring and thought-provoking. Stay tuned for next month when we review the graduate medical education articles.

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SGIM

RESEARCHERS' CORNER

PROTECTING YOUR INTELLECTUAL PROPERTY: INSIGHTS FROM A RECENT STUDY

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You have created a new survey. How can you optimize the copyright to increase the impact from the survey's publication?

Consider the long life of the 1964 Simon and Garfunkel song, "The Sound of Silence." Part of the song's power comes from allowing later artists, including the metal band Disturbed, to reinterpret it for new audiences in this century. While assessment tools and music have different licensing rules, the broader question applies: how can you ensure that your work is disseminated under terms that you choose? It is important to remember that every time you publish, your article is intellectual property (IP) and copyrighted per the hosting journal's policy.

But what if your publication also contains a new survey, questionnaire, or other novel assessment tool that you developed? If you are not proactive in choosing the copyright type for your goals, you may regret submitting the article to a traditional journal that imposes a restrictive copyright that you can neither modify nor grant permissions to colleagues. Alternatively, if your journal is a modern open-access journal, you may regret its very permissive copyright that allows everyone, even commercial users, to use your assessment tool without cost. You are not alone in feeling lost among copyright options.



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We recently published a study that compared these copyright options for their impact on assessment tools' impact, as measured by citations per year by journals indexed by MEDLINE over time.¹ All surveys, regardless of copyright type, initially had rising citation counts per year; however, assessment tools with permissive copyrights were more likely to maintain rising citation counts over the years than were surveys with restrictive copyrights. In 2010, the Mini Mental State Examination (MMSE) was described as "gradually disappearing from textbooks, websites, and clinical toolkits." The sustained citations of tools using permissive copyrights were sometimes due to researchers expanding the role of the assessment tools to new clinical settings.

The practical implication of our study is that survey developers should identify their goals before publication. Is the aim widespread use, revenue generation, controlled versus collaborative evolution/development, or a blend of these?

The blended copyright option, beyond permissive/open or restrictive/closed, was articulated many years ago in the *New England Journal of Medicine*.² Newman, a clinician, and Feldman, a legal scholar, described creating a blended approach in which "the author retains the right to offer the work under a different license simultaneously." Thus, the authors may offer a permissive, "copyleft" option for noncommercial and scholarly users, "yet authors would maintain ownership and copyright of their tool and could profit by licensing it for a fee to commercial users or publishers who wished to include it in a non-copyleft work."²

A second aspect of permissive copyrights, in addition to whether to permit commercial use, is whether to permit "derivatives," or adaptations, of your assessment tool. Derivatives may be needed as concepts evolve, target populations broaden, or translations are needed. Derivatives may also allow researchers to shorten instruments when a full scale cannot fit within a broader survey that must measure related constructs.³ This issue is especially important when a survey is reused at the group level to estimate a population or organizational rate as a shortened survey may suffice.

Before your article is published, these two steps must be followed to implement a blended license:

- First, choose the license type for noncommercial users. I strongly encourage you to consult your institution's IP or legal office for the approach they will support as there are several ways to create a blended license. However, before you consult, as your

office may not be current with emerging publication practices, I also very much encourage you to browse the Creative Commons list of licenses and License Chooser to understand options before talking with your organization's legal office.⁴ For example, CC

BY-NC and CC BY-SA are both permissive licenses that have subtle differences. You should consider including a "BY" (attribution) element and not including a "ND" (no derivatives) element. The BY

element simply means you should be acknowledged in any usage of your survey.

- Secondly, place the IP component of your publication—for example, an assessment tool such as a survey, questionnaire, or decision aid that you created—on a preprint site with the license that you and your legal counsel choose. There are numerous preprint servers that can be compared at ASAPbio.⁵ The Open Science Foundation (OSF) and MedRxiv are both well-known, indexed by Google Scholar, and give multiple copyright options. OSF has the advantage of allowing the hosting of only the assessment tool without having to post a preprint of your manuscript.

In summary, the next time you develop an assessment tool and are ready to submit to a journal, stop. Think about the long-term goals of your tool. Be proactive and select a copyright so that your work can succeed by allowing users to reuse it under the terms you choose.

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PORTRAIT OF THE DOCTOR AS A YOUNG WOMAN

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1997: Local Chinese Buffet

“Dad, why do straws hold water inside if I put my finger over the top?” “There’s only so much space in the universe. When your finger is on the straw, everything is held in place as it should be. In this moment, everything is where and how it should be, and you can rest easy knowing this moment was created perfectly by the millions of other moments before it.”

2007: One Lazy Summer Afternoon

I tell my parents I want to be a doctor. “You can do anything you want.” Dad responds genuinely: “And don’t forget: there may be a path for you that isn’t yet paved.”

2012: Thanksgiving Break

“Sometime this week, I want to practice doing a head-to-toe physical exam on you,” I say while unpacking my new shiny stethoscope. “My professor says I should practice on as many different people as I can.”

He does not answer. When I look up, his discomfort—annoyance?—is palpable.

“I’ll think about it,” he replies, more sharply than expected.

“I promise nothing will hurt, Dad. It’s more about me going through all the steps for repetition.” I am frustrated now. I want to show off my new skills, to make him proud.

“I don’t want to be touched unnecessarily,” he says with finality. He turns back to the golf game.

By that time, the cancer had already spread to his bones.

2013: January

Bi-cal-ut-amide. I stared at the phonetics, trying to create a memorable visual cue for the medication and mechanism of action. Unlike my peers, I have been enjoying this block in medical school, relying on my skill for rote memorization. Satisfied, I create my flash card and move onto the next in an endless list of drugs to learn.

2014: May

Back at my parent’s house, I realized I forgot to bring toothpaste. I sighed at my lazy packing job, done hastily after my final exam that morning. I trudge over to

my parents’ bathroom, remembering how I’d snoop these drawers as a kid for trinkets, or, with luck, hidden Christmas gifts.

This time, a prescription bottle sat on the counter. “Odd,” I pondered. Neither of my parents took medication. I scanned the label, wondering if Dad had caught a small illness.

Its label reads bicalutamide. Recognition sparked deep in my neurons. But I don’t understand—why would he be taking this?

When Mom gets home, I casually mention the new medication on Dad’s counter. There is a pause. “Do you know what it is?” she asked quietly. “It’s usually for cancer,” I replied casually, almost as a question that needed obvious correcting.

As the seconds passed, the puzzle pieces were starting to coalesce, and a crushing fear spread from my throat.

“He didn’t want anyone to know.”

2016: April

Today is my wedding day. Dad warns me not to hug him without warning.

“Don’t link your arm in mine too tightly. It hurts too much.”

2017: August

“I don’t want an obituary.”

I blinked at him, attempting to read his expression. He’d always been paranoid about where personal information was shared, especially on the internet.

“But it’s a chance to have your story told. I want you to be remembered,” I countered.

He grinned, his methadone dose beginning to kick in. “The way our atoms are here together, right here, right now—the universe will remember that, I think.” He readjusted his pillow under his hip. “But what do I know? It’s only my first time dying.”

2018: January

(Missed call): Dad, 3:52 PM

(Voicemail): Dad, 3:54 PM

“Jess, drive safe today. I can’t wait to see you. (chuckles). You know what I can’t stop thinking about? CAKE. C-A-K-E, cake! MMMMMM MM! I would love some



BREADTH (continued from page 14)

cake! If you remember, could you bring me some? Any cake. YES! Okay, love ya!" Click.

The frivolity he had before his illness—the one I remember from childhood—has re-emerged in hospice. I tell myself he is joking and won't remember the request later. Residency makes even picking up a slice of cake from the grocery store seem insurmountable. I never get him the cake.

2018: February

(Missed Call): Dad, 6:07 PM

(Voicemail): Dad, 6:07 PM

Click. "Hi Jess. I was just thinking about you, as usual. (laughter) I know you're probably still working hard. No need to call me back, I just wanted to hear your voice. I hope you have some time to care for yourself today. I love you."

2018: March

"I think I'm ready to jump into the remainder of the universe."

"How do you know?"

"When I look at the stars now, I feel at home."

2018: March

(Text Message) 9:39 AM

Dad: "Good morning honey munchkins. Rounds with ICU team today? Enjoy your triumphs, as usual. (kissing emoji)."

2018: April 14

The 28-hour ICU shift is brutal. My patient had attempted suicide by hanging. Confident at the end of my second year of residency, I comforted my intern who was struggling with the emotional toll of the losses. She has never lost anyone. I am losing someone as we speak.

I learn later Dad woke up for the final time, requesting a steak dinner and to see me. My mother and sister, strangers to the death I'd grown accustomed to, do not recognize this final awakening. They do not call. He never woke again.

2018: April 16

Twenty-four hours in Houston come to a close. Most were spent praying to a God I've never believed in to bring him back to me. I drive back to Austin in the dark for my next shift. I play Gordon Lightfoot on the stereo and cry.

2018: April 17

(Incoming call from Mom) 6:58 AM

"Mom."

"How do you tell if someone is dead?"

I walk my mom through checking a pulse, his absent

breathing, his unmoving pupils, his warmth now gone. I pronounce my Dad dead through the phone.

(Outgoing call—chief resident on call)

"My Dad died. I am about to start an ICU shift." I apologize for the inconvenience of my Dad's death.

"Sorry, that happened. Wait there while we find coverage."

"Okay," I say, as I turn my key in the ignition.

2018: 20 April

(Text from chief resident)

"We've got you covered 'til Monday."

It does not matter whether that is enough days for me. There is no individualization to bereavement leave. It will take years to recognize the trauma of returning to a setting of constant death less than a week after losing Dad.

2018: 23 April

I return. No one asks if I am okay except the overnight intern. I never forget him. I believe asking for help is weak; that is what the hidden curriculum of medical training teaches. I pretend I am strong as I terminally extubate a patient. I come to believe doctors are superhuman, caring for the sick while their own lives come apart. No one suggests otherwise.

2018: 25 April

(E-mail from program director)

Title: Chief position

"Thank you for your interest in chief resident. Our selection process was complex and saw the gifts of each applicant. We especially noted your enthusiasm for teaching and your qualities of a good mentor. After much consternation, the committee chose other applicants. I hope we can speak in person about your goals in the near future. Fondly, program director."

There is no mention of my loss. There is no recognition how the person who applied for the chief role was now fundamentally different from the person receiving the rejection.

2018: 30 April

This week's attending pulls me aside after rounds. "I'm so sorry to hear about your Dad. How are you doing?"

No other faculty will mention how he left the world. I miss him more, because it seems I am not allowed to speak of him. I wish someone would say his name, if only so he lives on a little longer.

2019: June

I graduate from residency. I receive the award for outstanding resident. I leave a chair empty for him, and it almost feels like he's just in the other room for now.



BREADTH (continued from page 15)

2023: January

"We were extremely impressed with your interview. It's like you were made for this role."

I become Associate Program Director in the same program where I once grieved alone.

2026: June

Over the years, loss and tragedy ripple through the lives of my residents, students, patients, and friends. For each, I sit and bear witness. For each, I say their name aloud and give the full reach of my heart. I pave the path in

medical education my father foretold—the one that was not yet there.

1977: June 30

(Dad's old notebook)

Portrait of the Artist as a Young Woman

Life is perfection in its dynamism—it does not have to remain in any state to be a perfect work of art. Life, as art, can only be understood at the end.

Dad was right. He never needed an obituary. He has me.

SGIM

IMPROVING CARE

WHEN REFERRAL IS NOT ENOUGH: ETHICAL LESSONS FROM RURAL NEURO-ONCOLOGY TRANSITIONS

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Introduction

In general internal medicine, a referral often marks the transition between one episode of care and the next. For rural patients, however, a referral may simply represent a set of instructions to navigate alone. This article illustrates the case of a rural patient with a presumed low-grade glioma and tumor-related epilepsy to examine a common but under-recognized ethical problem: clinically appropriate subspecialty care, even when available, may still be difficult to access. For general internists, the case highlights why referral completion should be understood as a matter of justice, beneficence, and meaningful patient autonomy, not simply discharge documentation.

A 68-year-old woman from rural Appalachia presented with several months of cognitive and behavioral changes, staring spells, falls, and new focal motor seizure activity. Brain MRI showed a non-enhancing right mesial temporal and periventricular FLAIR-hyperintense lesion most consistent with a low-grade glioma.¹ She developed

epilepsy *partialis continua* and was treated with antiseizure medications and corticosteroids, with improvement in seizure burden and mental status.

Local neurosurgical consultation concluded that there was no urgent operative indication and that biopsy or intervention would carry substantial neurologic risk given the lesion location. The consultants recommended evaluation at a tertiary neuro-oncology and epilepsy center, where specialized experts could clarify diagnosis, seizure management, and options for biopsy or surveillance.¹ By hospital day four, she was ambulatory, functionally independent, and medically stable for discharge. However, since she did not meet criteria for inpatient rehabilitation or skilled nursing placement, there was no disposition pathway that allowed direct transfer to a tertiary center.

This situation created an ethical problem: outpatient tertiary referral required initiation by an established primary care clinician, but the patient had not seen a pri-



IMPROVING CARE (continued from page 16)

mary care provider in several years. The inpatient team arranged a next-day primary care appointment, documented the need for urgent tertiary referral, provided the family with neuro-oncology contact information, and attempted to communicate with the new primary care office. Even with these efforts, the burden of coordination fell on the patient and her family, who were recovering from a frightening neurologic hospitalization, facing a four-hour trip to an academic center, and awaiting insurance authorization and scheduling. Two weeks later, when the primary care office initiated contact with the academic center, further follow-up was unavailable due to appointment constraints at the tertiary neuro-oncology office.

The injustice in this case was not intentional refusal of care. It was structural, echoing broader concerns about equitable health care access in rural communities.³ Tertiary expertise existed, and clinicians recognized its importance, but the pathway to reach it depended on geography, administrative rules, cross-system communication, and patient-driven navigation. For patients with brain tumors, where specialized evaluation may clarify diagnosis, seizure management, surveillance, biopsy, resection, or clinical trial options, these barriers have moral implications and are well described in the rural cancer care literature.^{2,5}

Three ethical lessons are especially relevant to general internists. First, justice requires attention to the practical attainability of care. A patient's zip code should not determine whether a clinically indicated specialty opinion can be obtained. Yet, in rural cancer care, distance, transportation, fragmented referral pathways, and limited navigation support can make access unattainable even when clinicians agree on the plan.^{2,5}

Second, beneficence is not achieved if the system identifies the right next step but lacks a reliable way to help the patient reach it. The inpatient team stabilized the patient's seizures and created the best plan available within local constraints. Still, a referral without closed-loop handoff led to failures at critical junctures: transfer of imaging, insurance authorization, scheduling, transportation, and clinician-to-clinician communication. A referral is not a bridge unless someone is accountable for helping the patient cross it.

Third, autonomy requires more than being told about options. It requires meaningful access to the information and the services needed to act on those options.³ When a patient is informed that not only is tertiary evaluation recommended but also must navigate an unfamiliar system during recovery from illness, autonomy risks becoming formal rather than substantive.

This case should *not* be read as a critique of individual clinicians; in actuality, it is a critique of referral architecture. General internists frequently occupy the space between hospital medicine, primary care, and subspecialty systems. This position gives us both a unique view of the problem and an opportunity to improve it.

At the individual level, internists can take many concrete steps. Before discharge from the hospital, the treating physician can place

"A referral is not a bridge unless someone is accountable for helping the patient cross it."

a direct phone call to the receiving specialist's office to establish clinician-to-clinician communication and expedite scheduling, a practice shown to improve referral completion and care coordination in rural settings.⁴ Internists can also proactively initiate insurance pre-authorization while the patient is hospitalized rather than deferring to the outpatient primary care provider. When available, requesting a tele-neuro-oncology or e-consult can help to bridge the gap for patients who face long travel distances.⁵ Lastly, providers can connect patients and families with patient navigation services, whether through hospital social work, cancer-specific navigators, or community non-profits, to reduce delays from screening through treatment initiation.

At the system levels, reform can include inpatient-initiated tertiary appointments before discharge, direct clinician-to-clinician referral agreements, embedded navigation support, and closed-loop workflows for record and image transfer.^{4,5}

Conclusion

This case contributes to the literature by identifying referral failure as both an ethical concern and a systemic problem in rural specialty cancer care.²⁻⁴ For trainees and general internists, it offers a practical framework for recognizing when "follow up outpatient" is not enough. The lesson is straightforward: ethical care is not complete when a referral is written, but when a patient has a realistic path to receiving it.

Patient Consent: Written informed consent for publication of this de-identified case was obtained.

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