



SGIM FORUM

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MEDICAL EDUCATION: ARTICLE I

BEYOND PRECEPTING: USING LONGITUDINAL CLINIC COACHING TO STRENGTHEN AMBULATORY EDUCATION

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Introduction

First-year (PGY1) Internal Medicine residents face numerous challenges as they transition from medical school to practicing primary care physicians. Continuity clinic can be a demanding experience, requiring PGY1s to develop key clinical and communication skills within a time-limited setting. They must manage patients with increasing autonomy, especially as outpatient care extends outside of the designated in-person visits. Concurrently, faculty preceptors balance expanding responsibilities beyond resident supervision, including ambulatory education, urgent clinical needs, trainee evaluations, and coordinating follow-up care. These time constraints typically lead to an inability for

faculty preceptors to complete direct observations of entire clinical encounters, review documentation, and provide timely feedback on PGY1s' performance in these areas.¹

To address these challenges, we developed the Clinic Coach Program, where each PGY1 is paired with a dedicated, ambulatory-based Clinic Coach Core Faculty mentor. This program aims to support individual clinic preceptors, enhance clinical oversight, increase the number of direct observations and feedback, and support professional development of new interns in the ambulatory setting. Our article highlights the implementation and impact of the Clinic Coach program on direct observations in continuity clinic.

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Clinic Coach Program

Our Internal Medicine Residency Program includes 34 categorical interns. Each of our three Clinic Coaches were assigned 10 PGY1s and required to host three individual coaching sessions during their intern year. The 3-4 primary care track interns were assigned to the Primary Care Track Program Director, who functioned as this cohort’s dedicated clinic coach. Coaching topics focused specifically on ambulatory patient care, including clinic workflow and resources, agenda setting, and inter-visit in-basket management. The three coaching sessions occurred during an intern’s continuity clinic session during the beginning, midpoint, and end of intern year timepoints. The Ambulatory Associate Program Director arranged coaching meetings that aligned intern clinic and coaches’ availability. Coaches were not responsible for precepting during the intern clinic session. Coaches did directly observe at least one entire patient encounter from start to finish, including the precepting portion, for each intern, and interns received immediate qualitative feedback from their clinic coach after the encounter. Additional meeting discussion points included optimization of the electronic medical record (EMR) for the ambulatory setting, in-basket management, documentation, and billing. Interns completed pre-meeting assessments reflecting on their clinic experience, identifying opportunities for clinic coach discussion, and improvement in the ambulatory setting. Coaches completed post-meeting assessments to document PGY1 goals, topics discussed, and feedback from direct observations. These assessments were for formative evaluation only and were not included in the formal clinical competency committee’s (CCC) reviews. However, if interns needed specific improvement in the ambulatory setting, the clinic coach served as a trusted mentor and could assist in performance improvement plans as deemed by the CCC. Outside of clinic sessions, clinic coaches also

provided additional longitudinal support for questions regarding clinic logistics, clinical decision making, and electronic in-basket management. Clinic coaches were granted core faculty positions within the residency program to help with protected time and funding.

Measurements and Data

Prior to and throughout implementation of the clinic coach program, individual clinic preceptors were asked to record and provide feedback on direct observations of all categorical and primary care track PGY1s. PGY1s also self-reported the number of direct observations completed by individual preceptor faculty and clinic coaches. All pre-post data from AY2023-AY2025 were analyzed using descriptive statistics.

A total of 103 pre-meeting intern assessments were completed by 64 unique PGY1s during AY2023-AY2025, with 94% of PGY1s completing at least one pre-meeting assessment. Clinic coaches completed 169 post-meeting assessments on 68 unique PGY1 residents. Substantial increases in the overall raw number of direct observations of clinic-based core skills reported by interns and preceptors were noted in AY2023-2025 compared to the two years pre-Clinic Coach program implementation (AY2021-2023) (see table). Prior to program implementation, only one intern had a direct observation of the entire clinic encounter completed by a faculty preceptor. Almost 90% (n=61) of interns had clinic coaches complete a direct observation of a clinic encounter in its entirety, 42.6% (n=29) of interns had clinic documentation reviewed, and 83.8% (n=57) of interns had one-on-one review of electronic in-baskets by their clinic coaches.

Discussion

As PGY1s are assigned the title of *primary care physician*, they assume the challenge of managing new, some-

Clinic-Based Number of Direct Observations Reported Two Years Pre- and Post-Clinic Coach Program Implementation		
Clinic-Based Direct Observations	AY2021-2023 Frequency (Pre-Clinic Coach Program Implementation)	AY2023-2025 Frequency (Post-Clinic Coach Program Implementation)
Pap smears	11	35
Manual BP	7	23
Telehealth	1	10
Telephone results management	6	44
Medicare Wellness visit	5	32
Return precautions counseling	5	28
Lifestyle modifications/healthcare maintenance	6	44
Physical exam maneuvers	3	34



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times very complex patients, in a busy clinic setting while continuing to develop and fine-tune their clinical skills. They are also tasked with effectively communicating and coordinating patient care beyond a single visit encounter. With the demands of faculty preceptors being high during any given clinic session, the ideal level of supervision for an intern is difficult to achieve.

As a result of the innovative Clinic Coach Program, PGY1 residents documented a significant increase in the raw number of directly observed skills ranging from physical exam maneuvers to delivering results by telephone conversation. Through three formal coaching sessions, Clinic Coaches completed direct observations of entire patient encounters, providing real-time, formative feedback in rapport building, agenda setting, and workflow navigation. Additionally, formal reviews of clinic notes and in-baskets were accomplished at these meetings. Nearly all interns had a clinic coach observe an entire clinic encounter, a feat proven infeasible for our clinic preceptors prior to the start of this program.

Intern feedback acquired from the PGY-1 pre-meeting assessments highlighted common areas of opportunity including visit navigation, time management, and EMR navigation. Based on quarterly guidance from both interns and coaches, future directions for this program include exploration of clinic coaching for all upper-level residents (currently offered to select PGY2s who need additional outpatient coaching), examining the effect of the program on residents' career choices, and incorporating chronic disease and preventative ambulatory knowledge into clinic coach sessions.

Conclusion

Dedicated clinic coaching is a feasible and impactful strategy to restore direct observation and timely, individualized feedback in the ambulatory training space.²⁻⁴ By separating formative coaching from the competing demands of routine precepting, residency training programs can better support intern development, enhance core outpatient skills, and promote comfort in the ambulatory space during the critical transition to independent clinical practice.

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FROM THE EDITOR

LEAVING A LEGACY: REFLECTIONS FROM A PROGRAM DIRECTOR

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Recently, I announced to the internal medicine residents at my institution that I will be stepping down as their program director at the end of this academic year. For the last seven years, my work identity has been that of a program director—one of the most important and joyous positions I have held. Coming into

a program at a new institution, meeting a team of passionate educators, and building a program together with the residents has been meaningful work. It was not an easy decision to step away from this role as it has helped me grow in ways I could not have imagined.

What have I learned from this position? Most of



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the time, I am the least intelligent person in the room so I should be quiet and listen. The residents care deeply about their patients but feel constant moral distress around their interactions with the healthcare system. Patients continue seeking care from resident physicians in clinic, graciously accepting a change in their primary care physician every three years. My colleagues continue to inspire with their outstanding dedication to their patients and their learners. Chief residents truly serve the program that shaped them into the physician leaders they have become. I have been humbled by the times I needed to “get out of the way” so that my APDs can fulfill their roles effectively. But most of all, I learned what matters most to me in my role: watching others uncover their own greatness.

Even though I am still the program director, I wanted to inform the residents and administrative team now in order to navigate the transition with transparency and thoughtfulness. As physicians, we spend hours honing our clinical craft, learning evidence-based medicine,

and staying up to date with new medical guidelines. As physicians, we are automatically designated the role of “team leader” with others expecting us to immediately perform like seasoned leaders. But how can I continue to lead during this transition? What can I do to ensure the legacy our team built together can sustain and continue growing?

I have wondered what I want people to remember. I want them to remember how they feel in our residency program: appreciated for being their authentic selves; encouraged to learn and grow; pushed in ways they didn’t think they could be; and inspired to make the world a better place. As our team and program navigate this transition together, we will strive to preserve and promote values of integrity, authenticity, equity, growth, and kindness. We all intend to leave programs better than we found them, but this program, my team, and the residents have left me better. I am grateful that I learned many valuable lessons and feel humbled yet excited to see how the program and the residents continue to flourish. **SGIM**

PRESIDENT’S COLUMN

THE PROFESSION WE LEAVE BEHIND

Mark D. Schwartz, MD

President, SGIM

“Every generation inherits a profession it did not create. Every generation decides what profession it will leave behind.”



This summer, I spent two weeks in Eastern Europe visiting the towns where my grandparents and great-grandparents were born. I walked streets they once knew, searched archives for fragments of their lives, and tried to imagine the worlds they left behind. I expected to learn more about

their past. Instead, I found myself thinking about the future they helped make possible for generations they would never meet.

After nearly 40 years in academic medicine, and now with the privilege of serving as President of SGIM, I find myself asking a similar question about our profession. Early in our careers we focus on building our own futures: where we belong and what kind of clinicians,

teachers, investigators, and leaders we hope to become. Somewhere along the way, the question shifts: *What has been entrusted to us, and what will we leave to those who come after?* That question takes on new urgency as SGIM prepares to launch a two-year effort to help shape the future of academic primary care internal medicine.

Every generation inherits a profession it did not create. Every generation decides what profession it will leave behind. Over the past year, I have had a similar conversation dozens of times. Not the same words but the same concerns such as:

- “We’re recruiting, but every search seems harder than the last.”
- “I’m spending more time fighting for protected time than using it.”



PRESIDENT'S COLUMN *(continued from page 4)*

- “I love primary care. I just don’t know if I can build a career doing it.”
- “Who’s going to do this work ten years from now?”

The details differ. The feeling does not. None of these conversations are really about recruitment, funding, promotion, artificial intelligence, or payment policy alone. They are all asking a larger question: “Does academic primary care internal medicine still have the future we hope it does?”

Every generation has confronted financial pressures, workforce shortages, and changing health systems. But today, those pressures are converging. Clinical practice has become more fragmented. Primary care remains poorly paid for the value it creates. Research funding is uncertain. Faculty struggle to find protected time to teach, mentor, and discover. Artificial intelligence is reshaping the work itself. No one of these forces will define our future. Together, they might.

In my last column, I wrote that one of the defining characteristics of general internists is our willingness to accept responsibility for problems that others find too complex, too uncertain, or too difficult to own.¹ I still believe that. Today, I think we are being asked to run toward a different fire. Not simply the care of individual patients, but the future of the profession itself.

As I wrestled with these questions, I found myself returning to Jonathan Sacks’ remarkable book *The Home We Build Together*.² One observation stayed with me. Genesis begins with God creating a home for humanity. By the end of Exodus, after the Israelites have become a people, they are asked to build the Mishkan—a dwelling place for God. Sacks suggests that this reversal marks a kind of moral maturity. We begin by receiving a home. Eventually, we are called to help build one.

Alexis de Tocqueville noticed something similar in nineteenth-century America. Free societies, he wrote, flourish because people come together to solve common problems.³ They become citizens by becoming builders.

Though they wrote in different centuries about very different subjects, they arrive at the same insight. Healthy communities are built by people who gradually move from receiving their benefits to accepting responsibility for their future. I realized they were describing professions as well. We enter them as beneficiaries. If they flourish, we eventually become their stewards.

Every one of us entered academic medicine because someone else had already built it. Someone trained us. Someone reviewed our first manuscript, invited us onto a committee, and introduced us to collaborators. Someone advocated for research funding and built residency programs, journals, mentoring networks, and professional societies that welcomed us long before we arrived. None

of us started from scratch. We inherited all of it. Now it is our turn to repair it where it is weak, strengthen it where it is fragile, and enlarge it as the next generation will need more room than we did.

Perhaps this is why these conversations matter so much. They are not simply about today’s problems but are also about tomorrow’s inheritance. That is why SGIM’s Council has decided to launch the “Task Force on the Future of Academic Primary Care Internal Medicine.” The Council has asked Drs. Tom McGinn and Ishani Ganguli to co-chair this effort. This will be a two-year project rather than a report written over a few months. The first responsibility of the Task Force is not to recommend, but to *listen*. Our work will not end with a report. From the start, we will build a coalition of partners committed to turning good ideas into action.

I hope members will see this as more than another SGIM committee. It reflects our shared sense that academic primary care stands at an important crossroads. Our generation has been entrusted with academic primary care at one of the most consequential moments in its history. If we hope to leave our profession stronger than we found it, we need to step back, listen carefully, think boldly, and imagine the future we want to build.

The Task Force brings together members from across the country and career stages, with diverse expertise in clinical care, research, education, operations, advocacy, and policy. We want to understand not only where academic primary care is struggling, but also where it is succeeding—and why. We want to identify ideas already emerging across the country and bring them into a shared conversation. Only then will we begin making recommendations.

This cannot be SGIM’s conversation alone. In addition to our members, we will invite health system leaders, educators, researchers, learners, professional societies, policymakers, advocacy groups, and philanthropic partners to help shape the questions and the answers.

Our work will focus on the following three broad questions:

1. How do we redesign practice so that comprehensive primary care internal medicine can flourish?
2. How do we strengthen the pipeline of students, residents, fellows, and faculty who will sustain the field?
3. And how do we rebuild the research enterprise needed to improve care and inform policy?

To give that work a bold horizon, we have adopted an aspiration we call the *Triple Double*: by 2035, doubling investment in primary care, doubling the primary care workforce, and doubling the nation’s academic capacity in primary care internal medicine.



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Success will be measured by what happens afterward: when departments begin experimenting with new practice models; when residency programs inspire more trainees to choose academic primary care; when researchers generate new evidence to strengthen practice, payment, and policy; and when health systems invest more deeply in comprehensive primary care.

It will be successful when professional societies, policymakers, educators, and clinicians begin pulling in the same direction, and when students, residents, and fellows once again see academic primary care as a profession where they can imagine a lifetime of meaningful work.

As I think back on my visit to Eastern Europe, I realize that my grandparents left behind far more than family stories. They left possibilities they could never have imagined. Their descendants are living lives beyond their wildest dreams.

I have seen what this Society can accomplish when its members decide that something matters. Together, we have shaped medical education, health services research, health policy, and mentoring across academic medicine. None of that happened because a committee wrote a report. It happened because members decided the future was worth building.

Our generation has been entrusted with the future of academic primary care at a moment when it needs both imagination and courage. The students, residents, and fellows entering our profession today will inherit what we choose to build. May they inherit a profession stronger than the one we received.

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FROM THE SOCIETY

Q & A ON PATHWAYS TO LEADERSHIP IN SGIM

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In 2024, SGIM's Council created a workgroup to launch a Leadership Pathway Program.¹ The workgroup was charged with developing pathways to make SGIM leadership opportunities welcoming, transparent, inclusive, and accessible. The goals were: 1) to assess the current state and advise SGIM leadership on how to enhance clarity, inclusivity, and preparedness for leadership opportunities across SGIM; and 2) to develop recommendations outlining pathways to SGIM leadership roles. Now that the workgroup has submitted a close-out report to Council, I asked leaders of the group to comment on their findings and recommendations.

EB: What did the workgroup identify as the main barriers to leadership development within the organization?

AS: The first barrier we identified was the need to codify existing leadership opportunities and eligibility criteria. The second barrier was the need to improve member knowledge and understanding of leadership opportunities within the organization. The third barrier was the need to prepare members for leadership roles.

During discussion of these barriers, the group identified several themes that warranted attention, especially when considering how best to reach all SGIM members at each career stage. To enhance the diversity of individ-



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uals entering leadership positions, SGIM should focus on increasing engagement of members from institutions and communities not well represented within the organization, using inclusive, non-ambiguous language in role descriptions along with broadened nomination criteria. SGIM should also do more to inform members about the desired range of perspectives to be represented in leadership roles. The group also decided it was important to estimate the degree of effort needed to implement tactics and define metrics for assessing the effectiveness of tactics.

EB: What are the main tactics that the workgroup focused on?

AS: The workgroup chose to focus on eight tactics that would have the greatest impact without requiring excessive effort.

1. Compile a list of existing leadership opportunities.
2. Charge each committee and commission with developing a templated transitional document for that group's leadership roles.
3. Develop graduated leadership roles for all committees, commissions, and other groups within the organization to promote mentored leadership development.
4. List the refined selection criteria on the SGIM website for each open position.
5. Develop an interactive workshop or special session on leadership opportunities to be presented at SGIM meetings.
6. Blend open calls for leadership applications with targeted outreach to achieve appropriate representation of different perspectives.
7. Provide standardized onboarding and support for key organizational leaders.

8. Inform mentors in all SGIM career development programs about leadership pathways and orientation/onboarding resources and invite feedback on tools and resources to be incorporated into future iterations.

While we initially brainstormed a much longer list of ideas to implement, I'm glad we strategically narrowed it to eight achievable tactics with the greatest potential impact within the two-year timeframe set in the workgroup's original charge.

EB: What do you believe are the most important outcomes of the group's work?

RK: For each of the eight tactics, we can point to a process or resource that has been established or an outcome that has been achieved. To achieve our first tactic of codifying leadership opportunities, we now have a searchable inventory of volunteer leadership roles on SGIM's website: <https://www.sgim.org/professional-career-development/volunteer-roles>.² Secondly, we launched a templated process for creating documents that support leadership transitions, including calls for applicants, position descriptions, hand-off instructions, and orientation materials. Third, we began to implement a more consistent definition of the leadership roles and term limits for SGIM's career development programs. Fourth, we created a new rubric to enhance transparency in the selection of leaders, after soliciting input from the Diversity, Equity, and Inclusion Task Force. Fifth, we initiated a flexible approach to presenting special sessions on leadership opportunities at SGIM's regional meetings, taking into consideration differences between regions in their schedules and timing. Sixth, in the 2026 Call for Volunteers, the descriptions of all positions were formatted to enhance clarity about qual-

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



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ifications and expectations. Seventh, special orientation sessions were given for new members of Council in 2025 and 2026. Lastly, the workgroup developed a toolkit for explaining the role SGIM can play in supporting members in their pursuit of promotion and success in an academic career. We hope the toolkit will be used by members individually and by institutional internal medicine leaders. We are exploring ways to deliver this content at the next national meeting. The Leadership Pathway Program's work is meant to elevate the rich opportunities SGIM already provides to members and refine these opportunities so that all members can navigate their own pathway to leadership that feels welcoming, transparent, inclusive, and accessible—with clarity on how to succeed in their chosen role.

EB: How will the work be sustained?

JG: As SGIM's Director of Leadership and Mentoring Programs, I am committed to ensuring that the workgroup's recommendations are incorporated into ongoing processes for selecting and supporting current and emerging leaders in the organization. By making it easier for members to find, step into, and thrive in key leadership roles, we are advancing our mission and putting our inclusive values into action.

EB: On behalf of SGIM's Council, I am extremely grateful for the tremendous work done by the Leadership Pathway Workgroup, which included Andrea Sikon (Chair), Ryan Kane (Co-Chair), Jillian Gann (staff liaison), Jenny Schmidt, Utibe Essien, Anu Paranjape, Eric Green, Marshall Chin, Elisha Brownfield, and Jada Bussey-Jones. I firmly believe the workgroup's contributions will greatly strengthen the pipeline of members who are encouraged and empowered to lead the organization in pursuing its mission and vision.

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MEDICAL EDUCATION: ARTICLE II

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

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During the 2026 SGIM Annual Meeting, the Education Committee presented the Medical Education Update. We searched PubMed for original medical education studies from 16 high-impact

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



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assess internal medicine (IM) relevance, medical education significance, generalizability, methodological rigor, innovativeness, and alignment to the 2026 SGIM meeting theme. We conducted a consensus meeting to select final articles. Here we synopsise the Graduate Medical Education (GME)-related manuscripts, each followed by a question for your consideration.

Association between End-of-Third-Year Objective Structured Clinical Examinations (OSCE) and ACGME Milestones during Intern Year¹

Berg et al. demonstrate that end-of-third-year Objective Structured Clinical Examinations (OSCE) performance is associated with selected measures of early residency performance, providing evidence for the potential value of OSCE data in UME-to-GME educational handoffs. This retrospective, correlational study analyzes data from 139 Sidney Kimmel Medical College graduates who completed a summative 10-station end-of-third-year OSCE in 2015-16 and subsequently entered IM residency. Milestone data were obtained from the varied Accreditation Council for Graduate Medical Education (ACGME) accredited programs where these graduates trained.

The OSCE was designed to mirror the former United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills examination and generated Integrated Clinical Encounter (ICE) scores, reflecting history-taking, physical examination, and post-encounter clinical reasoning/documentation skills, as well as separate communication skills scores. The investigators correlated these OSCE measures with six-month intern-year ACGME Milestone 1.0 ratings in Patient Care (PC1 and PC2) and Interpersonal and Communication Skills (ICS1 and ICS2) using Spearman correlation coefficients. ICE scores demonstrated statistically significant, albeit small, correlations with PC1 ($r=0.28$), PC2 ($r=0.20$), and ICS1 ($r=0.19$), whereas communication skills scores were not significantly associated with any milestone domain.

The authors propose that the ICE domain may capture foundational clinical reasoning and patient-care skills that persist into residency. Despite modestly observed effect sizes and limitation to one medical school and IM trainees, the magnitude of the associations was comparable to those reported for other commonly used residency selection metrics. These findings may support the use of OSCE performance as one component of a competency-based educational handoff and as a potential tool for identifying incoming residents who may benefit from targeted early learning plans.

How should we use UME OSCE data when thinking about the UME to GME transition?

Energizing and Empowering Advocacy: A Qualitative Study of US Internal Medicine Trainees and Faculty Perspectives on Physician Advocacy²

This qualitative single institution study informs educators interested in building an advocacy curriculum. 48 faculty and resident physicians completed surveys that informed focus group discussions; 33 physicians participated in focus groups or interviews. Authors then used thematic analysis to identify key themes within a constructivist paradigm:

1. Supporting health and wellbeing in its broadest sense
2. Viewing physicians in a position of power to advocate
3. Lack of political education among physicians
4. Need for interprofessional collaboration
5. Need for exposure to role models
6. Importance of institutional culture.

Themes emphasized both desire and need for specific skills training and for the creation of collaborative advocacy initiatives. Further analysis of focus groups' comments established the value of incorporating advocacy discussions into routine teaching and existing educational venues and using varied communication platforms to highlight advocacy work led by local physicians.

How can educators help learners amplify their voice and serve as agents of change?

Food Insecurity, Burnout, and Social Isolation among Resident and Fellow Physicians³

This multisite, multistate study aimed to characterize the risk of food insecurity (FI) in trainees, and its association with burnout, social isolation and institutional loyalty. They surveyed 3,408 trainees using previously validated instruments to measure FI (US Household Food Security Survey Module), isolation (Patient Reported Outcomes Measurement Information System Social Isolation scale), and burnout (emotional exhaustion and depersonalization domains of the Maslach Burnout Inventory).

The response rate was 49%. Overall prevalence of FI was 13.7%, with notable differences based on whether one was from a large metro (16-21%) or small metro area (4.5%), identified as Black or African American (22.4%) or White (8.4%), and if PGY1 (17%) or $\geq$ PGY5 or higher (10%). Those with FI were more likely to experience burnout (prevalence of 62%) than those without FI (39%). FI was associated with higher social isolation scores, and those with FI were less likely to consider staying at their current institution after training.

How can educators identify trainees struggling with food insecurity and provide resources?



MEDICAL EDUCATION: ARTICLE II (continued from page 9)

Senior Residents' Perspectives and Intentions to Teach in Outpatient Primary Care Settings⁴

This qualitative study of 13 graduating residents going into ambulatory practice used semi-structured interviews to explore the factors that influence graduating residents' willingness to precept in the outpatient clinical setting. The authors identified four main themes:

1. Witnessing advantages and disadvantages of precepting: *"It's one thing to learn and practice medicine, but it's another thing to teach...it keeps you sharp."* While others used words such as "stressful," and "exhausting" to describe precepting.
2. Preparedness to practice and teach in the outpatient setting: *"We don't have as many opportunities to do outpatient teaching."*
3. Physician responsibility to teach: *"We have an obligation to the next generation"* while others said *"There's no moral obligation to teach."*
4. Clinical demands: *"It's literally, we're just trying to survive."*

The authors conclude that greater opportunities to practice ambulatory education skills, efforts to promote teaching as a core physician responsibility, and system level changes to compensate teaching are needed to foster resident's development as outpatient preceptors.

How can we provide residents with greater ambulatory teaching experience to build their confidence?

Artificial Intelligence Based Assessment of Clinical Reasoning Documentation: An Observational Study of the Impact of the Clinical Learning Environment on Resident Documentation Quality⁵

Authors sought to use AI and large-scale objective data to identify which aspects of the clinical learning environment affect the quality of residents' clinical reasoning documentation. They conducted an observational, retrospective cross-sectional analysis of 37,750 IM admission notes written by 474 residents across two NY residency sites from 2018-23. A supervised machine-learning model classified notes as low vs. high-quality clinical reasoning documentation after evaluating the assessment and plan section of each note. Investigators linked note quality to clinical learning environment variables, including shift type (day vs. night) and note order within a shift as markers of workload. Models also adjusted for patient factors such as age, sex, comorbidity burden, and primary diagnosis.

Higher-quality documentation was more likely in notes for older, complex patients and for some diagnoses.

After adjustment, documentation quality improved with advancing academic year. Night-shift notes tended to be of higher quality than day-shift notes; however, notes written late in the shift were of lower quality. Quality declined as the number of notes increased within a shift, suggesting workload effects. This study demonstrated that resident performance extends beyond individual effort or ability. Workload, shift structure, patient volume, team design, specialty exposure, and feedback systems can influence how well residents demonstrate clinical reasoning.

How do we best adjust resident workload to help improve clinical reasoning documentation?

These articles highlight the value of exposure to role-models in advocacy or outpatient precepting, the importance of high-quality assessment of clinical skills, and the continued disparities that impact trainees. We hope they inspire you to innovate in medical education.

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HOSPITALS IN THE UNITED STATES: A HISTORY OF ACCUMULATION

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Hospitals were not always what we picture today. In this article, we highlight historical changes in hospital care leading to “solutions” that added burdens to the healthcare system without delivering the promised outcomes.

Early hospitals were almshouses run by religious orders, places to die with more dignity than dying alone. The first ones, such as the Hôtel-Dieu in Paris, France, and the monastic infirmaries scattered across medieval Europe, were as interested in isolating contagion from the surrounding population as treating it. Charity was the operating mode, and death was the expected outcome. Going to a hospital meant there was no one to provide care at home; usually, the patients were poor, foreign, or both.

In 1847, the Charitable Era collided with the Scientific Revolution in Vienna, Austria, when Ignaz Semmelweis showed that physicians who washed their hands before delivering babies could cut deaths from childbed fever.¹ Yet he was ridiculed for two decades by colleagues who took offense at the suggestion that their “healing” hands were the problem. Semmelweis died in an asylum in 1865, long before handwashing became standard practice.

During the Crimean War, Florence Nightingale standardized nursing by reorganizing the British military hospital at Scutari and watched the death rate plummet. In 1867, Joseph Lister finally gained acceptance within the British medical establishment for his use of carbolic acid. With these landmark achievements, hospitals became places where patients could recover. By the time anesthesia (1846), antisepsis (1867), and the X-ray (1895) had each found their footing, the modern hospital was technically possible, even if not yet socially accepted.

Evolution of Today's Hospital

The “modern” American hospital was built between 1946 and the early 1980s. Key events helped to shape it, including the Hill-Burton Act, which paid for thousands of community hospitals; Medicare's prospective payment system, enacted in 1983, ended the era of cost-plus reimbursement and required hospitals to operate like businesses; the Institute of Medicine's books *To Err Is Human*² in 1999 and *Crossing the Quality Chasm*³ in 2001 generated

a quality and safety movement that provided a vocabulary for medical errors and quality gaps that were leading to unnecessary patient deaths. Then came Lean and Six Sigma, two manufacturing methods borrowed from Toyota and Motorola—Lean strips waste out of a workflow; Six Sigma reduces variation and defects. Hospitals adopted both the way they were sold, through consulting engagements, and most of those engagements left behind a permanent process improvement department.

Each of these “solutions” arrived as a fix for the era before it. By the start of the 21st century, the American hospital had become a place where federally financed construction, business-style payment, a safety vocabulary, and industrial process improvement systems all operated at once. None of these older initiatives were ever replaced by the solution that followed.

Health care has now moved into the Value Era. The vocabulary has changed to include population health, total cost of care, hospital-at-home, and site-neutral payment. The forces that produced this value vocabulary are real. By 2030, 20% of the population will be over age 65. Labor costs top 60% of hospital operating expenses and continue to rise. Across more than 1,300 hospitals, the median operating margin through June 2026 was 2.5%, uncompensated care kept climbing, and the thinnest cash reserves belonged to the small and rural hospitals least able to absorb the strain.⁴ This business model is clearly not sustainable and is forcing some hospitals to close.

We Are Not Failing. We Are Accumulating

History demonstrates that every new era inherits the “operational debt” of prior eras while assuming the new model will solve all the problems. The almshouse left health care with undertrained nursing staff to help people survive. The scientific revolution left specialists who could not communicate with one another. The Hill-Burton era left more than 1,000 community hospitals, most in the 200-bed range, that were not built to handle the volume of an aging population or the technological advances of modern medicine. The corporate era has left consolidation that has not, on net, reduced costs or improved quality.⁵ The quality revolution provides elab-



PERSPECTIVE *(continued from page 11)*

orate, difficult-to-implement, and uninterpretable measurement systems. The value era is adding risk contracts, value-based payment arrangements in which a hospital shares the savings when the total cost of caring for its population comes in under target and absorbs part of the loss when it does not. One more layer to administer.

Accumulation Is the Problem

The accumulation is not metaphorical. It is structural and visible when viewing the payment system, regulatory agencies, and physical structures.

The payment layers are easiest to see side by side (see table). The Medicare Prospective Payment System of 1983 created reimbursement based on Diagnosis Related Groups. It did not replace fee-for-service. It sat alongside it. Outpatient prospective payment, Medicare Severity DRGs, MACRA with its Merit-based Incentive Payment System, and then ACO REACH arrived in turn, alongside bundled payments, hospital-at-home waivers, and site-neutral pilots. Every model is still active. Hospitals now operate within five overlapping reimbursement systems simultaneously, with different rules, timelines, incentives, and revenue-cycle staff who exist primarily to translate them. Nothing was retired. Everything was additive.

The regulatory architecture is no different (see table). The Joint Commission was chartered in 1951, and everything since, HCAHPS surveys, Hospital Value-Based Purchasing, CMS Star Ratings, Leapfrog and U.S. News rankings, state-specific reporting, and Magnet Recognition for nursing, arrived with its own reporting infrastructure and dedicated staff, on the implicit assumption that every earlier mandate remained in force. No initiative was ever sunset.

A review of the physical hospital footprint tells a similar story. The Hill-Burton hospitals built between 1946 and 1975 still account for most American inpatient capacity. These hospitals were designed for surgical recovery and acute medical stays of several days. They were not designed for behavioral health boarding, for Skilled Nursing Facility (SNF)-ineligible discharge holds, for the Emergency Department volumes a modern community generates, or for the geriatric population we now serve. The walls are the same, but the hospitals' roles have changed.

This is not a critique of any single era; it is what happens when no era is formally sunset. The result is "accumulation": the gradual increase in processes over time. Health care has become overburdened and inefficient under the accumulated weight of the myriad individual "solutions."

The Future

The most useful consideration is not how to fix the current model; but instead, healthcare needs to identify which functions belong elsewhere. Today's American hospital is a multi-purpose facility that emerged by accretion. It accomplishes some aspects of health care superbly. But it is forced to address issues that no other part of the healthcare system was built to tackle. A reform agenda that does not recognize this evolution in hospitals and healthcare history will fail.

Success or failure in the next era of hospital transformation depends on recognition of what came before, not the achievements, but the accumulated debt. Every charter, every payment formula, every quality metric instituted since 1946 is still present, doing some version

Payment and Regulatory Accumulation in U.S. Hospitals: Layers Introduced and Never Retired	
Payment Models	
1983	Inpatient Prospective Payment System (Diagnosis Related Group-based reimbursement), operating alongside persisting fee-for-service
2000	Outpatient Prospective Payment System
2007	Medicare Severity Diagnosis Related Groups (MS-DRGs)
2013-23	Bundled payments, hospital-at-home waivers, site-neutral pilots, and the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model
2015	Medicare Access and CHIP Reauthorization Act (MACRA) and the Merit-based Incentive Payment System (MIPS)
Regulation and Reporting	
1951	The Joint Commission chartered
1990s-present	Leapfrog surveys, U.S. News rankings, Magnet Recognition, and state-specific reporting requirements
2006	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
2012	Hospital Value-Based Purchasing
2016	Centers for Medicare and Medicaid Services (CMS) Star Ratings



PERSPECTIVE (continued from page 12)

of what it was intended to do, doing other things it was never meant to do, and quietly subsidizing the gaps in everything that came after. True reform requires a “debt inventory.”

What do healthcare leaders owe to the next generation of general internists and patients? A clear accounting of the current situation and the honesty to say that the future work is not improvement at the margins. It is diving into the middle, sorting through five generations of inherited infrastructure, and deciding what is kept, what is redirected, and what to let go. SGIM members are well-positioned to lead this reformation.

We can keep stacking new models and calling it reform, or we can inventory what we inherited and decide what to let go. Not both.

The views expressed are the authors’ own and do not represent UT Southwestern Medical Center, the Department of Veterans Affairs, or Tulane University.

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SIGN OF THE TIMES

BEYOND SEMI-ANNUAL RESIDENT REVIEWS: BEST PRACTICES TO PERFORMING RESIDENT-CENTERED SEMI-ANNUAL MEETINGS

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Semi-annual resident performance review meetings are an Accreditation Council for Graduate Medical Education (ACGME) mandate, yet there is no template or best practice for how to perform them. The ACGME mandates that each resident meet at least twice yearly with a program director (PD) or their designate

with input from the clinical competency committee, to evaluate the resident’s progress along specialty-specific milestones and create an individualized learning plan.¹ However, the ACGME only requires review of performance; it does not require career counseling, wellness check-ins, or soliciting feedback about the program.



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Many programs strive to include at least some of these elements during their semi-annual meetings. In this article, we will describe our guidance for conducting a resident-centered semi-annual meeting that incorporates all the essential elements.

Typically, a PD/designate utilizes summative feedback in the form of written evaluations to evaluate their resident's progress. Jackson, et al. found that written evaluations by attending physicians of Internal Medicine residents were of moderate or low quality and not always aligned with information needed for milestones.² It is important for the PD/designate to recognize the limitations of written evaluations when meeting with residents.

Taking a mentoring approach to semi-annual meetings allows PD/designates an opportunity to extend beyond evaluations that can be of variable quality and usefulness in aiding resident development. Narrative reviews show that mentoring can contribute to doctors' health and well-being by enhancing relationships and physical and psychological health and may lead to better work performance.³ Mentorship has also been shown to increase career satisfaction.⁴ Programs are committed to helping residents grow as physicians. Both residents and faculty feel receiving feedback is important to resident learning.⁵

An ideal semi-annual meeting involves a resident who is feeling and performing well, has the appropriate amount of confidence for their stage of training, is prepared for the meeting, is receptive to feedback, has taken initiative with their career planning, and, ideally, has insightful feedback for the program. The PD/designate should be emotionally and intellectually ready before starting the semi-annual meeting, knowing that their frame of mind can leak unwittingly onto the resident. A calm temperament helps the PD/designate navigate challenging situations, like imparting constructive feedback or discussing the resident's disagreement with the assessment of the evaluators.

In addition to providing feedback about resident performance, the semi-annual review meeting is an opportunity to serve multiple needs, including career counseling, wellness check-ins, and feedback for the program. It helps to allow time for the resident to bring up topics they would like to discuss to make sure the meeting is helpful for them. At the end of an effective semi-annual review meeting, the PD/designate will leave with a better understanding of the resident's overall well-being and clinical performance, and the resident will have gained valuable one-on-one career coaching.

A Semi-Annual Resident Review Meeting Roadmap: What You Can Start Today

The following five steps illustrate how to conduct a productive, resident-centered, semi-annual meeting. The typical one is scheduled for one hour; admittedly, any

of these five steps could easily fill one hour on its own. However, this road map can guide the PD/designate to best utilize their available time:

1. **Gather your resources.** Make sure your resources are gathered and ready. Your coordinator should have helped to gather needed materials, including evaluations, clinical competency committee data, procedure logs, and attendance records. To ensure a productive conversation, PD/designates should review these materials ahead of time and be prepared to address specific concerns, including performance and well-being questions.
2. **Check in with your resident, normalize the resident experience, and prioritize their goals for the meeting.** Is there something they want to discuss during the meeting? How are they doing? Are they tired or feeling well? We recommend approaching residents in distress with recognition and compassion, as current training may pose different pressures, stress, and moral distress. By naming their feelings and normalizing their experience, PD/designates can help residents know that they are not alone in their struggle and self-doubt.
3. **Give summative feedback and appreciation.** PD/designates can discuss strengths and areas for improvement and show genuine appreciation for their work in the program, serving patients, the community, and supporting their colleagues.
4. **Coaching: Set goals for the next 6 months.** PD/designates can help residents identify SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals for the next six months to work towards their planned career goals. PD/designates can also check in with progress towards fellowship or job applications, advancement of research and scholarly activity, review residents' current mentoring teams, and facilitate connections with any additional mentors to assist with career development and planning.
5. **Elicit feedback about the program.** By asking for feedback for the program, PD/designates demonstrate a desire to improve as well. PD/designates can ask about specific rotations, attending or fellow supervisors, didactic experiences, wellbeing resources, scheduling, and more.

Utilizing these five steps can help the PD/designate accomplish the ACGME goal of performance review while also allowing time to discuss professional development, wellness, and feedback for the program.

What You Can Do Long Term

Long-term goals for improving semi-annual meetings include faculty development about evaluations, establish-



SIGN OF THE TIMES (continued from page 14)

ing mental health support, and utilizing feedback elicited during these meetings. Training faculty and designates to give high-quality feedback, both in person and via written evaluations, will both strengthen the culture of feedback in your program and ensure higher quality data is available for review during semi-annual meetings. PD/designates should familiarize themselves with available mental health resources in their institution. The newest generation of residents may be more open about their struggles than prior generations, but many would still benefit from accessing mental health resources. Finally, semi-annual feedback should be made available for Program Evaluation Committees and utilized to improve programs over the long-term.

Conclusion

The semi-annual meeting is not only a designated time for summative feedback to a resident but also an opportunity for mentoring and fostering growth of the resident *and* the program. A resident should leave the meeting feeling seen, appreciated, and motivated, and come away with concrete plans for self-improvement over the next weeks or months. The PD/designate should leave the meeting with a better understanding of the resident's state of mind, self-understanding, and goals. Finally, it can be a space where a PD/designate can gain a better understanding of the resident experience and utilize the feedback to improve their program.

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THROUGH A COMPASSIONATE LENS: WHAT PHOTOGRAPHY TAUGHT ME IN ACADEMIC MEDICINE

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Long before I held formal leadership roles, photography taught me to recognize what matters. Each frame is shaped by where you stand, when you press the shutter, what you include, and what you leave outside it. Those choices taught me so much of what I apply to my role in academic medicine today.

Leadership is often defined by decisiveness, authority, and expertise. However, the experiences that have most shaped me did *not* begin with having the right answers. They began from a conscious decision to view others and myself through a compassionate lens.

Compassion is often oversimplified as empathy. It's a deliberate practice of curiosity, patience, and presence. It informs how I care for patients, coach residents, nurture the relationships that sustain me outside of work, and extend grace to myself in a profession that rarely pauses. This article talks about how the same elements that make a meaningful photograph—focus, light, composition, and perspective—closely mirror the principles of compassionate leadership.

Focus: Seeing the Person beyond the Problem

Focus tells the eyes where to land. By narrowing the depth of field, we can start paying attention to the “one subject” that matters in that moment. In medicine, it often feels like a fight against that kind of focus. The sheer volume of tasks like reviewing labs, placing orders, corresponding with consultants, and documenting can be overstimulating. Amid all this chaos, the “patient” often gets replaced by the “disease,” and it is easy to lose sight of the human experience behind it.

Compassion begins with being intentional about where to look. It reminds me to notice the person behind the diagnosis. It also prompts me to be perceptive: to the uncertainties hidden in silence, the fears of the unknown, and the vulnerabilities accompanying illness. The moments I treasure most don't hinge on complex medical judgments; they appear when I slow down, listen fully, admit that I don't have all the answers, or allow a pause in a space that feels rushed.

The same applies in education. Sometimes, visible concerns, such as delinquent documentation and challenges with pre-rounding, may be only part of the picture. What lies beneath may be burnout, imposter syndrome, or other mental health struggles.

In these moments, compassion itself becomes a kind of focus, bringing the person—not just the problem—into view.

Light: Revealing What Is Hidden

One of the humbling lessons photography offers is that the most surreal shots often emerge under the darkest skies. As you stand beneath the night sky, it may seem empty. But with the right lens, a longer exposure, and some patience, the luminous Milky Way appears. Capturing this image requires trusting that there is light, even when you cannot see it.

Guiding residents, especially those who are struggling, has taught me to make a similar adjustment. Our training systems are built around evaluations and metrics, which naturally draw attention to deficits. Yet learners often possess qualities such as empathy, resilience, or the ability to form meaningful connections with patients that may not be easily captured within traditional frameworks. Recognizing meaningful growth requires looking beyond the immediate struggle and searching for strengths not yet apparent.

Being compassionate doesn't mean ignoring areas that need work or avoiding hard truths. In fact, some of the most compassionate conversations I've had with residents were also the most direct. Compassion means telling the truth even when uncomfortable, setting clear expectations, and holding people accountable while still honoring their autonomy. The tone of feedback delivery matters as much as its content. It determines whether the feedback is experienced as judgment or as an invitation to grow.

Like photographing night skies, this work takes time. It calls us to adjust our lens and remain curious about what might still be hidden.



BREADTH (continued from page 16)

Composition: Walking with Others

Composition concerns how elements relate within a frame. The pictures that really stay with us don't fixate on an isolated subject. Rather, they bring together different elements so the whole scene can narrate its story.

Working in health care has a way of making it feel like there's little room for life outside work. The demands of the job push relationships to the margins of our lives, leaving little room for the people who sustain us in and outside of our professional roles.

We must also recognize that education is deeply relational. Residents often learn from and emulate the behaviors they observe in their attendings. Some of the most enduring lessons for trainees may come not from formal curricula, but from witnessing generosity during a busy shift, disagreement handled without humiliation, or kindness offered when no one is watching.

In the composition of a meaningful life, these relationships are essential parts of the frame, and not merely background details.

Perspective: The Lens of Self-Compassion

Perspective is shaped by distance. That means recognizing when to step back from the viewfinder to see the whole landscape. Unfortunately, the culture of medicine doesn't encourage this kind of distance. It rewards long hours and nonstop productivity. This relentless need to do more and be more can often result in burnout. In such an environment, being kind to yourself can feel unfamiliar and perhaps even indulgent.

I've realized, however, that self-compassion is essential for sustainable leadership. We need those moments of stillness to reconnect with why we started this in the first place. I've had to learn and constantly remind myself that just because I *could* have done more doesn't mean what I did wasn't enough. It is also about resisting guilt over unfinished tasks and remembering that our best effort has value, even when the to-do list is exhaustive.

Leadership doesn't require us to be in constant motion; sometimes clarity comes only after we stop and re-focus.

The Responsibility of the Lens

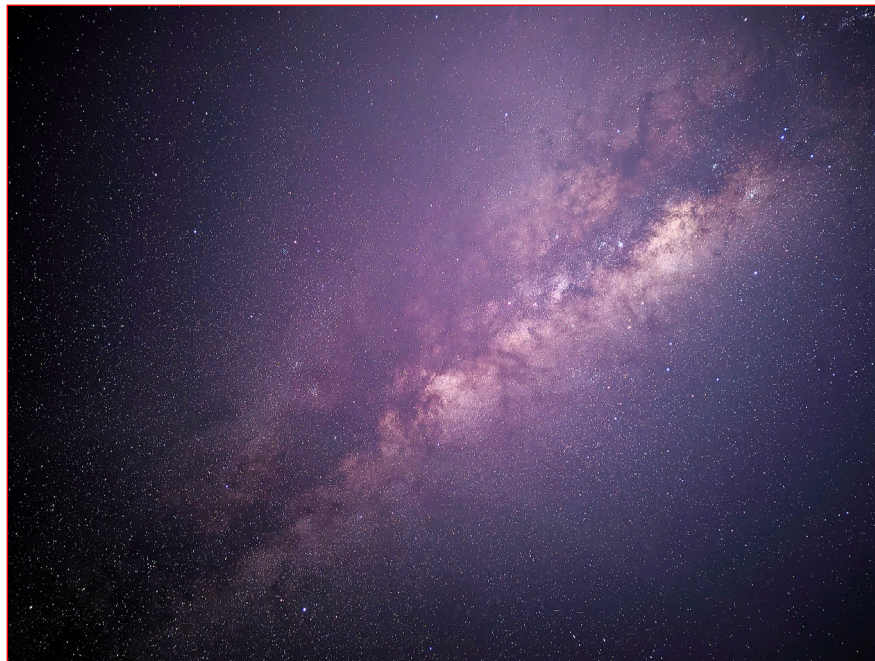
A photograph ultimately reveals something about the person behind the camera. The images we capture reflect what we choose to notice, what we consider important, and our interpretation of the world around us.

Leadership works similarly. Every interaction with patients, trainees, colleagues, and even ourselves reflects the lens through which we see others. A lens grounded in compassion opens space for trust, growth, and connection.

For me, leadership means choosing curiosity over judgment, presence over urgency, and connection over distance. Photography taught me that what appears invisible at first glance may simply require a different lens.

Like the stars and galaxies in the darkest skies portrayed in this photograph, sometimes the brightest light is already there, simply waiting for us to adjust our focus and look again.

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(See what is, and what might become! Photo taken by the Author.)

MANAGEMENT REASONING IN HOSPITAL MEDICINE: A CASE-BASED FRAMEWORK

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Introduction

Management reasoning is the process of deciding among treatment, testing, follow-up, and resource-allocation options.^{1,2} Key features of management reasoning—weighing harms and benefits, estimating probabilities, determining thresholds, and reassessing response—are relevant in both outpatient and inpatient care.³ Inpatient medicine, however, is uniquely impacted by shiftwork, repeated handoffs, admission and observation decisions, bed capacity, and transitions of care. The following case illustrates how these hospital-specific contextual features interact with core management reasoning tasks.

Case, Part 1: From Emergency Department to Admission

A 72-year-old woman with heart failure with preserved ejection fraction presents to the emergency department at 7:30 PM with weeks of intermittent chest pressure and dyspnea. Physical examination is consistent with volume overload. An electrocardiogram shows no ischemic changes, high-sensitivity troponin and NT-pro-BNP are mildly elevated, platelets are mildly decreased, and chest radiograph shows cephalization. She recently missed two primary care appointments because of transportation difficulties and is unsure of her medications. The emergency department requests inpatient admission for acute coronary syndrome rule-out.

First Management Challenge: Hospital Admission

In this case, the challenge is not simply diagnosing acute coronary syndrome. The hospitalist must also decide whether the patient should be admitted to the hospital or discharged safely home. This requires estimating the probability of a time-sensitive diagnosis, identifying “can’t miss” conditions, weighing the harms of hospitalization against the risks of outpatient management, and determining the threshold for continued monitoring. The appropriate choice depends not only on disease probability but also on expected testing needs, anticipated clinical

trajectory, available observation protocols, follow-up reliability, and whether the patient requires hospital-level treatment. Inpatient admission may be appropriate when multiple active problems, treatment needs, or social barriers are present; however, admission solely because outpatient follow-up is difficult may expose the patient to unnecessary risks, including delirium and hospital-acquired infection. In this case, the team admits the patient because she requires serial troponin measurements, intravenous diuresis, medication reconciliation, reassessment of her symptoms and volume status, and is expected to stay beyond two midnights.

Case, Part 2: Night to Day

The accepting nocturnist begins intravenous diuresis, orders serial electrocardiograms and troponins, verifies that the patient no longer has pain, and identifies the medication list as an unresolved safety issue.

Second Management Challenge: Shiftwork

At night, the management options differ from those available during the day. Some consultants, diagnostic tests, pharmacies, and collateral sources may be less accessible. The nocturnist therefore prioritizes stabilization, time-sensitive decisions, and preparation for daytime care.

Similarly, shiftwork changes the management time horizon. The overnight clinician must decide what must happen now versus what can safely wait. A high-quality handoff does more than summarize diagnoses and plans; it communicates management reasoning to mitigate duplicative testing, contradictory plans, or an unnecessary extension of stay. Effective handoff ensures that the daytime hospitalist knows to complete a full medication reconciliation and other tasks that were unfeasible at night.

Case, Part 3: Daytime Hospitalist Care

By morning, the patient’s chest pressure has resolved, serial troponins and platelets are unchanged, and her dyspnea has improved. The daytime hospitalist reassesses the working probabilities and reprioritizes the



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plan. The immediate concern for acute coronary syndrome has decreased, while medication reconciliation, volume status, thrombocytopenia evaluation, and discharge feasibility are more prominent.

Third Management Challenge: Reassessment, Reprioritization, and Parallel Work

Hospital management often requires parallel work by multiple team members with the goal of safe discharge. For this patient, the hospitalist is simultaneously monitoring clinical improvement while partnering with the larger multidisciplinary team. Specifically, the pharmacist clarifies medication dosing with the outpatient pharmacy, the physical therapist assesses mobility for recommended discharge disposition, and the case manager evaluates transportation benefits. Waiting to begin discharge planning until all diagnostic questions are resolved can create avoidable delays.

Case, Part 4: Additional Testing

Since the patient was admitted in part for evaluation of acute coronary syndrome, the daytime hospitalist is considering whether the patient should obtain an inpatient stress test. The hospitalist notes that several patients in the emergency department are awaiting an inpatient bed.

Fourth Management Challenge: Length of Stay

Traditionally considered an operational metric, length of stay also functions as a clinical variable. Each additional hospital day may allow further monitoring or testing, yet also carries potential harm, including immobility, sleep disruption, delirium, medication errors, and hospital-acquired complications. The relevant question is not simply, “Can the patient remain for another test?” but “*Will the expected value of that test during this hospitalization exceed the risks of continued hospitalization?*”

For this patient, the team considers her current probability of unstable disease, whether the result would change immediate management, the timing and availability of testing, renal function, functional capacity, and the likelihood that outpatient testing can occur quickly. A test that is clinically reasonable but currently unavailable may add a full hospital day. Conversely, deferring testing without a reliable transition plan may convert an efficiency gain into a missed diagnosis or return visit. Length-of-stay reasoning therefore requires explicit integration of clinical benefit, timing, patient vulnerability, and follow-up reliability.

Fifth Management Challenge: Bed Management and Stewardship

Hospitals often operate near or at capacity. Bed availability should not override an individual patient’s safety needs, but it is part of the context in which hospitalists practice. A hospital bed is a shared and limited resource;

avoidable delays can affect patients beyond the one currently being managed.

Bed management requires management reasoning. For example, clinicians must determine whether 1) a patient still needs an acute-care bed, 2) discharge tasks can be completed earlier in the day, and 3) management in the outpatient setting is feasible and safe. This is not synonymous with premature discharge. Rather, it is the identification of what remains medically necessary, what resources are available where and when, and what assistance is required to allow patients timely access to appropriate healthcare resources.

Case, Part 5: Discharge

Based on the patient’s clinical improvement, the team decides against an inpatient stress test. The patient is now euvolemic with improved thrombocytopenia and deemed clinically ready for discharge. The team ensures that the patient has her home medications, understands her new diuretic regimen, and is aware of scheduled follow-up appointments. The patient’s discharge summary explains her diagnosis, which symptoms should prompt urgent reevaluation, and who is responsible for outpatient ischemic evaluation. The inpatient team notes that transportation has been a barrier to attending outpatient visits, and the inpatient social worker has started paperwork for obtaining medical rides.

Sixth Management Challenge: Care Transitions and Readmission Prevention

The patient is ready to leave the hospital only when the receiving outpatient plan is safe. Management reasoning regarding transitions of care begins at admission and includes identifying the clinician who will assume responsibility for the patient’s care, reconciling medications, communicating results, arranging follow-up, and anticipating pitfalls. The hospitalist must decide which problems require resolution before discharge versus which can safely be transferred to the outpatient setting.

Minimizing 30-day readmissions is not achieved by extending hospitalizations or completing every conceivable test before discharge. Readmission risk may reflect unresolved illness, medication confusion, poor access, inadequate communication, or a new and unrelated event. Management reasoning requires identifying modifiable risks without treating readmission as an outcome entirely under the hospitalist’s control. A safe transition balances the harms of continued hospitalization against the risks of transferring care too early or without adequate support.

Conclusion

Inpatient management reasoning uses many of the same foundational cognitive processes as outpatient care. Its distinctive features arise from the structure of hospi-



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Management Reasoning in Hospital Medicine Teaching Guide		
Contextual Feature	Description	Framework for Teaching: Questions on Rounds
Hospital admission decision	Determining whether the patient can be managed safely in the outpatient setting or requires hospitalization based on diagnostic uncertainty, treatment needs, anticipated clinical trajectory, and follow-up reliability.	Does this patient need hospital-level care now, and is the stay observation or inpatient?
Shiftwork and management time horizon	Adapting decisions to the priorities, resources, and constraints of the current shift while distinguishing tasks that must occur immediately from those that can safely wait.	What must be accomplished during this shift, and what can safely wait for the next team?
Handoffs and continuity of reasoning	Communicating not only diagnoses and tasks but also the rationale, contingencies, and unresolved uncertainties underlying the management plan.	What reasoning, uncertainty, and contingency plan must be communicated to the next clinician in addition to the task list?
Choosing stepwise versus parallel approaches	Deciding whether management tasks should occur sequentially or simultaneously based on their dependencies, urgency, risks, and potential to delay care.	Which management tasks should occur in parallel to prevent delay, and which depend on another result or decision first?
Length of stay as a clinical variable	Evaluating whether the expected benefit of another hospital day exceeds the clinical risks and opportunity costs of continued hospitalization.	What ongoing clinical need justifies the next hospital day, and would another day meaningfully change management?
Bed management and stewardship of capacity	Recognizing hospital beds as limited shared resources while ensuring that capacity pressures do not supersede the needs of individual patients.	Does this patient still require the current level of hospital care, and can we reduce avoidable delay without compromising safety?
Transitions of care	Determining which problems must be resolved before discharge and which can be transferred safely to outpatient clinicians with clear communication, ownership, and contingency planning.	Which problems must be resolved before discharge, and which can be transferred safely, to whom, and with what contingency plan?
Access to outpatient care	Incorporating transportation, appointment availability, health literacy, medication access, and other barriers into the feasibility of the discharge plan.	Is the outpatient plan achievable given the patient's transportation, medication access, health literacy, support, and follow-up availability?
Readmission prevention	Identifying modifiable risks for return to the hospital without unnecessarily prolonged hospitalizations or indiscriminate testing.	What modifiable factors could bring this patient back to the hospital, and which can we address before discharge?
Disposition and clinical efficiency	Coordinating the timing, sequence, and ownership of care to support a safe discharge and reduce preventable delays.	What is the safest appropriate disposition, and what unresolved barrier is preventing the patient from reaching it today?

talization: care is delivered across shifts, patients move between settings, clinical work competes with time and capacity constraints, and responsibility must be transferred safely to the primary care physician at discharge. These features can also prompt a unique teaching framework and questions on rounds (see table).

A case-based approach makes these interactions visible and emphasizes that high-quality hospital care depends not only on choosing the correct treatment but also on selecting the appropriate setting, timing, sequence, and owner for each element of the plan.

Acknowledgments: We thank our colleagues at Weill Cornell Hospital Medicine for their contributions.

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