

SGIM FORUM

IN THIS ISSUE:

What Are General Internists For?.....	1	Will I Be Okay after Surgery? Counseling Our Patients on the Road to Recovery.....	11
Smile More: Spotlighting Hidden Hurdles Experienced by Women Leaders	3	50 Years of SGIM: How Women's Lives Have Changed in the Workplace and at Home	13
Tiering Health Care Apart: When Better Care Becomes a Luxury Good	5	Arts and Humanities in Medicine: Trainee Reflections on Addiction	15
Q & A on #ProudtobeGIM: Empowering the Next Generation of Leaders	7	Reflections on the Fiscal Frontier: Lessons Learned at the Intersection of Leadership and Finance in Academic Medicine	17
Preventative Screening Guidelines: Population vs. Individual Benefit	8		

SIGN OF THE TIMES

WHAT ARE GENERAL INTERNISTS FOR?

Sabrina Felson, MD; Erin Krebs, MD, MPH; Mark D. Schwartz, MD

Dr. Felson (Sabrina.Felson@va.gov) is a Clinical Associate Professor at NYU Grossman School of Medicine and General Internist at the VA New York Harbor. Dr. Krebs (Erin.Krebs@va.gov) is Chief of GIM at the Minneapolis Veterans Affairs Health Care System and Professor of Medicine at the University of Minnesota. Dr. Schwartz (Mark.Schwartz@nyulangone.org) is President of SGIM.

There is a moment in almost every primary care practice that rarely appears on a clinic schedule. A nurse practitioner knocks on the door. A physician assistant sends a quick message through the electronic health record. A physician colleague stops you in the hallway. “*Can I get your thoughts on this patient?*” The patient has already been seen. The history has been taken. The medications reconciled. The guideline followed. But something doesn’t fit. The symptoms persist despite multiple specialty visits. The diagnoses seem to compete rather than converge. The question is no longer, *What should I do next?* It is, *What am I missing?*

For many general internists, these are among the most satisfying moments of the day. These questions call upon the habits and skills that drew many of us to internal medicine: stepping back from the details, integrating across organ systems, managing uncertainty, and helping patients make sense of complex and often conflicting information.

Yet this work remains largely informal. It is squeezed between scheduled visits, dependent upon collegial goodwill, and almost invisible to the systems that organize, measure, and pay for primary care.

We often think of consultation as something that happens between primary care and specialists. But what if one of the next important innovations in primary care was interdisciplinary consultation within primary care? And what if in a workforce increasingly reliant on advanced practice clinicians, consultation became one of the defining contributions of the general internist? In this essay, we argue for recovering the general internist’s consultative role and redesigning primary care so that physician expertise is available when patients and their care teams need it most.

Consultation Has Always Been Part of Our Identity

The consultative role we are describing is, in one sense, entirely new. In another, it is among the oldest traditions



SIGN OF THE TIMES (continued from page 1)

in general internal medicine. Long before electronic consultations and multidisciplinary teams, community physicians turned to experienced general internists when patients presented with diagnostic uncertainty or multi-system illness. Internists' expertise lies not only in mastering a single organ system but also in discovering and integrating seemingly disparate information across multiple organ systems. Consultation was once one of the defining professional contributions of general internal medicine.

The GIM consultant identity has never disappeared, but it is neglected and underused in the current healthcare system. As primary care has become busier, panel sizes have grown, and productivity pressures have intensified, there has been less protected space for expert consultative work. Much of a general internist's day is now consumed by the essential demands of longitudinal care: preventive care, chronic disease management and acute care needs, medication reconciliation, inbox management, documentation, and countless administrative responsibilities. The demand for primary care has made it harder to preserve complex work in internal medicine, shifting more of the care we could do onto our subspecialty colleagues.

Meanwhile, the primary care workforce evolves dramatically. Nurse practitioners and physician assistants now provide longitudinal care for millions of patients and are indispensable partners in meeting the nation's primary care needs.¹ Rather than viewing this evolution as a threat to the general internist, we should welcome the opportunity for the growth it offers. Interdisciplinary collaboration allows general internists to expand patient access to our medical expertise.

The question is no longer whether physicians and advanced practice clinicians should work together—they already do. The question is this: If comprehensive primary care requires diverse expertise, how do we sustain a physician workforce and match patient need to clinician expertise?

Recovering an Old Role

Recovering the consultative role is part of the answer. This recovered role will need to be supported by shifts in workload toward smaller continuity panels that allow protected time for consultation on patients with greater complexity. Continuity remains one of primary care's defining and sustained strengths, while consultation—also once a core feature of internal medicine—has been squeezed out of our day-to-day practice. The goal is not to replace continuity, but to improve access and medical care for all patients while enabling physicians to concentrate more effort on patients with complex medical needs.

Imagine a practice in which every general internist maintained a smaller continuity panel while also serving as a resource for colleagues caring for patients whose problems exceeded the reach of guidelines or routine

workflows. Rather than fitting consultations into the margins of the day, physicians would have protected (and compensated) time to help NP- and PA-empaneled patients struggling with diagnostic uncertainty, multimorbidity, unexplained symptoms, polypharmacy, difficult tradeoffs, and the countless situations in which a physician's second opinion could be critical or, at very least, reassuring.

We have begun calling this role the *GenMed Consultant*, although the name matters less than the underlying idea. Consultation should be recognized as a core function of primary care rather than an interruption to it. Experienced general internists bring a distinctive expertise—not in one organ system, but in integrating across diseases, specialties, treatments, and patient goals while preserving continuity.²

Importantly, this is not a proposal to recreate hierarchical supervision of nurse practitioners and physician assistants. Modern primary care depends on the independent judgment, experience, and enduring patient relationships that advanced practice clinicians bring to their work. The physician's contribution is distinct. The goal is complementary expertise, with each clinician practicing at the top of their abilities and having access to colleagues whose expertise supplements their own.

Many high-functioning group practices already incorporate informal consultation. Hallway conversations, electronic messages, and curbside consultations occur every day because excellent primary care clinicians recognize when another perspective may help. The innovation is not the consultation itself. The innovation is acknowledging that this work is valuable enough to design for, protect, study, and reward.

Seen this way, the GenMed Consultant is *not* a departure from primary care. It gives new structure and value to a role that general internists have long played.

One Example: IM-PACT

Within the Minneapolis VA Health Care System, colleagues have begun testing one possible implementation through the Internal Medicine-Patient Aligned Care Team (IM-PACT). The model pairs physicians and advanced practice clinicians—each responsible for their own panel of primary care patients—while protecting time for consultation around patients with greater diagnostic or management complexity. Consultation is initiated by independent advanced practice clinicians and occurs in weekly team huddles, informal communications, e-consults, or direct patient visits, depending on the clinical need.

Early clinician feedback has been positive, although whether the model improves patient care remains an empirical question. For now, IM-PACT shows that consultation within primary care can be designed as an intentional part of physician work rather than left as an after-hours favor between busy colleagues.



SIGN OF THE TIMES *(continued from page 2)*

An Invitation to the SGIM Community

The GenMed Consultant is one possible answer, not a single blueprint. Some practices may emphasize formal consultation; others may embed physicians as master clinicians within interdisciplinary teams or develop hybrid models suited to local needs. Whatever the structure, our enduring values should remain the same: whole-person care, continuity, intellectual breadth, teamwork, and sound clinical judgment.

As a community, we have spent years asking how to recruit more primary care clinicians, improve payment, reduce administrative burden, and strengthen team-based care. Those conversations remain essential. But the changing workforce also requires us to ask what role primary care physicians should play within it.

What Are General Internists For?

If we can answer that question with greater clarity, we may discover that the future of our profession lies not in preserving yesterday's job description, but in recovering our oldest strengths and expressing them in new ways.

SGIM was founded on the conviction that general internal medicine had something irreplaceable to offer. As SGIM marks 50 years, we have an opportunity to ask again what that contribution should be in a changing

primary care workforce. General internists are at their best when complexity overwhelms algorithms, illness spans organ systems, and patients need a clinician who can integrate, interpret, and guide. Our challenge is to redesign primary care so there is time, space, and support for that work to flourish again.

At the 2027 SGIM annual meeting, we will launch a new SGIM interest group focused on new models of primary care like the GenMed Consultant. If this resonates with your experience—whether you have offered that hallway consultation or needed one—we invite you to join us.

References

1. Auerbach DI, Buerhaus PI, Staiger DO. Implications of the rapid growth of the Nurse Practitioner Workforce in the US: An examination of recent changes in demographic, employment, and earnings characteristics of nurse practitioners and the implications of those changes. *Health Aff (Millwood)*. 2020 Feb;39(2):273-279. doi:10.1377/hlthaff.2019.00686.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x.

SGIM

FROM THE EDITOR

SMILE MORE: SPOTLIGHTING HIDDEN HURDLES EXPERIENCED BY WOMEN LEADERS

Alia Chisty, MD, MS

Dr. Chisty (achisty@pennstatehealth.psu.edu) is Associate Professor of Medicine at Penn State College of Medicine and one of the Co-Editors-in-Chief of SGIM Forum.

There is a well-recognized gap for women in medicine at the highest levels of leadership. According to the AAMC State of Women in Academic Medicine 2023-24, 45% of full-time faculty identify as women, but only 29% of full professors, 27% of deans, and 25% of department chairs are women.¹ In addition to well-known challenges such as pay disparity, lack of sponsorship, and implicit and explicit biases, women leaders face additional unique challenges. Many responsibilities of women leaders

in academic medicine align with “office housework,” including mentoring, committee work, or DEI-related activities, which lead to non-promotable but important, mission-aligned work. Other tasks, like negotiating for budgets or making difficult decisions about cutting positions, force women leaders to walk the likability-competency tightrope. Women face increased stress due to microaggressions from superiors, peers, and the people under their leadership, which may influence early attri-



FROM THE EDITOR (continued from page 3)

tion from leadership roles. Often, women hold back from applying for leadership positions either because they feel underqualified or have a negative visceral reaction to self-promotion. Some challenges may be further compounded when women have intersecting identities, such as being underrepresented in medicine (URiM).

I have wondered why some smart and strong women leaders I admire have been criticized for their direct leadership styles. Society expects women to display communal traits such as warmth, empathy, and collaboration. However, leadership requires agentic traits like decisiveness and assertiveness. Therefore, women leaders face this difficult social trap—the likeability-competence trap—between being perceived as competent leaders, which can make them less likeable, and meeting the social norms of likeability and warmth, which might make them seem less effective. So how can women leaders be viewed as strong yet approachable and warm but not timid?

Difficult conversations require psychological safety. But building a psychologically safe culture requires high emotional labor. Researchers at MIT describe this as the *empathy tax*, which can disproportionately fall on women leaders. They found that 81.6% of surveyed women in management spend at least 30% of their workweek on caring tasks; 76% of respondents stated that organizational care work falls predominantly on women; and 35.8% of female managers report that this emotional load makes them more likely to leave their job.²

How can women leaders navigate this empathy tax? Palena Neale, PhD in Gender and International Relations and a leadership coach, suggested some tangible strategies. A practical step to address emotional labor is to start naming it and monitoring relational work the same way we track results.³ For example, how many mentoring hours were logged this month? How many letters of recommendation were written?

Secondly, women experience a high cognitive load running dual processes simultaneously, one that is task-oriented and one that monitors relational dynamics of involved parties. This constant multi-tasking can contribute to burnout. We can reduce the mental load by using structured meeting formats and feedback processes, debriefing with trusted peers or mentors, and rotating emotional check-ins across the team.³ By sharing the effort, we can reclaim some mental space.

Thirdly, even though empathetic leadership promotes psychological safety, it cannot be limitless.³ Babcock et al's research demonstrates that women are more likely to take on "non-promotable tasks" like "emotional caretaking" and being equity champions.⁴ By setting office hours, employing cognitive empathy techniques that use curiosity and inquiry to understand perspectives,⁵ and, by ensuring that this work aligns with one's mission, we can help sustain compassion and career longevity.

Finally, women, especially from underrepresented groups, can navigate stereotype threat and identity-based perceptions.³ Women leaders and those navigating intersecting identities are often tasked with addressing diversity efforts for institutions. By building teams with people from varied lived experiences, ensuring that the entire team takes on this responsibility together, and creating networks of peers, mentors, and allies for private debriefing, leaders can combat some of these pressures.

As we reflect on the upcoming 50th anniversary of SGIM, I want to thank SGIM for creating a space where the different voices of academic generalists have been valued and heard. For me personally, SGIM has been my professional home, and through the Education Committee, the Career Advising Program, and the Women and Medicine Commission, I have found like-minded physician leaders who have given me the community I need to pursue work that I believe in. It has also created a supportive space for me to explore some of the challenges I have experienced in my career, like navigating being a woman leader, surviving mid-career crisis, searching for career vitality, and regaining compassion satisfaction. As we look forward to the next 50 years, I hope SGIM continues to be a beacon for other academic generalists who are looking for community, connection, and home.

References

1. Lautenberger DM, Dandar VM. The state of women in academic medicine 2023-2024: Progressing toward equity. *AAMC*. https://store.aamc.org/downloadable/download/sample/sample_id/639/. Published 2024. Accessed October 15, 2026.
2. Ammerman C, Purushothaman D. The empathy tax female leaders pay. *MIT Sloan Management Rvw*. <https://sloanreview.mit.edu/article/the-empathy-tax-female-leaders-pay/>. Published June 8, 2026. Accessed October 15, 2026.
3. Neale PR. The hidden emotional labor draining women leaders. *Psychology Today*. <https://www.psychologytoday.com/us/blog/leading-for-success/202603/the-hidden-emotional-labor-draining-women-leaders>. Published March 4, 2026. Accessed October 15, 2026.
4. Babcock L, Recalde MP, Vesterlund L, et al. Gender differences in accepting and receiving requests for tasks with low promotability. *Am Econ Rev*. 2017; 107(3):714-747.
5. Price N. Cognitive empathy: What it is, why it matters. *Forbes*. <https://www.forbes.com/sites/forbes-booksauthors/2023/08/14/cognitive-empathy-what-it-is-why-it-matters/>. Published August 14, 2023. Accessed October 15, 2026.

TIERING HEALTH CARE APART: WHEN BETTER CARE BECOMES A LUXURY GOOD

Mark D. Schwartz, MD
President, SGIM

"Some things are too important to be reserved for first class. Primary care is one of them."



About 15 years ago, while my father was dying of heart failure in Florida, a bright orange water bottle arrived in the mail. Emblazoned across the side were five letters: MDVIP. Along with the water bottle came a brochure. My wife and I were invited to an all-expenses-paid weekend in Scottsdale, Arizona, to learn about a new model of primary care. Patients would pay an annual membership fee. Physicians would care for a much smaller panel of patients. Access would be easier. Visits would be longer. The doctor would be more available.

I was appalled. At the time, we were academic general internists caring for diverse patient populations in public clinics. The idea of shrinking my practice to a fraction of its size and limiting access to people who could afford a membership fee felt contrary to everything that had drawn me into medicine.

But there was another part of me that had a different reaction. My father was struggling. I was flying back and forth to Florida trying to help him navigate a fragmented healthcare system. He had a primary care physician whom he liked and trusted, but like many, the doctor was overwhelmed. My dad needed more time, coordination, and guidance. He needed someone who could help him manage medications, communicate with specialists, sort through conflicting recommendations, and make sense of a complicated illness.

As I read this glossy brochure, I found myself thinking this would be wonderful for my father. But I also thought, if this idea scales, what happens to everyone else? What would happen if only some people could get this kind of care? Today, that question feels more urgent than ever. The growth of concierge and direct primary care raises a larger question for me: what happens when better care becomes another way Americans are sorted into tiers?

SGIM Forum

Co-Editors-in-Chief

Megan McNamara, MD, MS
Alia Chisty, MD, MS
SGIMForumEditor@gmail.com

Managing Editor

Frank Darmstadt
frank.darmstadt@gmail.com

Past Editor-in-Chief

Michael Landry, MD, MSc, FACP
mlandry@tulane.edu

Editorial Board

Yousaf Ali, MD, MS
Yousaf_Ali@URMC.Rochester.edu
Ebrahim Barkoudah, MD, MPH, MBA
Ebrahim.Barkoudah@UTSouthwestern.edu
Cory Bhowmik, MD, MPH, EdM
abhowmik1@pride.hofstra.edu
Alfred Burger, MD, MS
aburger.md@gmail.com
Claire Ciarkowski, MD
claire.ciarkowski@hsc.utah.edu
Elaine B. Cruz, DO
exc406@case.edu

Jillian M. Gann
gannj@sgim.org
Shanu Gupta, MD, FACP
shanugupta@usf.edu
Tracey L. Henry, MD, MPH, MS
tlhenry@emory.edu
Christopher D. Jackson, MD, FSSCI
christopherjackson@usf.edu
Lubna Khawaja, MD, FHM
khawaja@bcm.edu
Michael Klein, MD
michael-klein@uiowa.edu

Susana Morales, MD
srm2001@med.cornell.edu
Amirala Pasha, DO, JD, FACP
pasha.amirala@mayo.edu
Janani Raveendran, MD, MEd
janani01@hotmail.com
Gaetan Sgro, MD
gaetan.sgro@va.gov
Madhav Sharma, MD, FACP
Madhav.Sharma@stvincenthospital.com
Taylor Smith, MPS
smitht@sgim.org

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



PRESIDENT'S COLUMN (continued from page 5)

Concierge medicine and direct primary care (DPC) continue to grow.¹ Estimates vary, but a substantial number of primary care physicians now practice in models that charge patients membership fees in exchange for enhanced access and smaller patient panels. Physicians may care for 500 patients rather than 2,000 or more. Their patients can often receive same-day appointments, direct messaging, longer visits, and a physician who has the time to coordinate care in ways that many traditional practices struggle to provide.

Many physicians who move into these models report greater professional satisfaction, saying they are *“taking back primary care.”* Many patients report better experiences. I get it. I understand the appeal. Who would not want fewer prior authorizations, fewer administrative burdens, and more time with patients? Who would not want to practice medicine the way they imagined they would when they entered the profession?

The growth of concierge and direct primary care should be understood not only as a change in practice design but also as a signal. It tells us something important about the failure of our current system to support the kind of primary care that patients and physicians want. However, it also raises a troubling question: What happens when access to that better experience depends on ability to pay? The math is harsh. For every full-time primary care physician who shifts to a concierge or DPC practice, as many as 1,500 patients lose their doctor. That reality is multiplying quickly.

The issue extends far beyond health care. America is becoming a stratified, tiered nation. We see it when boarding airplanes. We see it in sports arenas with luxury boxes and exclusive clubs. We see it in housing markets where entire neighborhoods become inaccessible to middle-class families. We see it in education, in travel, in entertainment, and increasingly even in information itself, as premium AI tools and subscription services offer advantages unavailable to those who cannot afford them.

If there is an opportunity to monetize access, someone will find a way to do it. The result goes beyond economic stratification to social separation. We live in different neighborhoods. Attend different schools. Travel differently. Consume different information. Experience different institutions. Increasingly, Americans live in different, tiered worlds.

My wife and I are children of the middle class. She grew up in a rented apartment in Queens, New York. I grew up in a modest house in Brooklyn, New York, that my parents purchased for \$36,000. We attended public schools and city colleges. We graduated from medical school with debt that took years to repay. Forty years later, after careers in academic medicine, we have been very fortunate. We have achieved financial security that neither of our families could have imagined.

But our children face a different reality. Like many young adults, they struggle to envision how they might live near us in New York City. Housing prices have outpaced incomes. Entire neighborhoods that once housed working-class and middle-class families have become inaccessible. The ladder is steeper. The distance between tiers is expanding, and mobility between them is harder.

Health care has always reflected broader social divisions. We have long maintained separate systems for people with commercial insurance, public insurance, and no insurance at all. The 2010 Affordable Care Act narrowed some of those divides. By expanding coverage, it brought millions of Americans into the healthcare system. It represented an important step toward the principle that access to care should not depend entirely on wealth or employment. Yet a new divide is emerging. Insurance still matters, but access increasingly depends on whether patients can afford the price of admission to certain practices.

As primary care physician shortages worsen, the implications are real and significant. Every physician who reduces a panel from 2,000 patients to 500 patients creates better access for some patients while reducing overall access for many others. Viewed individually, these decisions are understandable. Viewed collectively, they are accelerating the shortage of primary care access in a country where almost 100 million already say they do not have a regular source of health care.

Concierge physicians are responding rationally to powerful incentives, and patients are responding rationally to their desires and needs. The issue is larger than their individual choices. It points to deeper failures in how we finance and organize primary care.

Physicians cannot be expected to absorb endless administrative burdens in dysfunctional systems. Patients seek care that is more accessible and responsive. Every physician who leaves traditional practice is casting a vote of no confidence in the system they left behind.

Rather than blame physicians or patients, we should ask why timely access, continuity, coordination, and meaningful relationships have become so difficult to provide in mainstream primary care. Why should these be luxury goods? Why should physicians need to escape the system to practice the kind of medicine they trained to provide?

I do not know the answer. But we should listen to what patients and physicians are telling us. We must innovate to create a system in which the things patients value most—access, continuity, coordination, trust, and relationships—are not available only to those who can afford an extra fee.

That is part of the challenge SGIM is taking up through the Task Force on the Future of Academic Primary Care Internal Medicine that I introduced in last month's SGIM Forum.² We are starting by listening to understand what is driving people toward and away from



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

academic primary care, and what it will take to build models of practice that work better for both patients and physicians.

We think of schools, libraries, and parks as public goods worth preserving because they bring people together across differences. For generations, primary care has quietly served that same role. It is one of the few places where Americans from every walk of life have entered through the same front door. We should be very careful before we lose that.

Fifteen years ago, I wished my father had exactly the kind of physician MDVIP promised. Today I wish for something different: a system in which every patient can receive that kind of care without needing a membership card.

Some things are too important to be reserved for first class. Primary care is one of them.

References

1. Zhu JM, Marsh T, Polsky D, et al. Growth in Number of Practices and Clinicians Participating in Concierge and Direct Primary Care, 2018–23. *Health Aff (Millwood)*. 2025 Dec;44(12):1473-1481. doi:10.1377/hlthaff.2025.00656.
2. Schwartz M. The profession we leave behind. SGIM Forum. <https://www.sgim.org/article/the-profession-we-leave-behind/>. Published October 2026. Accessed October 15, 2026.

SGIM

FROM THE SOCIETY

Q & A ON #PROUDTOBEGIM: EMPOWERING THE NEXT GENERATION OF LEADERS

Eric B. Bass, MD, MPH; Elizabeth Davey, MBA; Francine Jetton, MA, CAE; Shelly-Ann Fluker, MD

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Ms. Davey (daveye@sgim.org) is SGIM's Development Officer. Ms. Jetton (jettonf@sgim.org) is SGIM's Senior Director of Communications and Publications. Dr. Fluker (shelly-ann.fluker@emory.edu) is the Chair of the SGIM 50th Anniversary Celebration Workgroup.

Our society began in 1978 as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM), supported by the American College of Physicians and a grant from the Robert Wood Johnson Foundation. The inaugural national meeting was held in April 1978 with 178 attendees. After membership surged, we rebranded as SGIM and became an independent entity in 1987. Over the last year, SGIM's Development Officer (Liz Davey) has been working with the Senior Director of Communications and Publications (Francine Jetton) to guide a workgroup (led by Shelly-Ann Fluker, MD) formed by Council to develop plans for celebrating SGIM's 50th anniversary in the 2027-28 academic year. Now that we're beginning to implement the plans, we want to share the team's perspective on the importance of the #ProudtobeGIM fundraising campaign that will play a central role in celebrating the 50th anniversary.

EB: What does the 50th Anniversary Celebration Workgroup see as its main objectives?

SAF: The objectives of the workgroup are to: 1) develop plans for communicating with members about the history and accomplishments of SGIM in its first 50 years while also thinking about the vision for the next 10-20 years; 2) formulate recommendations for engaging the membership team in plans for celebrating the 50th anniversary; 3) generate ideas for celebrating the 50th anniversary at the national and regional meetings in the 2027-28 academic year; and 4) provide guidance to the Philanthropy Committee in developing fundraising activities as part of the celebration.

EB: Why are we launching the #ProudtobeGIM fundraising campaign as part of the celebration of SGIM's 50th anniversary?

FJ: A decade ago, SGIM launched #ProudtobeGIM to give general internists a way to explain why their field is special—to medical students and residents weighing a specialty and to patients, colleagues, policymakers, and friends.¹ “We are advisors, we are innovators, we are problem-solvers, we are internists,” the campaign



FROM THE SOCIETY (continued from page 7)

declared. It worked because it named something members already felt but rarely said out loud.

Now as SGIM is preparing to mark its 50th anniversary, we're asking members who felt that pride to put resources behind it. Instead of only telling trainees why GIM is worth choosing, the new #ProudtobeGIM campaign asks established members to make sure the next generation gets the chance to choose a rewarding career in GIM. #ProudtobeGIM isn't just a feeling anymore. It's also a fund.

EB: What is the focus of the new #ProudtobeGIM campaign?

LD: The full name of the campaign conveys its focus: “#ProudtobeGIM: Empowering the Next Generation of Leaders.” For nearly 50 years, SGIM has represented physicians who coordinate care, innovate the future of medicine, and stay with patients for a lifetime. The new campaign is intended to give every member an opportunity to invest directly in the trainees and early-career physicians who will carry GIM forward. Every gift will help fund scholarships, Annual Meeting access, career development programming, and leadership training for the next generation.

Our goal is \$500,000 by June 2028. In just the first four days of the campaign at SGIM's 2026 Annual Meeting, more than 100 members made donations. We have already received donations totaling more than

\$27,000, with gifts ranging from \$5 to \$10,000. This isn't a campaign about a few people making large gifts. It is about all members making a commitment to invest in the future of GIM. Members have spent nearly 50 years building a treasured community. Now members have a chance to give the next generation a reason and opportunity to be #ProudtobeGIM.

EB: As a member of SGIM since 1989 and CEO since 2017, I am #ProudtobeGIM! In appreciation of all that SGIM has done to advance my career in academic GIM and the rewarding careers of many other members of my generation, I am committed to giving my strongest possible support to the #ProudtobeGIM campaign that will help empower the next generation of leaders to meet current challenges and opportunities. Please visit www.sgim.org/proudtobegim to learn more about the #ProudtobeGIM campaign and make a gift to support the next generation of GIM leaders.²

References

1. Why I'm #ProudtobeGIM. *YouTube*. <https://www.youtube.com/watch?v=5BrFLxvs1-o>. Uploaded August 3, 2021. Accessed October 15, 2026.
2. ProudtobeGIM. *SGIM*. <https://www.sgim.org/sgim-community/support-us/proud-to-be-gim/>. Published October 2026. Accessed October 15, 2026.

SGIM

HEALTH POLICY

PREVENTATIVE SCREENING GUIDELINES: POPULATION VS. INDIVIDUAL BENEFIT

Ebrahim Barkoudah, MD, MPH, MBA, FACP; Michael Landry, MD, MSc, FACP

Dr. Barkoudah (ebrahim.barkoudah@utsouthwestern.edu) is the Chief of the Division of Hospital Medicine and Associate Professor of Internal Medicine at UT Southwestern Medical Center in Dallas, Texas. Dr. Landry (mlandry@tulane.edu) is Chief of Medicine at the Southeast Louisiana Veterans Healthcare System and Associate Professor of Internal Medicine and Pediatrics at Tulane University School of Medicine in New Orleans, Louisiana.

Screening did not begin as prevention. It began as containment of health threats to the public. This article traces how screening shifted from protecting the public to protecting the individual, why the frameworks built to guide that shift keep accumulating, and how the burden of reconciling them has landed on the generalist.

From Containment to Prevention

The earliest organized screening programs of the 19th century were quarantine efforts to keep cholera out of the harbor, and tuberculosis programs that identified cases in the population to protect the community. Detection was for the community. The individual was a vector, not a patient. The idea that healthcare systems would screen an asymptomatic



HEALTH POLICY *(continued from page 8)*

person to help that person, rather than to protect the people around them, is younger than insulin, first isolated in 1921.

George Papanicolaou, a Greek-born pathologist at Cornell, described abnormal cervical cells in 1928 and spent two decades ignored by colleagues. By the 1950s, when the Pap smear became routine in American practice, cervical cancer mortality had begun to fall in step with its growing use. The founding ethos of modern preventive medicine was set: earlier is always better.

James Wilson, a British public-health physician, and Gunnar Jungner, a Swedish clinical chemist, set out 10 principles of screening in a 1968 WHO monograph that still anchors every screening debate. The following four carry the argument:¹

1. The disease should be important.
2. The test should be acceptable and accurate.
3. Treatment for early disease should improve outcomes more than treatment for late disease.
4. The cost of finding cases should be reasonable relative to the cost of care.

These criteria, sober and unromantic, were written after Wilson and Jungner watched tuberculosis screening drift in Britain: mass chest X-ray screening kept running after falling TB prevalence had thinned its yield, so each new case cost more to find while the burden on the people being screened stayed the same.

The United States Preventive Services Task Force (USPSTF) was chartered in 1984 to bring the discipline of Wilson and Jungner into American clinical practice. The USPSTF grading system (A through D, plus I for insufficient evidence) became the closest thing American medicine had to a referee. Its method was population-level by design. Benefit was counted as how many people must be screened to prevent one death over a lifetime. The USPSTF was never trying to tell an individual patient what to do. It was trying to guide a primary care physician (PCP) on what to recommend, on average, to a panel of patients. Few of those patients matched the trial population exactly.

This key distinction was lost almost immediately. Specialty societies reviewed the same evidence yet reached different conclusions. The American Cancer Society kept recommending annual mammography starting at 40 while the USPSTF moved to biennial at 50 in 2009, then back to biennial at 40 in 2024.² The American Urological Association recommended PSA discussion at 55 while the USPSTF gave prostate screening a D grade in 2012 and walked it back to a C six years later. Each society was technically correct within its own analytic frame. But the frames were not the same.

The trials that meant to settle these discrepancies did not settle them. The Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial (PLCO) reported no

mortality benefit from PSA screenings at 13-year follow-ups.³ The European Randomized Study of Screening for Prostate Cancer (ERSPC) reported a 20% reduction in prostate cancer mortality with screening at 16 years.⁴ Both trials were large and published in top-tier journals. They reached opposite conclusions because they asked subtly different questions of subtly different populations, with different PSA testing rates in the control arms.

What Accumulation Looks Like in Screening

Every era of screening produced a framework meant to resolve the population-versus-individual tension, and each one was added to the last rather than put in its place. Wilson and Jungner did not replace clinical judgment. The USPSTF did not replace Wilson and Jungner. Shared decision-making did not replace the USPSTF. Risk stratification is not replacing shared decision-making. We have kept all these recommendations, which are layered and sometimes contradictory.

Patients feel the accumulation directly: a 55-year-old man with a family history of prostate cancer sees three physicians and gets three different recommendations on PSA screening. A 42-year-old woman is told by her gynecologist to start mammography and by her internist that she can wait, both citing 2024 breast cancer screening guidelines. A former smoker qualifies for lung cancer screening with low-dose CT, but his insurance wants a separate shared-decision-making visit before paying. The guidelines are real. The infrastructure to personalize them to an individual patient is uneven at best.

The Future of Added Screening

Personalized risk-based screening is the newest proposed answer. Polygenic risk scores. Multi-cancer early detection assays. Risk calculators inside the electronic health record. A 2025 Lancet Public Health meta-analysis put pooled acceptability of risk-based screening itself, screening intensity set by personal risk rather than age alone, at 78% among the public and 86% among healthcare professionals, though the professional estimate carried a confidence interval (64% to 99%) wide enough to counsel caution.⁵ Though the technology is improving and the evidence is real, it is being added on top of everything else. Personalized risk screening is not replacing anything. It will not retire the USPSTF recommendations any more than the USPSTF retired Wilson and Jungner. Medicine will keep all of it.

The Counterargument: Why It Does Not Hold

The strongest counterargument is that this accumulation is fine. Layered guidance is what a mature, evidence-based field looks like. Clinicians are expected to integrate population evidence with individual risk, and the tension between the two is productive, not pathological.



HEALTH POLICY (continued from page 9)

The problem is that the PCP and the patient bear this friction. The researchers finish their trials and publish. The risk-score developers add their expertise. The specialty society adds its recommendations. The USPSTF does its work. None of them are in the room when a patient is handed five frameworks and asked to settle on a plan, and none of them own the conversation that follows. That accountability falls on whoever holds the pen, or the computer mouse, at the end of the visit.

What Health Care Owes

What health care owes is not another framework. The patient and the PCP are owed a cleaner accounting of which framework settles which question, and the discipline to retire an older one rather than append to it. Health care owes PCPs a defensible default: one guideline-concordant starting recommendation for the average-risk patient, which a clinician can deviate from with documentation, rather than a thicket of mutually defensible options with no starting point at all. Patients are entitled to the truth that whether to be screened is often genuinely unsettled, and that the right answer depends as much on what they value as on what the evidence shows.

The honest version of this conversation, with patients, trainees, and colleagues, is shorter than the literature suggests. Screening sometimes saves lives, and screening sometimes harms people the disease would never have touched. Population guidelines and individual decisions are not opposites. They are different tasks.

Health care has spent four decades pretending that a population recommendation and an individual patient's decision could be produced by the same instrument, and that instrument has not held. SGIM members must force the issue. We must press specialty societies and the USPSTF to state plainly which framework answers which question. And we must teach our trainees that a documented default beats a menu of five equally defensible options.

The next era of screening will not succeed by adding another layer. For the first time since Wilson and Jungner, health care will succeed by deciding what to subtract.

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

References

1. Wilson JMG, Jungner G. Principles and practice of screening for disease. Public Health Papers No. 34. World Health Organization. <https://iris.who.int/items/7a67638b-14e3-4dba-b013-dc206ff279d8>. Published 1968. Accessed October 15, 2026.
2. US Preventive Services Task Force; Nicholson WK, Silverstein M, et al. Screening for breast cancer: US Preventive Services Task Force recommendation statement. *JAMA*. 2024;331(22):1918-1930. doi:10.1001/jama.2024.5534.
3. Andriole GL, Crawford ED, Grubb RL, 3rd, et al. Prostate cancer screening in the randomized Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial: Mortality results after 13 years of follow-up. *J Natl Cancer Inst*. 2012;104(2):125-132. doi:10.1093/jnci/djr500. Epub 2012 Jan 6.
4. Hugosson J, Roobol MJ, Mansson M, et al. A 16-yr follow-up of the European Randomized Study of Screening for Prostate Cancer. *Eur Urol*. 2019;76(1):43-51. doi:10.1016/j.eururo.2019.02.009. Epub 2019 Feb 26.
5. Tan NQP, Nargund RS, Douglas EE, et al. Acceptability and perceptions of personalised risk-based cancer screening among health-care professionals and the general public: A systematic review and meta-analysis. *Lancet Public Health*. 2025;10(2):e85-e96. doi:10.1016/S2468-2667(24)00278-0.

SGIM

SGIM
RENEW YOUR
SGIM MEMBERSHIP

Your Focus is Healthcare | Our Focus is You

Go to: sgim.org/renew



WILL I BE OKAY AFTER SURGERY? COUNSELING OUR PATIENTS ON THE ROAD TO RECOVERY

Ryan Munyon, MD; Richard Silbert, MD; Matthew A. Pappas, MD; Michele Fang, MD

Dr. Munyon (rmunyon@pennstatehealth.psu.edu) is an Associate Professor of Medicine at Penn State College of Medicine, and Director of the Consult and Co-Management Service at Penn State Milton S. Hershey Medical Center, in Hershey, PA. Dr. Silbert (silbert.richard@mayo.edu) is an Assistant Professor of Medicine at Mayo Clinic College of Medicine and Science and a consultant in the Division of General Internal Medicine at Mayo Clinic in Rochester, MN. Dr. Pappas (pappasm@ccf.org) is an Assistant Professor of Medicine and academic hospitalist at the Integrated Hospital-based Care Institute at Cleveland Clinic, in Cleveland, OH. Dr. Fang (michele.fang@pennmedicine.upenn.edu) is a Professor of Clinical Medicine at the Perelman School of Medicine, and leads surgical co-management and the medicine consult elective at the Hospital of the University of Pennsylvania in Philadelphia, PA.

From Clinical Updates in Perioperative Medicine, SGIM Annual Meeting 2026

Every time Mr. Frank comes to the office, he talks about his greatest joy: going to a cabin in one of the northern counties of the state and fishing with his grandchildren. However, walking down to the lake has become more difficult due to diabetes and heart failure. In addition, home support has been frayed with the passing of his wife 18 months ago. Now facing a major urologic procedure, he has one major question: “*Will I be okay after surgery?*”

For years, we have answered with the numbers we had on hand: mortality, complications, length of stay, readmissions, and likelihood of discharge to a rehabilitation unit, often limited only to the 30 days after surgery. In a medical environment biased toward procedures, it is important to highlight the risks that matter most to the patient. Many older adults want to know if they’ll maintain themselves after surgery: walk to the mailbox, remember to take their pills, live in their own home, and participate in their community.

The Functional Improvement Trajectories (FIT) After Surgery,¹ by Wijeyesundera et al, is a prospective cohort study of older patients undergoing major noncardiac surgery to determine what percentage of patients would experience worsening postoperative disability or death over a year.

As a group, the presenters at this year’s SGIM Updates in Perioperative Medicine session used a mini-Delphi ranking method for selecting the top seven articles from May 2025 to February 2026 that most informed perioperative care. From these, we chose FIT After Surgery as the most consequential perioperative paper of 2025-26 by unanimous vote.

The Study

Researchers followed 2,007 adults aged 65 and older across 17 Canadian hospitals, all of whom underwent major elective noncardiac surgery requiring a two-night stay between 2019 and 2024. They excluded joint replacements due to the high volume of literature about their disability recovery. They also excluded endovascular procedures, neurosurgery, palliative operations, and patients with severe dementia because of the unique causes of disability in these patients, or because prolonged recovery wasn’t expected.

Researchers collected information on patient demographics as well as social support, functional status, and performance on frailty scales at clinic visits prior to surgery, then at 1, 3, 6, 9, and 12 months postoperatively. Patients were also assessed on the World Health Organization Disability Assessment Schedule (WHODAS) 2.0.² This scale covers six domains of functioning (cognition, mobility, self-care, strength of interactions with other people, life activities, and participation in community events) to assess not only a patient’s cognition, frailty and ability to complete ADLs (Activities of Daily Living)/IADLs (Instrumental Activities of Daily Living), but also the effects of disease on a patient’s participation in society. The follow-up rate was excellent, at 90% for the 12-month endpoint.

The population was similar to most geriatric patients undergoing elective surgery: median age was 72, 43% were frail, 24% had pre-existing moderate disability, 14% suffered from mild cognitive impairment, 85% had an American Society of Anesthesiologists (ASA) Physical Status Class III (severe systemic disease) or IV (severe systemic disease that is a constant threat to life), and nearly half were having surgery for cancer.

“Many older adults want to know, ‘Will I be okay after surgery?’”



BEST PRACTICES *(continued from page 11)*

Primary outcomes were increased disability on the WHODAS scale or death at six months, or a composite of both outcomes at one year.

What They Found

By six months postoperatively, 16.5% of patients had died or experienced a significant decline in function. At 12 months, 20.7% of patients suffered an increase in disability or death. Patients with increased postoperative disability scores reported greater pain, depression, and decisional regret, while also reporting lower quality of life. Functional decline was associated with diminished quality of life and increased reliance on caregivers, further underscoring the need to incorporate functional outcomes into perioperative decision-making and shared decision-making discussions.

Who's at Risk

A few predictors were most associated with the primary and secondary outcomes within 95% confidence intervals across all models: frailty, cognitive impairment, use of a mobility aid, smoking, and open (versus minimally invasive) procedures. Many of these factors have been elucidated in other studies, and this study showed possibly helpful discrimination, with c-statistic values between 0.66 and 0.68. Weak social support didn't have a consistent effect across all models.

What This Means for Us

We can take a few lessons from this study for our perioperative risk assessment discussions with patients planning for major procedures outside of the categories listed above.

- *Make frailty screening routine.* The Clinical Frailty Scale³ has a growing body of evidence to support its prediction of postoperative outcomes. Assessment takes under a minute and relies on discussion of a patient's ADLs, iADLs and general life expectancy.
- *Treat social support as a clinical variable, not a social work afterthought.* Three-quarters of patients in this study went home with no formal support services, and having inadequate support showed a trend toward worse outcomes. It is important to anticipate whether a patient has someone to help with meals, transportation, or dressing prior to surgery.
- *Bring function into the consent conversation.* Make a practice of discussing risks of disability as much as we discuss cardiac risk or survival odds. This is information patients deserve before they decide on surgery, especially given the association between increased disability, regret, and depression.
- *Consider cognition screening.* Cognitive impairment was tested using the Ascertain Dementia 8-item in-

terview⁴ throughout the study. Although this variable wasn't a significant predictor of functional decline, a brief screen can flag patients who may benefit from extra support, caregiver involvement, or closer post-op monitoring.

Although these screenings increase visit complexity, the increasing body of knowledge warrants discussion of frailty, cognition, social support, and function prior to surgery.

Limitations

This observational study of patients completing surgery provides no estimate of the functional decline for patients forgoing surgery. The study used a patient-reported measure for disability scoring and did not compare WHODAS scores against clinical measurements. As has been done in other frailty studies, comorbidities were not combined with frailty status scores in multivariate analysis. Medical comorbidities are already assessed within frailty scoring, so these were not adjusted simultaneously in the model to prevent amplification of these risk factors. Because the construct of frailty encompasses multiple predictors of decline, which components are most predictive remains unclear. Finally, this study does not inform whether targeted interventions might reduce the expected functional decline. Evidence to support the use of exercise or multicomponent prehabilitation interventions to improve outcomes (for which interventions often require complex systems change and institutional investment) remains limited.⁵

Take-Home Points

The FIT After Surgery study provides important evidence to help reframe the central question of perioperative care from “*will this patient survive surgery?*” to “*how will this patient's life be altered by having or not having surgery?*” While most older patients recover from surgery, a significant proportion will experience worsening disability and/or mortality after non-orthopedic or neurosurgical procedures. While the literature continues to hone prediction models, it is often internists, with their longitudinal relationship, who can lead conversations on what matters most to the patient, advocate for robust disability risk discussions, and help guide patients to the best possible choice about surgery.

References

1. Wijeyesundera DN, Alibhai SM, Puts MT, et al. Significant new disability after major non-cardiac surgery in older adults aged 65 years and older in Canada: A multicentre prospective cohort study. *Lancet Healthy Longev.* 2025 Nov;6(11):100789. doi:10.1016/j.lanhl.2025.100789. Epub 2025 Nov 26.



BEST PRACTICES (continued from page 12)

2. Andrews G, Kemp A, Sunderland M, et al. Normative data for the 12 item WHO Disability Assessment Schedule 2.0. *PLoS One*. 2009 Dec 17; 4(12):e8343. doi:10.1371/journal.pone.0008343.
3. Falk EH, Guðnadóttir G, Alfredsson J, et al. The association between the clinical frailty scale and adverse health outcomes in older adults in acute clinical settings – A systematic review of the literature. *Clin Interv Aging*. 2023 Feb 18;18:249-261. doi:10.2147/CIA.S388160. eCollection 2023.
4. Galvin JE, Roe CM, Powlishta KK, et al. The AD8: A brief informant interview to detect dementia. *Neurology*. 2005 Aug 23;65(4):559-64.
5. McIsaac DI, Kidd G, Gillis C, et al. Relative efficacy of prehabilitation interventions and their components: systematic review with network and component network meta-analyses of randomised controlled trials. *BMJ*. 2025 Jan 22;388:e081164. doi:10.1136/bmj-2024-081164.

SGIM

PERSPECTIVE

50 YEARS OF SGIM: HOW WOMEN'S LIVES HAVE CHANGED IN THE WORKPLACE AND AT HOME

Kristin A. Swedish, MD, MPH; Anne Cioletti, MD

Dr. Swedish (kswedish@montefiore.org) is an Associate Professor at Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, New York. Dr. Cioletti (anne.cioletti@hsc.utah.edu) is a Professor at the University of Utah, Salt Lake City, Utah.

As SGIM approaches its 50th anniversary, the Women and Medicine Commission is launching a series to reflect on how academic medicine and SGIM have evolved over the past five decades and where opportunities for growth remain. In this article, we look back at changes that made the workplace more manageable and supportive for women, particularly those in medicine.

Several social and legal factors influenced this progress. An early wave of feminism in the 1960s brought increased attention to women's participation in higher education and the workforce. In addition, laws passed in the 1970s prohibiting sex-based discrimination in higher education expanded opportunities for women to pursue advanced degrees and higher-skilled, longer-term careers.

When SGIM was founded, current essential workplace supports, such as parental leave, child care assistance, lactation accommodations, and discussion of work-life integration, were largely absent, even with increasing numbers of women entering the workforce and medical professions at that time. As participation of women has increased, we highlight some key advances

of the past 50 years, focusing on laws, policies, and cultural shifts that have supported parents, especially mothers, in the workplace.

Parental Leave

The Pregnancy Discrimination Act of 1978, an amendment of Title VII of the Civil Rights Act of 1964, marked an important step toward protecting women in the workplace by prohibiting discrimination based on pregnancy, childbirth, or related medical conditions. This law required companies that offered temporary disability programs to treat pregnancy as any other temporary disability.¹ Conversations about paid maternity leave began to gain traction at the federal level in the 1980s, but meaningful legislative action did not arrive until 1993 when Congress passed the Family and Medical Leave Act (FMLA).¹ This provided eligible employees with up to 12 weeks of unpaid, job-protected leave, which some women were able to use for parental leave. While access to paid family leave has expanded significantly since then, the United States, unlike other high-income countries, still lacks a federal paid family leave program. Today, multiple states have mandatory, comprehensive paid family leaves



PERSPECTIVE (continued from page 13)

and others have voluntary paid family leave systems; however, less than 15% of civilians had access to paid parental leave as of the mid-2010s.¹

Child Care

As more women entered the workforce following World War II, it became increasingly common for children to have two working parents, creating a growing need for reliable child care. For many families, child care remained an informal patchwork of support from relatives, neighbors, and community networks. Federal efforts to address these needs began in 1962 to better support early childhood education and care. In 1971, Congress passed the Comprehensive Child Development Act, which would have expanded access to childcare centers. However, President Nixon vetoed the bill, arguing that child care was primarily a family matter, leaving childcare systems to evolve through state initiatives and grassroots efforts.²

By the 1970s, many working parents still struggled to find affordable, dependable child care. Efforts to expand childcare support gained momentum in the late 1980s and 1990s, particularly as welfare reform policies increasingly emphasized employment. Although childcare funding and programs expanded during this period, access remained uneven and workforce turnover was high.² Even so, the use of formal child care continued to grow. Despite more parents in the workforce today, the American childcare system continues to lag behind other industrialized nations, where often priority is placed on balancing work and child care by providing childcare assistance to all, not only lower income families.²

Breastfeeding and Lactation

In the United States, breastfeeding rates declined from the late 19th century through the 1970s as commercially available infant formula became increasingly popular. The infant feeding industry's aggressive promotion of formula over breastfeeding, including direct-to-consumer advertisement, contributed to a global decline in breastfeeding during that time.³ Additionally, changing social attitudes in the 1960s and 1970s, including the women's movement that encouraged women to reclaim traditionally female experiences on their own terms, helped spark renewed interest in breastfeeding.

Over the next 30 years, the percentage of infants who breastfed and duration of breastfeeding increased in the United States.³ Concerns about infant safety also brought greater attention to infant feeding practices. After reports of infant deaths linked to an unsafe formula product, Congress passed the Infant Formula Act of 1980, establishing federal standards for the safety and nutritional quality of infant formula.³ These efforts helped inform broader international standards adopted by the World Health Organization.

Despite growing recognition of the benefits of breastfeeding, workplace support for lactating parents lagged. Many women returning to work faced challenges finding time and appropriate space to pump breast milk. It was not until 2022 that the Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act expanded federal protections thereby requiring employers to provide reasonable break time and private space for most breastfeeding employees to express milk while at work.⁴

Women at Home

Women's roles at home have evolved over the past decades, although changes have not always occurred evenly across work and family responsibilities. Among different-gender two-parent households in 1965, women spent 8.4 hours per week doing paid work and just over 40 hours per week on housework and child care. In comparison, their male partners spent 42 hours in paid work and about 9 hours per week on housework and child care.⁵ By 2011, women's participation in paid work increased dramatically, rising to 21.4 hours per week. At the same time, work in the house remained at over 30 hours per week. The distribution changed for fathers as well: 37.1 hours doing paid work with about 11 hours of work at home per week.⁵

Today, more women than ever are balancing careers, family responsibilities, and the demands of running a household. While the landscape looks very different from what it did 50 years ago, achieving a sustainable balance between these roles remains a challenge. Although women spend fewer hours on housework than previous generations, they continue to shoulder substantial caregiving responsibilities while participating in the workforce at higher rates, which contributes to increased stress.⁵

"As SGIM approaches its 50th anniversary, the Women and Medicine Commission is launching a series to reflect on how academic medicine and SGIM have evolved over the past five decades and where opportunities for growth remain. In this article, we look back at changes that made the workplace more manageable and supportive for women, particularly those in medicine."



PERSPECTIVE (continued from page 14)

Looking Ahead

Although increasing protections and resources exist for child care, parental leave, and lactation support, more attention is needed. Women continue to struggle with protections for parental leave. Although parental leave and lactation may be covered, the inequity shows up in more nuanced ways: productivity limitations, procedure scheduling, adequate space for lactation, and impact on promotion. Although considerable strides have been made for improved workforce support around child care, lactation, and leave, the work is not done. Early and consistent advocacy by institutions, professional organizations, and individuals is crucial for continued work in this area.

References

1. Sholar MA. The history of family leave policies in the United States. *OAH*. <https://www.oah.org/tah/november-3/the-history-of-family-leave-policies-in-the-united-states/>. Accessed October 15, 2026.
2. Michel S. History of child care in the US. *VCU*. <https://socialwelfare.library.vcu.edu/programs/child-care-the-american-history/>. Published January 19, 2011. Accessed October 15, 2026.
3. Stevens EE, Patric TE, Pickler R. A history of infant feeding. *J Perinat Educ*. 2009 Spring;18(2):32-9. doi: 10.1624/105812409X426314. PMID: 20190854; PMCID: PMC2684040.
4. Congress. HR 3110 – PUMP for Nursing Mothers Act. *Congress.gov*. <https://www.congress.gov/bill/117th-congress/house-bill/3110>. Sponsored May 21, 2021. Accessed October 15, 2026.
5. Parker K, Wang W. Modern parenthood: Roles of moms and dads converge as they balance work and family. *Pew Research Ctr*. <https://www.pewresearch.org/social-trends/2013/03/14/chapter-4-how-mothers-and-fathers-spend-their-time/>. Published March 14, 2013. Accessed October 15, 2026.

SGIM

BREADTH

ARTS AND HUMANITIES IN MEDICINE: TRAINEE REFLECTIONS ON ADDICTION

Iyare Idiakhova, MD; Daniel Cooper, MD; Jennifer Caputo-Seidler, MD; Holly Pursley, MD, MSPH, FACP

Dr. Idiakhova (iyareidiakhova@gmail.com) completed Internal Medicine Residency at the Thomas Hospital Internal Medicine Residency Program in Fairhope, Alabama, in 2026 and is now an Addiction Medicine Fellow at SSM Health/St. Louis University School of Medicine. Dr. Cooper (dpcooper@uabmc.edu) is an Internal Medicine-Pediatrics Chief Resident at the University of Alabama at Birmingham. Dr. Caputo-Seidler (jcaputos@usf.edu) is an Associate Professor of Medicine at the University of South Florida. Dr. Pursley (holly.pursley@infirmarhealth.org) is an Associate Program Director, Thomas Hospital Internal Medicine Residency Program.

The 2026 SGIM Southern Region Arts and Humanities session in New Orleans sparked enthusiastic and emotional audience participation. As presenters shared their narrative and visual works on addiction, difficult patient interactions, death, fear, and joy in the art of medicine, we laughed and shed tears together in a packed conference room that overflowed into the hallway.

The session was chaired by Dr. Jennifer Caputo-Seidler, Associate Professor of Medicine at the University of South Florida, and Dr. Holly Pursley, Associate Program Director, Thomas Hospital Internal Medicine Residency Program. It featured resident physicians from across the Southern Region. Their voices will be show-

cased through a series of articles in SGIM Forum. This first article will cover the area of addiction in order to display the voices of resident physicians from across the Southern Region.

The Uneven Compassion: Alcohol, Opioids, and the Faces of Withdrawal

by Iyare Idiakhova, MD

I have seen withdrawal take many forms: tremors and sweats, moans, and silence. Yet the way those tremors are met depends not just on the patient but also on what substance their body is begging for. When a patient comes in with alcohol withdrawal, there is often a collective urgency. Nurses check Clinical Institute



BREADTH (continued from page 15)

Withdrawal Assessment for Alcohol (CIWA) scores diligently; physicians adjust benzodiazepines with care. There is an undertone of sympathy: *“He’s a drinker, poor guy,”* someone might say. We picture a man who’s fallen on hard times, maybe started drinking to ease stress. Someone we could imagine being or at least knowing. But when the same restlessness, sweat, and pain belong to someone withdrawing from opioids, the tone changes. The air stiffens. *“He’s drug-seeking,”* we hear. *“Don’t let him manipulate you.”* Suddenly, compassion is rationed. Withdrawal becomes a moral issue rather than a medical one. In medicine, we pride ourselves on objectivity; yet, even in our clinical spaces, society’s prejudices find a voice. Alcohol is a familiar demon; one we’ve all shared a drink with. Opioids, however, belong to “them,” the people on the other side of the tent city, the faces on the evening news.

I remember a patient admitted for alcohol withdrawal. His tremors shook the bedrails, but his room was busy with care—warm blankets, gentle words, staff frequently checking, CIWA protocol in place, and receiving Ativan as needed. Later that week, another patient came in for opioid withdrawal. She had the same pallor, the same trembling hands, but she lay alone. Her moans brought irritation, not empathy. *“She’s dramatic,”* someone whispered.

I couldn’t help but think: what if our compassion depended on what we’ve tasted? Maybe alcohol withdrawal feels more relatable because nearly everyone knows what it’s like to drink that glass of wine after a grueling day. We can imagine how it could get away from us. But few can imagine injecting fentanyl under a bridge. The difference is familiarity. The difference is stigma. However, both are illnesses of the same organ, the brain. Both destroy families, take jobs, and leave scars unseen. Both require courage to survive. When we meet patients in withdrawal, we are not meeting their choices. We are meeting their biology, their pain, their stories. We owe them the same compassion whether the substance was poured into a glass or drawn into a syringe. In the end, withdrawal is not a character flaw; it’s the body’s desperate cry for equilibrium. The only difference is in how we choose to listen.

Treat Me Like a Person

by Daniel Cooper, MD

“Are you this man’s doctor?” The seven security guards blinked at me, awaiting a response as I scurried up to the emergency department bathroom. Out of the door blasted a disheveled man with a hiking backpack, dilapidated boots, and a wad of cash in his hand. Security interpreted him as dangerous, but I saw restlessness and fear of relapse. *“Let’s talk,”* I started as he brushed by me, close enough to make security rock on their heels.

We returned to his room with his entourage in pursuit. He began packing his backpack with personal possessions, hospital-issued socks, and plastic silverware alike. I spoke to him, at length, about his medical problems, substance use, and thoughts of not wanting to be “here” any longer. The more we talked, the less he packed. He stayed. Three days later, he was discharged to the substance use program that denied him three admissions prior. When I asked why he stayed, he reminded me of our time in the emergency department and how scared he really was, but *“you talked me down, doc.”*

The next day we admitted another patient who had been here before, multiple times. His presence was marked by frequent refusal of medication, throwing things, and frustration from all parties involved in his care, including himself. Despite this, our stellar nursing staff and medical team treated him with the respect that he may not have earned but nonetheless deserved. At the end of his second week with us, he was anxious to leave the hospital. He had already called his ride, collected his belongings, and self-transferred to his wheelchair. At this point, our team could not convince him to stay, as he used the term *AMA* like it was one of his medical conditions.

Surprisingly, I found him in the same room the next morning. *“Doc,”* he said, *“you know why I stayed?”* I raised my eyebrows in reply, already grinning. *“It was because you said you were disappointed in me. I trust you. I want to get better; I just don’t know how.”*

In the ICU, Dr. K made us chuckle every time she entered a room with her upbeat *“Yoo-hoo, Dr. K here.”* She explained everything she was doing to the patient regardless of whether we thought they could hear us. Dr. K’s tenderheartedness sat in stark contrast to the brutality of the ICU. It was something we had difficulty wrapping our heads around at first—it was so easy to become caught up in the critical illnesses next door, the constant barrage of clinical information, and the needs of the care team. It was exceedingly difficult to deliver humanity to the inhuman illnesses our patients were experiencing. Nonetheless, our team began modeling her lighthearted narration. Jumps in heart rates and spontaneous movement toward our cold stethoscopes accompanied our “one-on-none” discussions. Even though most patients couldn’t necessarily hear us, where was the harm in seeing and speaking to them as people?

At what point do we become a doctor? It is not when we put on a long white coat. It is not when we add a two-letter suffix to the end of our name. It is certainly not when we pass Step One, Two, Three, or beyond. Residency is the opportunity to “experience” without the risks associated with independence. It allows patients to look to us to confirm the day’s plan without them knowing how the opposite was just proposed outside the room.



BREADTH (continued from page 16)

It is the opportunity for the patient to practice their fake story before they present their true, opposite story, to the attending. Residency is our quintessential mortal combat against imposter syndrome.

We become a doctor when we are someone's doctor; when they place their trust in us to heal them. Someone's physician seeks answers on behalf of their patient. To become someone's doctor is not completing a set of checkboxes it is a set of experiences. Thankfully, res-

idency is a set of experiences that creates a myriad of anecdotes that improve the care delivered. No patient will tell us to refer to them as a diagnosis, nor will they have A, B, C, or D emblazoned on their chest. Despite the thrill of central lines and hyponatremia, the most valuable lesson I have learned in residency so far is the humanism, in how to be not-just-a-doctor, but be someone's doctor. That someone is a person, after all.

SGIM

LEADERSHIP AND HEALTHCARE ADMINISTRATION

REFLECTIONS ON THE FISCAL FRONTIER: LESSONS LEARNED AT THE INTERSECTION OF LEADERSHIP AND FINANCE IN ACADEMIC MEDICINE

Sumi K. Sahai, MD

Dr. Sahai (ssahai@mdanderson.org) is a Professor of Medicine at the University of Texas MD Anderson Cancer Center and was previously the Division Chief of General Internal Medicine at the University of Texas Medical Branch at Galveston (UTMB) from 2020-26.

The following column is a reflective piece based on the lecture of the same name given by the author at the 2026 Hess Institute at the Annual SGIM meeting at National Harbor.

In February 2020, when I joined my alma mater as Division Chief of General Medicine, I felt I had a strong understanding of how academic medicine works. I was a proud member of Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) for more than five years. I spent 16 years at another institution rising through the leadership ranks and was recruited to revitalize a division providing inpatient and outpatient care. I mastered clinical operations, faculty development, education, and quality improvement. My leadership philosophy was that of a servant leader. My goal was to transform an insular division and lead it to national prominence. I ended every division meeting with the exhortation to *"think beyond the island."*

The most humbling lesson of my leadership journey is that understanding an academic medical center's finances is very different from how the money flows through the institution. Within a month of starting as Division Chief, our world was turned upside down due to the COVID-19

pandemic. My carefully constructed division roadmap and financial plans were swept away, and it took years to regain our course. Throughout my years as Division Chief, I repeatedly found myself confronting financial realities that challenged my assumptions about authority, accountability, and value. The experience was frustrating, educational, and occasionally disillusioning. Yet it made me a better leader because it forced me to examine the gap between what I felt should happen and what does happen within the system.

One mistake I most readily admit today is accepting a Division Chief position without first obtaining a thorough understanding of the institution's funds-flow model. Even though I thought I had done my due diligence by meeting with Department and Division administrators and asking questions about budgetary authority before accepting the position, the reality was that I had not dug deep enough. At the time, I assumed that because responsibility for outcomes rested with me, authority over resources would follow. I quickly learned that accountability and authority are not always distributed equally within academic medicine. I tell new leaders that understanding funds flow should be among their first priorities



LEADERSHIP AND HEALTHCARE ADMINISTRATION *(continued from page 17)*

because many of the frustrations they will experience can be traced back to financial assumptions that prove incorrect.

The longer I served in leadership, the more I came to appreciate the difference between how academic medicine should function and how it functions. I believe that education should be supported by educational funding, research should be supported by grants, and clinical care should support itself. However, the reality is far messier. Revenue sources overlap, priorities compete, and institutional survival often depends on balancing multiple missions.

Over time, I became less concerned with whether a system was fair and more concerned with understanding the rules under which that system operated. That shift in perspective was one of the most important aspects of my leadership journey.

At first, I saw budgeting primarily as a financial exercise. Eventually, I recognized that budgeting systems shape behavior. What institutions measure becomes what institutions value. The challenge is that not everything that matters can be measured. I encountered many situations in which hospitalists, nocturnists, and primary care physicians provided value to patients and to the health system while appearing financially underproductive on paper. The more I reviewed financial reports, the more convinced I became that numbers tell only part of the story. They can identify problems and trends, but they rarely capture the full value of a clinician, a program, or a mission.

One area where I underestimated the challenge was academic time. When I arrived at UTMB with the goal of building an academic division, I assumed that faculty would naturally embrace scholarship if given protected time. What I failed to appreciate was that faculty pay attention to incentives. If Relative Value Units (RVUs) are rewarded while scholarship receives little recognition, clinicians will predictably focus on RVU-generating activities. I realized that the issue was not faculty motivation. The issue was organizational alignment. We often expressed support for academic work while simultaneously rewarding something else. This experience taught me that organizational culture is revealed through incentives rather than mission statements.

No issue challenged my thinking more than primary care. As a general internist, I believed in the value of primary care, but my leadership experience exposed me to the challenge of proving that value within tra-

ditional financial frameworks. Primary care generates downstream revenue, yet much of that value disappears when viewed through the lens of hierarchical budgeting. I found myself frustrated by systems that could calculate RVU production but struggled to recognize the patient relationships, referrals, admissions, procedures, and

diagnostic testing that primary care physicians make possible. The lesson I learned was not that budgeting systems are wrong, but that they are incomplete. Important decisions are often made using imperfect measures of value.

The issue of graduate medical education funding was similarly enlightening. I remember calculating the dollars associated with resident education and concluding that resources should reach my division. I was surprised to discover how little transparency existed around these funding streams. Over time, I learned that many leaders share similar frustrations. The lesson for me was not simply about money. It was about understanding that institutional priorities and institutional accounting are not always aligned in obvious ways. I also learned that assumptions based on logic and assumptions based on reality are not always the same thing.

If there is one area where I became increasingly vocal during my years as Division Chief, it was faculty advocacy. Some of my most difficult conversations occurred when financial metrics suggested one course of action while my knowledge of the faculty member suggested another. I repeatedly encountered situations in which exceptional productivity was viewed as evidence of success when it reflected exhaustion, understaffing, and unsustainable workloads. Early in my career, I paid too much attention to productivity reports. Later, I learned to ask a different question: what is the human story behind these numbers? That shift fundamentally changed how I approached leadership decisions.

I also became skeptical of the way healthcare organizations discuss cost savings. I spent years watching programs that improve efficiency, reduce waste, and lower costs while receiving less attention than initiatives that generated new revenue. I assumed that demonstrating significant savings would be sufficient to justify continued investment. Experience taught me otherwise. The reality is that healthcare organizations frequently reward revenue generation more than cost avoidance. Cost savings only appear on the balance sheet once and then disappear, but revenue generation is forever. Accepting that reality was difficult because it conflicted with my own

“Early in my career, I paid too much attention to productivity reports. Later, I learned to ask a different question: what is the human story behind these numbers? That shift fundamentally changed how I approached leadership decisions.”



LEADERSHIP AND HEALTHCARE ADMINISTRATION *(continued from page 18)*

sense of logic. Yet understanding it allowed me to become a more effective advocate because I learned how decisions were being evaluated.

The greatest lesson from my time as a Division Chief is that leadership is far more complicated than I appreciated when I began. I loved the people part of the job and helping faculty succeed in their chosen missions. I entered leadership believing that good ideas, hard work, and dedication to the mission would be enough. While those qualities remain essential, they are insufficient without an understanding of how resources are allocated and how organizations make decisions. At the same time, I remain convinced that financial performance alone cannot define success in academic medicine. After nearly six years in the role of Division Chief, it was time for me to step back and return to clinical medicine. I have now returned to

the UT MD Anderson Cancer Center in a purely clinical role, with no leadership responsibilities. My friends and colleagues continue to remark that even though I am enjoying my time not being in charge, “they” will find a way to pull me back in.

If I have one regret, it is that I did not learn some of these lessons earlier. If I have one source of pride, it is that throughout the process I never stopped viewing myself as an advocate for my faculty. Budgets, RVUs, margins, and funds-flow models are all important. But the *true* mission of academic medicine remains education, discovery, and patient care. The numbers matter, but they are not the reason we exist. My experience taught me that the responsibility of leadership is not merely to manage the numbers; it is to ensure that the numbers never become more important than the people behind them.

SGIM