Weill Cornell Medicine

Clinical Scholars Program

for new academic faculty in the sections of hospital in the Division of General Internal Medicine.

Program Directors:
Alice Tang, MD MHPE
Justin Choi, MD MSc
Art Evans, MD MPH

2025 – 2026

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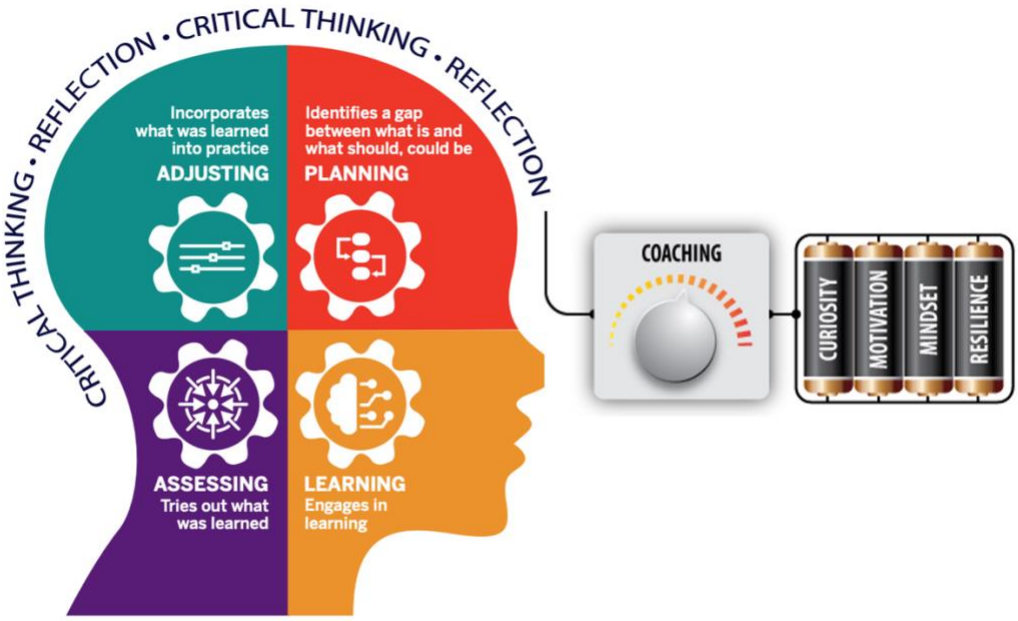
Introduction

The Weill Cornell Clinical Scholars Program is a one-year, intensive faculty development program for early-career hospitalists who aspire to become leaders in academic medicine. Clinical Scholars share a common curriculum while also formulating an individualized learning and career development plan that fits their specific academic interests.

Goal

The overall goal of the program is to cultivate personal growth and adaptive expertise who both explore new concepts (learn) and invent new solutions (innovate).



Cutrer, William B., Bonnie Miller, Martin V. Pusic, George Mejicano, Rajesh S. Mangrulkar, Larry D. Gruppen, Richard E. Hawkins, Susan E. Skochelak, and Donald E. Moore Jr. "Fostering the development of master adaptive learners: a conceptual model to guide skill acquisition in medical education." Academic Medicine 92, no. 1 (2017): 70-75.

Program Objectives

By the end of the Clinical Scholars Program, scholars will:

1. Deliver outstanding patient care and clinical teaching using foundational skills acquired in the didactic curriculum.
2. Identify an academic niche—developing expertise, leadership, and scholarship within it.
3. Harness a mentoring team composed of peers, content experts, and coaches to achieve and sustain a career with vitality.
4. Adopt a growth mindset, using feedback and deliberate practice to develop expertise.

Program Overview

The Clinical Scholars Program consists of: (i) a foundational curriculum in the first half of the year; and (ii) longitudinal peer coaching and group mentoring components throughout the first year.

The curriculum develops skills in foundational areas of academic medicine—clinical teaching, clinical epidemiology and advanced evidence-based medicine, clinical reasoning, quality improvement and patient safety, research methods and academic writing, ethics and humanism, leadership, point-of-care ultrasound, and artificial intelligence.

The program also offers longitudinal peer coaching and group peer mentoring to foster self-reflection, strengths identification, values clarification, career planning, goal-setting, and feedback for deliberate practice and development of expertise.

During the second half of the year, scholars identify an academic focus, assemble a mentoring team, and develop a scholarly project. In their second year, scholars will be supported by peers and program directors to execute their scholarly project and create scholarship (including the option to participate in a 12-week scholarly writing course).

Program Structure

This is a one-year program that includes:

- 8 weeks of common curriculum (interactive small-group skills development)
- 4 weeks of vacation and holidays
- 20–24 weeks of clinical work as hospitalist (primarily days but some nights)
- Longitudinal peer coaching and facilitated group peer mentoring

Financial compensation will depend on rank and amount of clinical work the clinical scholar chooses (flexible), ranging from 75% to 100% of fulltime faculty salary.

Sample Year-at-a-Glance Schedule (Year 1)

Week*	Key Activities
1 (July 1)	Orientation
2 – 6	On/Off PA Service
7	Curriculum Learning Block 1
8	Off for ABIM Exam
9	Curriculum Learning Block 2
10 – 15	On/Off PA and Housestaff Service
16	Curriculum Learning Block 3
17	Off
18	Curriculum Learning Block 4
19 – 22	On/Off PA and/or Housestaff Service
23 – 24	Curriculum Learning Blocks 5 & 6
25 – 28	On/Off PA Service
29 – 30	Curriculum Learning Blocks 7 & 8
31 – 51	On/Off PA Service Assemble mentoring team; develop scholarly proposal
52	CSP Celebration of Growth (Graduation Event)

*Monthly Colorado-Cornell EBM Case Conferences

Clinical Scholars Program Expectations

1. Attend all Curricular Elements for the Clinical Scholars Program

- Review all curricular sessions on your outlook calendar; If you anticipate a conflict, please notify program directors (Tang/Choi/Evans) ASAP.
- If you are unable to attend a session due to illness or emergency, please notify the faculty leading the session, the program directors, and Faudia Pasha
- Some sessions may require clinical shift coverage and/or schedule swaps (in the second half of the year). Please check your clinical schedule EARLY and plan accordingly.

2. Engage in Coaching with the EXCEL (Excellence through Coaching, Evaluation, and Learning) Program

- **Before First Housestaff Rotation (September):**
    i. Meet with EXCEL Coach to get to know each other, reflect on your strengths and opportunities for growth, and set goals for the rotation.
    ii. Review your housestaff team expectations document that you created.
    iii. Coordinate two EXCEL Coaching sessions where your coach can observe you for 30–60 minutes on morning rounds. Meet in the office 15 minutes prior to rounds and then again in the afternoon for 30 minutes of coaching.
- **September–March:** Meet with EXCEL Coach to review feedback from PAs and colleagues; create goals around interprofessional collaboration and clinical care.

3. Complete Clinical Teaching Requirement & Educator's Portfolio

- Complete 12 hours of clinical teaching
    i. 3 virtual journal club-style EBM teaching sessions with first year medical students (70min each) – Tentatively 3/18, 3/24, 4/29/2026
- Enter teaching and feedback in Educator's Portfolio & review with coach
  Please access on the Hospital Medicine OneDrive: Promotion for Clinician Educators

4. Create a Scholarly Proposal (Year 1)

- Develop a scholarly proposal to execute over the next 1–2 years that addresses a 'problem' you have within your academic focus of interest. See Table on next page.
- During the first half of the year, you will identify a specific problem in your field and articulate the existing gap that align with your long-term career goals.
- In the second half of the year, you will workshop your draft proposal in a series of group meetings with other Clinical Scholars and CSP directors. Please reserve the following dates (3:00 – 4:30 pm):
  March 4 | April 1 | April 22 | May 13
- Your written proposal (5 page maximum, excluding references and appendices) will be due at the end of the year. You will deliver a 5–7-minute presentation at the Clinical Scholars Program Celebration of Growth on **June 10, 6:00 – 8:00 pm**

- The proposal will consist of the following sections:

Section	Key Questions to Address	Considerations
Background	What specific problem exists? What gap in knowledge, practice, or education does it create? Why does it matter now?	Conduct a targeted needs assessment; perform literature review; survey/interview stakeholders
Project Plan	What study/intervention will fill this gap? What methodology (quantitative, qualitative, mixed-methods)? What outcome measures?	Align methods to questions/objectives
Goals Alignment	How does this project fit into your overall career goals and area of expertise you hope to develop?	
Timeline and Budget	What is the timeframe in which you plan to complete this project? What resources are required?	Major milestones; funding; personnel; software; equipment
Mentorship	What mentor(s) will help you successfully complete the project? How will you motivate them to be involved (i.e., How may they benefit from supporting you and this project?)	Consider content experts, methodological experts, peers, stakeholders who may have valuable perspectives or access to resources you may need

5. Implement Scholarly Proposal and Create Scholarship (Year 2)

- Clinical Scholars are expected to transform their proposal into scholarly output.
- Scholarly outputs may be peer-reviewed publication, abstract/poster at regional or national meeting, curriculum with formal evaluation, quality improvement project with measurable impact, secured grant funding, digital scholarship, invited talk, etc.
- Clinical Scholars may choose to pursue formal academic/scholarly writing training by enrolling in *Scholarly Writing Incubator for Clinicians* (12-week course, Sept–Dec)

Artificial Intelligence in Medicine

Total Hours: 20

Course Directors

Karlen Ulubabyan, MD
Assistant Professor, Hospital Medicine
Eulho (EJ) Jung, PhD
Assistant Professor, Department of Health Professions Education (HPE)
Uniformed Service University of the Health Sciences

Goal: Develop foundational knowledge, practical skills, and an ethical framework to thoughtfully and responsibly integrate generative artificial intelligence to augment clinical care, medical education, and scholarship.

Objectives

By the end of the course, participants will be able to:

- Describe how large language models (LLMs) function and generate outputs.
- Apply prompt engineering techniques to optimize LLM outputs.
- Recognize benefits and limitations of generative AI in clinical and educational contexts.
- Identify and mitigate risks including hallucinations, privacy breaches, and algorithmic bias.
- Navigate institutional and legal frameworks surrounding responsible AI use.
- Demonstrate practical applications of GAI in clinical reasoning, teaching, and scholarly writing.

Description

This course equips faculty with the knowledge and skills to responsibly integrate generative artificial intelligence (GAI) and large language models (LLMs) into clinical practice, education, and research. Participants will explore core AI concepts, learn practical applications and develop competency in applying GAI technology across varied use cases. Sessions will be interactive, including discussion of controversial aspects of AI integration and hands-on exercises using simulated patient cases to illustrate key clinical and educational applications.

The curriculum aims to reinforce best practices and professional guidelines to support responsible application of GAI technology, with careful review of key ethical considerations including issues of equity, patient privacy, potential for inaccuracy, and the need for transparency and physician oversight.

By the end of the course, participants will have developed a foundation to responsibly leverage AI to advance clinical and scholarly goals.

Critical Readings

1. American Medical Association. (2019). *AMA principles for artificial intelligence in health care*. https://www.ama-assn.org/system/files/ama-ai-principles.pdf
2. Triola MM, Rodman A. *Generative AI and the Future of Medical Education: Core Competencies for Educators and Learners*. Acad Med. 2024;99(5):622–626.
3. Tu W, Song H, Lakhani P, et al. Towards conversational diagnostic artificial intelligence. *Nature*. 2025;628(8015):909–916. doi:10.1038/s41586-025-08866-7. https://www.nature.com/articles/s41586-025-08866-7

Clinical Reasoning

Total Hours: 25

Course Directors

Justin Choi, MD, MSc
Assistant Professor, Hospital Medicine
Brendan Reilly, MD
Honorary Professor of Medicine, Geisel School of Medicine at Dartmouth

Goal: Provide foundational knowledge and skills in teaching and learning clinical reasoning

Objectives

By the end of the week, participants should be able to:

- Describe relevant theory and models of clinical reasoning and decision making.
- Recognize cognitive biases and errors in clinical reasoning.
- Apply theory-informed, evidence-based strategies for teaching and assessing clinical reasoning.
- Develop best practices for teaching clinical reasoning in the clinical environment and in team settings.

Description

Clinical reasoning is a fundamental skill in clinical practice that refers to *how* clinicians think (cognitive processes) in making informed judgments and decisions about patient care. As team leaders and educators, academic hospitalists must understand concepts of clinical reasoning, and strategies for teaching and assessing it, for improving patient safety, quality of care, and education of trainees. This course aims to provide foundational knowledge and skills in teaching and learning clinical reasoning. Topics include diagnostic reasoning, management reasoning, models of decision making, cognitive biases, assessment, team decision making, uncertainty, and others.

Critical Readings

Kassirer JP, Kopelman RI. Learning clinical reasoning. Baltimore, MD Williams & Wilkins. 1991.

Eva KW. What every teacher needs to know about clinical reasoning. Med Educ. 2005 Jan;39(1):98-106.

Bowen, J. Educational Strategies to Promote Clinical Diagnostic Reasoning; N Engl J Med 2006; 355: 2217-2225.

Reilly, B. Inconvenient truths about effective clinical teaching; Lancet 2007; 370: 705–711.

Croskerry P. A universal model of diagnostic reasoning. Acad Med. 2009 Aug;84(8):1022-8.

Graber ML. Educational strategies to reduce diagnostic error: can you teach this stuff? Adv Health Sci Educ Theory Pract. 2009 Sep;14 Suppl 1:63-9.

Kahneman, Daniel. *Thinking, Fast and Slow*. New York: Farrar, Straus and Giroux, 2011.
Rencic J. Twelve tips for teaching expertise in clinical reasoning. Med Teach. 2011;33(11):887-92.

Simpkin AL, Schwartzstein RM. Tolerating Uncertainty — The Next Medical Revolution?; N Engl J Med 2016; 375: 1713-1715.

Norman GR, Monteiro SD, Sherbino J, Ilgen JS, Schmidt HG, Mamede S. The Causes of Errors in Clinical Reasoning: Cognitive Biases, Knowledge Deficits, and Dual Process Thinking. Acad Med. 2017;92(1):23-30

Clinical Teaching

Total Hours: 25

Course Directors

Alice Tang, MD, MHPE
Assistant Professor, Hospital Medicine
Assistant Chief for Education, Hospital Medicine
Shira Sachs, MD
Assistant Professor, Hospital Medicine
Associate Program Director, Internal Medicine Residency Program
Co-Director, Medical Education Track, Internal Medicine Residency Program

Goal: Create a shared mental model and skillset for best practices in clinical teaching to be effective clinician educators.

Objectives

By the end of the week, participants should be able to:

- Identify factors contributing to the "learning climate"
- Apply strategies to create a supportive learning climate which fosters trainee resiliency and growth
- Create optimal balance between autonomy and supervision to maximize trainees' performance
- Distinguish formative from summative assessment
- Use direct observation to provide low-inference feedback and competence-based assessments
- Apply best practices for providing feedback and establishing a coaching relationship
- Describe the role of goals and objectives in the development of teaching sessions and curricula
- Incorporate learning theory to design effective teaching sessions and curricula
- Use AI tools to enhance just-in-time teaching and assessment

Description

This course will use a combination of small group discussion, self-reflection, journal club, role play, and peer coaching to develop foundational skills in clinical teaching. Topics covered include best practices for establishing the learning climate, bedside teaching, facilitating resident autonomy, setting expectations, feedback, assessment, and peer observation. It hones skills of delivering a chalk talk or other teaching session through incorporating learning theory, goals and objectives, and optimal AI-use.

Following this course, scholars will practice their clinical teaching skills in the authentic teaching environment on the general medicine housestaff service with direct observation and feedback from an assigned EXCEL Coach.

Critical Readings

Brodsky, Tess & Newman. Designing a Teaching Session: The Who, Why, What and How. Med Ed Portal. 2011.

B Reilly. Inconvenient Truths about Effective Clinical Teaching. The Lancet. 2007.

D Duncan & A S Southon. Six Ways to Discourage Learning. University of Colorado & American Astronomical Society Education Office.

T Beckman & M Lee. Proposal for a Collaborative Approach to Clinical Teaching. Mayo Clinic Proceedings. 2009.

S Ramani & S Krackov. Twelve Tips for Giving Feedback Effectively in the Clinical Environment. Medical Teacher. 2012

Atul Gawande's article on coaching in medicine:
https://www.newyorker.com/magazine/2011/10/03/personal-best

Ende, J. (1983). Feedback in clinical medical education. JAMA: The Journal of the American Medical Association, 250(6), 777–781.

Kathleen Finn, Victor Chiappa, Alberto Puig & Daniel P. Hunt (2011) How to become a better clinical teacher: A collaborative peer observation process, Medical Teacher, 33:2, 151-155.

Clinical Epidemiology and Advanced EBM

Course Directors

Total Hours: 41

Arthur Evans, MD, MPH
Professor of Medicine
Chief Emeritus, Hospital Medicine
Brett Fischer, MD
Assistant Professor, Hospital Medicine
Director, EBM and Biostatistics Course for WCM Medical Students
Director, EBM Curriculum, Internal Medicine Residency Program

Goal: Develop the skills to interpret and apply EBM concepts to patient care and teach trainees.

Objectives

A sampling of the learning objectives include:

1. **Diagnostic Test Interpretation and Clinical Reasoning**
   - Correctly interpret and calculate test characteristics (sensitivity, specificity, likelihood ratios).
   - Accurately interpret ROC curves and identify best cutpoints.
   - Appreciate various biases in studies of diagnostic tests, such as work-up bias and bias from indeterminate results.
   - Apply universal principles to make decisions about when it is best to observe, test, or treat.
2. **Study Results: Interpretation and Application to Individual Patients**
   - Appreciate difficulties and ambiguities of describing risks in quantitative and qualitative terms.
   - Calculate NNT and risk difference from relative risks and odds ratios.
   - Understand the limitations of hazard ratios.
   - Appreciate the impact of heterogeneity on results interpretation and application.
   - Correctly interpret P-values and confidence intervals.
3. **Critical Appraisal**
   - Use a standardized approach to assess internal validity and external validity of clinical trials, observational studies, and systematic reviews and meta-analyses.

Description

All teaching is problem-based and interactive, where learners are encouraged to struggle, fail, and persist until they feel comfortable in teaching the concepts to others. Successfully applying research findings reported in the literature to an individual patient's unique circumstances requires an ability to judge the validity (internal and external) of the reported results and an ability to translate research findings into something clinically meaningful. This requires a robust appreciation for the role of chance, bias, and confounding in producing erroneous conclusions. It also requires skills in the interpretation and use of likelihood ratios, ROC curves, odds ratios, relative risk reductions, hazard ratios, regression coefficients, P-values, and confidence intervals.

Critical Readings

Diagnostic Test Interpretation and Clinical Reasoning:

Baduashvili A, Guyatt G, Evans AT. ROC Anatomy-Getting the Most Out of Your Diagnostic Test. JGIM. 2019.

Fischer BG, Evans AT. SpPin and SnNout Are Not Enough. It's Time to Fully Embrace Likelihood Ratios and Probabilistic Reasoning to Achieve Diagnostic Excellence. JGIM. 2023.

Users' Guides to the Medical Literature. Chapter 18: Diagnostic Tests.

Lachs MS, et al. Spectrum bias in the evaluation of diagnostic tests: lessons from the rapid dipstick test for urinary tract infection. Ann Intern Med. 1992.

Punglia RS, et al. Effect of verification bias on screening for prostate cancer by measurement of prostate-specific antigen. NEJM. 2003.

Pauker SG, Kassirer JP. Therapeutic decision making: a cost-benefit analysis. NEJM. 1975.

Pauker SG, Kassirer JP. The threshold approach to clinical decision making. NEJM. 1980.

Study Results: Interpretation and Application to Individual Patients

Baduashvili A, Evans AT, Cutler T. How to understand and teach P values: a diagnostic test framework. JCE. 2020.

Nuzzo R. Scientific method: statistical errors. Nature. 2014.

Goodman SN. Of P-values and Bayes: a modest proposal. Epidemiology. 2001.

Ioannidis JP. Why most published research findings are false. PLoS Med. 2005.

Diamond GA, Kaul S. Prior convictions: Bayesian approaches to the analysis and interpretation of clinical megatrials. JACC. 2004.

Greenland S, et al. Statistical tests, P values, confidence intervals, and power: a guide to misinterpretations. Eur J Epidemiol. 2016;31(4):337-350. doi:10.1007/s10654-016-0149-3

Perneger TV, Agoritsas T. Doctors and patients' susceptibility to framing bias: a randomized trial. JGIM. 2011.

Spruance SL, et al. Hazard ratio in clinical trials. Antimicrob Agents Chemother. 2004.

Vickers AJ, Kent DM. The Lake Wobegon Effect: Why Most Patients Are at Below-Average Risk. Ann Intern Med. 2015.

Hawkins AT, Samuels LR. Use of Confidence Intervals in Interpreting Nonstatistically Significant Results. JAMA. 2021.

Goligher EC, et al. Extracorporeal Membrane Oxygenation for Severe Acute Respiratory Distress Syndrome and Posterior Probability of Mortality Benefit in a Post Hoc Bayesian Analysis of a Randomized Clinical Trial. JAMA. 2018.

Critical Appraisal

Users' Guides to the Medical Literature Chapters

7: Therapy (Randomized Trials)

12.4: Composite End Points

13.4: Surrogate Outcomes

14: Harm (Observational Studies)

15.2: Adjusted Analyses

20: Prognosis

22 and 23: Systematic Review and Meta-analysis

Ethics and Humanism

Total Hours: 20

Course Directors

Laura Kolbe, MD
Assistant Professor, Hospital Medicine
Clinical Ethicist, Weill Cornell Medicine

Nekee Pandya, MD
Assistant Professor, Hospital Medicine
Co-Director, Compassionate Care Curriculum, Internal Medicine Residency Program
Clinical Ethicist, Weill Cornell Medicine

Goals & Objectives: Introduce clinical scholars to conceptual frameworks and real-world problem-solving applications of common and emerging topics in contemporary medical ethics and in the care of select patient populations.

Description

This course surveys the ethical issues facing physicians, medical trainees, and patients. Participants will learn how to confront ethical challenges in real time and will examine the various methods of resolving ethical conflicts on the wards. Participants will learn to untangle complex ethical and clinical problems using frameworks including principlism, ethical pragmatism, structural competence, trauma-informed care, and narrative medicine. They will also become acquainted with culturally and legally relevant factors in ethical decision-making pertinent to New York State and New York City.

Through a combination of lectures and interactive case-based sessions, participants will become confident ethical reasoners and team leaders on topics pertinent to hospital medicine, ranging from the care of incapacitated patients, the practice of trauma-informed care, the management of “unsafe” discharges, the rights and duties of healthcare proxies and surrogate decision-makers, the recognition and management of moral distress and moral injury, and the foundations of ethical and effective team-building and debriefing. Participants will also gain clinical skills in trauma-informed care and in MAT (medication-assisted treatment) for patients with substance use disorders.

Critical Readings

Gerber, Megan, MD, FACP. "Trauma-Informed Care." American College of Physicians New York Chapter YouTube channel. Available at: https://www.youtube.com/watch?v=NwKzSKUzB0k

Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014 Feb;103:126-133.

Scales D. Communicating Against the Current. J Health Care Poor Underserved. 2018;29(3):1046-1053.

Scales D, Gorman J. Screening for Information Environments: A Role for Health Systems to Address the Misinformation Crisis. J Prim Care Community Health. 2022 Jan-Dec;13:21501319221087870.

Vien A, Kolbe L, Fried M. 5 Pearls on Stigma in Opioid-Use Disorder. CORE IM podcast. Available at: https://www.coreimpodcast.com/2021/09/29/5-pearls-on-stigma-in-opioid-use-disorder/

Gabbay E, McCarthy MW, Fins JJ. The Care of the Ultra-Orthodox Jewish Patient. *J Relig Health.* 2017;56(2):545-560.

McCarthy MW, Real de Asua D, Fins JJ. The Rise of Hospitalists: An Opportunity for Clinical Ethics. *J Clin Ethics.* 2017;28(4):325-332.

McCarthy MW, Fins JJ. Teaching Clinical Ethics at the Bedside: William Osler and the Essential Role of the Hospitalist. *AMA J Ethics. 2017;19(6):528-532.*

Kolbe L. Hospital Discharge as a Locus for Curiosity, Affirmation, and Advocacy. Perspect Biol Med. 2022;65(2):221-231.

Kolbe L, Nelson RH, Robertson-Preidler J, Schuman O, de Melo-Martín I. Is a Video Worth a Thousand Words? AMA J Ethics. 2022 Jul 1;24(7):E549-555.

Zaharias G. What is narrative-based medicine? Narrative-based medicine 1. Can Fam Physician. 2018 Mar;64(3):176-180.

Coyle, Daniel. The Culture Code: the secrets of highly successful groups. New York, Bantam, 2018.

Amy C. Edmondson, Richard M. Bohmer and Gary P. Pisano. *Disrupted Routines: Team Learning and New Technology Implementation in Hospitals*. Administrative Science Quarterly. Vol 46, No 4. 2001. pp. 685-716.

Academic Writing

Total Hours: 15

Course Directors

Justin Choi, MD, MSc
Assistant Professor of Medicine
Laura Kolbe, MD
Assistant Professor, Hospital Medicine
Clinical Ethicist, Weill Cornell Medicine

Goal: To support clinicians in transforming an initial idea or ongoing project into a full, submission-ready manuscript for a peer-reviewed journal.

Objectives

By the end of the course, participants should be able to:

- Develop a manuscript idea aligned with a scholarly conversation.
- Frame a compelling problem and craft a reader-centered argument.
- Implement a structured process of planning, writing, and revising.
- Apply principles of scholarly style, structure, and tone to enhance writing quality.
- Conduct and respond to an in-class peer review; submit to a peer-reviewed journal.

Description

This is an optional 12-week course (called *Scholarly Writing Incubator for Clinicians*) designed to support clinicians in transforming an initial idea or ongoing project into a full, submission-ready manuscript for a peer-reviewed journal. The course blends self-paced modules, interactive exercises, writing time, peer support, and personalized feedback to develop writing skills, scholarly productivity, and build a community of scholars. Topics include how to join a scholarly conversation, problem articulation, crafting arguments, macro- and microrevising, peer review, data visualization, narrative writing, and planning for writing.

All academic writing genres are welcome—perspectives, research reports, reviews, conceptual essays, narratives, etc. Calls for applications will be sent July for course start date in first week of September.

Critical Readings

AMA Manual of Style: A Guide for Authors and Editors. 11th ed.

Belcher WL. Writing Your Journal Article in Twelve Weeks. 2nd Edition. University of Chicago Press; 2019.

Booth W, Colomb G, Williams J. The Craft of Research. 5th Edition. University of Chicago Press; 2024.

Browner WS. Publishing and presenting clinical research. Lippincott Williams & Wilkins; 2012 Mar 19.

Clark RP. Murder Your Darlings: And other gentle writing advice from Aristotle to Zinsser. Little, Brown Spark; 2020 Jan 21.

Klass, Perri. "Morality Tales." *Harvard Medicine Magazine*, 15 Aug. 2024, https://magazine.hms.harvard.edu/articles/morality-tales.

Lamott A. Bird by bird: Some instructions on writing and life. Vintage; 1995 Sep 1.

Lingard L, Watling C. Story, not study: 30 brief lessons to inspire health researchers as writers. Cham: Springer International Publishing; 2021 Apr 26.

Silvia PJ. How to write a lot: A practical guide to productive academic writing. American Psychological Association; 2018 Sep 25.

Tufte ER. The visual display of quantitative information. Cheshire, CT: Graphics press; 1997.

White EB, Strunk W. The elements of style. 4th ed.

Zeiger M. Essentials of writing biomedical research papers. 2nd ed.

Zinsser WK. On writing well: The classic guide to writing nonfiction. Quill/A Harper Collins Books; 2001.

Quality and Patient Safety

Total Hours: 18

Course Directors

Jennifer Lee, MD
Associate Professor, Hospital Medicine
Assistant Dean, Program Development and Operations

Rebecca Berger, MD
Assistant Professor, Hospital Medicine
Assistant Chief, Hospital Medicine
Epic Clinical Leadership Group Member and Hospital Medicine Epic Champion

Goal: Exposure to the fundamentals of quality assurance, quality improvement and patient safety essential for aligning operational and regulatory imperatives of the institution with the academic and clinical mission of hospital medicine physicians

Objectives

By the end of the course, participants should be able to:

- Learn and integrate rigorous QI and patient safety tools into clinical practice.
- Develop skills to become effective leaders and mentors in clinical excellence.
- Apply simple tools to maintain personal and project team wellness to prevent burnout and overcome barriers to success.
- Explore opportunities for academic productivity through scholarship in QI.

Description

Career success at academic medical institutions has been centered on achievements in the tripartite mission of research, education and patient care. With continuing changes to the academic environment and expectations in healthcare delivery, new challenges arise for many junior faculty without traditional research training in balancing those three domains and achieving professional fulfillment of the mission. Training in advanced quality improvement (QI) and safety science provides junior faculty with a pathway to achieve academic scholarship through curriculum development, mentorship and publications.

Critical Readings

Davidoff F, Batalden P, Stevens D, Ogrinc G, Mooney S. *Publication Guidelines For Quality Improvement In Health Care: Evolution Of The SQUIRE Project*. Qual Saf Health Care 2008;17(Suppl I):i3–i9

Neeman N, Sehgal NL. *Perspective: A Road Map for Academic Departments to Promote Scholarship in Quality Improvement and Patient Safety.* Acad Med 2012;87(2):168-71.

Scott SD, Hirschinger LE, Cox KR, et al. *The Natural History of Recovery for the Healthcare Provider "Second Victim" After Adverse Patient Events.* BMJ Quality & Safety 2009;18:325-330.

Schiff GD. *Diagnosis and Diagnostic Errors: Time For A New Paradigm.* BMJ Qual Saf 2013. doi:10.1136/bmjqs-2013-002426.

Amalberti R, Auroy Y, Berwick D, Barach P. *Five System Barriers to Achieving Ultrasafe Health Care.* Ann Intern Med 2005; 142(9)756-765.

Siddique SM, Ketwaroo G, Newberry C, Mathews S, V Khungar,1 Mehta SJ. *How to Incorporate Quality Improvement and Patient Safety Projects in Your Training.* Gastroenterology 2018;154:1564–1568.

Langley GL, et al. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd Edition. San Francisco, California, USA: Jossey-Bass Publishers; 2009.

Wachter RM. Understanding Patient Safety. 3rd Edition. McGraw-Hill Education; 2018.

Leadership

Total Hours: 28

Course Directors

Maya Hogg, MD
Assistant Professor, Hospital Medicine
Chief of Medicine, NewYork-Presbyterian Lower Manhattan Hospital
Vice Chair, Weill Department of Medicine

Anand Singh, MD, MSc
Assistant Professor, Hospital Medicine
Chief, Hospital Medicine, NewYork-Presbyterian Brooklyn Methodist Hospital

Goal: Develop foundational skills to be effective leaders in any context: clinical teams, research collaboratives, educational programs, hospital operations, and more.

Objectives

By the end of the course, participants should be able to:

- Learn tools and methods for improving self-awareness and how we motivate others.
- Develop leadership skills in team dynamics, conflict resolution, and negotiation.
- Learn the key building blocks for creating a successful growth-oriented culture.
- Develop skills to understand and promote diversity in academic medicine.
- Design personalized plans for career and personal growth that promote flow, productivity, and vitality.

Description

As hospitalists, we are called upon to serve a variety of leadership roles throughout our careers, whether it be in patient care, medical education, research collaborations, or hospital operations. These roles require us to utilize unique skill sets in navigating complex social dynamics to advocate for ourselves, our colleagues, and our patients, to ensure success and the best possible outcomes. This course aims to give new hospitalists the foundational skills necessary to become the next generation of leaders in academic hospital medicine, to empower them to build a culture of growth and success. Participants will engage in activities that will promote awareness of themselves and of how they interact, impact, and motivate others. They will apply their own experiences to discussions on conflict resolution, negotiation, wellness, and inclusivity. They will hear from local leaders in the field and design a personalized strategy and roadmap for their own career development and personal growth. It is our hope that clinical scholars will not only be inspired but also have the drive and knowledge to inspire others. This course will tie together and reinforce key concepts introduced in the Group Peer Mentoring program using a leadership lens.

Critical Readings

The Culture Code: The Secrets of Highly Successful Groups by Daniel Coyle, Will Damron

How to Know a Person: The Art of Seeing Others Deeply and Being Deeply Seen by David Brooks

Extreme Ownership by Jocko Willink, Leif Babin

The Dichotomy of Leadership by Jocko Willink, Leif Babin

The Power of Moments by Chip and Dan Heath

Think Again: The Power of Knowing What You Don't Know by Adam Grant

Drive: The Surprising Truth About What Motivates Us by Daniel Pink

Point-of-Care Ultrasound (POCUS)

Total Hours: 40

Course Directors

Tanping Wong, MD
Associate Professor, Hospital Medicine
Director, Weill Cornell POCUS Fellowship

Goals & Objectives

This course is designed to achieve competency in image acquisition, image interpretation, and clinical integration in the following areas: basic cardiology, lung and pleural disease, kidney and bladder, lower extremity veins, and approach to shock, dyspnea, and acute renal failure.

Description

This week-long course will give you the skills to confidently integrate POCUS into your everyday practice. Learn through hands-on scanning, image interpretation, case discussions, and evidence review. The course covers applications in cardiac, pulmonary and pleural, renal, GU, abdominal, biliary, vascular, and musculoskeletal sonography.

- Scan with live models
- Low 2:1 student-to-teacher ratio
- All course faculty are certified by the American College of Chest Physicians, engaged in the development of national guidelines, and teach at conferences held by the American College of Physicians and the Society of Hospital Medicine

Critical Readings

Soni, N., Arntfield, R., Kory, P. (2015). *Point of Care Ultrasound, 1e*. Philadelphia, PA: Saunders, Elsevier.

Previous Clinical Scholars and Current Roles and Activities

Clinical Scholars 2017–2018	
Kimberly Bloom-Feshbach	Director of Virtual Hospitalist Program; Director of Patient Care and Physicianship course for MS1; Director of institution-wide Group Peer Mentoring Program; Co-Director of doctor/patient communication course (NewYork Presbyterian enterprise-wide course); funded and published qualitative researcher.
Justin Choi	Co-Director of PGY1 Clinical Reasoning Curriculum; Co-Director of Patient Care and Physicianship course for MS1; Master of Science in Clinical Investigation; PhD Doctoral candidate in Health Professions Education; Co-Investigator on National Hospital Medicine Research Consortium.
Annie Kim	Associate Director of Medicine Clerkship; Co-Director of South Korea and Weill Cornell Hospital Medicine Collaborative; Facilitator for Group Peer Mentoring program.
Dhruv Khullar	Director of Center for the Study of Physician Practice and Leadership; contributing writer for *The New Yorker*; prolific author in lay press and prestigious high-impact medical journals.
Jigar Contractor	Unit Medical Director; Co-Investigator on National Hospital Medicine Research Consortium.
Clinical Scholars 2018–2019	
Brett Fischer	Director of EBM and Biostatistics course for MS1 and MS2; Director of Journal Club and EBM curriculum for residents; Editorial Fellow for Journal of Hospital Medicine; Tutor Trainee at McMaster Evidence-Based Clinical Practice workshops; POCUS instructor for the national/international Weill Cornell POCUS Course.
David Scales	Faculty Scholar in Health Equity program; published in NEJM; JumpStart (pre-K) award winner from WCM; $1.25 million in grants from the Robert Wood Johnson Foundation for research on medical misinformation and building vaccine confidence; consultant to the Surgeon General and National Academies of Science committee.
Rebecca Berger	Assistant Chief of Hospital Medicine; Director of Patent Safety, Inpatient Medicine Services; Epic Clinical Leadership Group Member and Hospital Medicine Epic champion; Faculty mentor, Quality Improvement Academy; Instructor, WCM Graduate School and Cornell Tech health policy courses.
Shira Sachs	Associate Program Director, IM Residency Program; Co-Director of Medical Education for the IM Residency Program; Co-Director and Co-investigator of Mastering the Art and Nuance of Team Leadership and Education (MANTLE) Rotation; Core Faculty for the Master Coach Program.
Clinical Scholars 2019–2020	
Will Levine	Site Director of Lower Manhattan Hospital Sub-Internship; Assistant Course Director for Transition to Residency; Clinical Skills Center Core Faculty Member.
Devin Worster	Senior Project Lead with Partners in Health (PIH) – United States: strengthening public health systems for vulnerable populations in North Carolina with a focus on Community Health Worker program implementation, evaluation, and policy; Technical Advisor and prior Program Coordinator for Noncommunicable Disease and Palliative Care with PIH in Chiapas, Mexico.
Laura Kolbe	Chief of Medical Ethics, NYP-Brooklyn Methodist; Associate Program Director, IM Residency Program at NYP-Brooklyn Methodist; Award-winning poet book author; published author of essays and reviews for the Washington Post, the Wall Street Journal, The New York Review of Books; Director, Covid Recovery Unit (2020).