

Give residents more practice with the deteriorating inpatient.

Interactive acute-care decisions, case-specific feedback and reporting that helps faculty follow participation and guide teaching.

Assess → Prioritize → Treat → Reassess → Escalate → Reflect

For the learner

- Work through evolving inpatient cases involving hypoxia, shock, arrhythmias, sepsis and altered mental status.
- Ask for findings, interpret available ECGs/chest films, choose actions and reassess.
- Review case teaching and personalized feedback after the case.

For the program

- Fit practice into intern preparation, night-float teaching or a longitudinal curriculum.
- Follow named participation and review pooled learning patterns when enough data are available.
- Use findings for faculty discussion and the next practice session.

Designed to complement your curriculum. Individual decision practice adds another place to rehearse between supervised clinical work and facilitated simulation. It does not teach hands-on procedural technique or certify independent practice.

Start with one cohort and a defined use

Choose a faculty owner, a realistic practice schedule and a review date. Confirm network access, orientation and how faculty will follow up. Evaluate participation, return use, learner/faculty feedback, clinical concerns and support effort.

Current phase: residents are piloting the simulator while clinical review continues. Ask which cases and modes are ready for your cohort. No CME credit is currently offered.

Program reporting includes named participation. Personal mean-score sharing is a separate learner opt-in; participation CSVs exclude scores. Pooled results require sufficient learners and scored opportunities. AI feedback may need clinical correction.

Why consider virtual-patient practice?

A review of 51 randomized trials found that virtual-patient education favored assessed skills over traditional education, with substantial variation and generally low-quality evidence.* [Kononowicz et al., 2019](#).

Recent randomized AI-patient studies reported benefits in history-taking assessments. Their settings and systems differ from inpatient stabilization. [Brügge et al., 2024](#); [Luo et al., 2025](#).

Findings are mixed, including a trial where greater virtual-case exposure did not improve clinical examination scores: [infectious-disease trial, 2022](#).

* These studies evaluated other systems; SigVy's effect on independent clinical skills or patient outcomes has not yet been established.

A transparent program budget

Annual packages combine an enrolled-seat limit with shared case capacity. Size the allowance to your curriculum.

Illustrative plan: 25 residents	Annual amount
Up to 30 seats; 600 included cases	\$3,000
300 additional cases committed at signup × \$4	\$1,200
900 planned starts: three per resident per month	\$4,200

Illustration assumes 25 participants for 12 months, no cushion; \$168 per resident annually. Starts include retries and abandoned attempts, so completion goals may need more capacity. Mid-term additions are \$5.50 each. Cases expire with the term; no rollover. Final quote states taxes, dates and all contract terms.

Paid program pilot: 6 months, up to 50 seats, 450 cases, \$2,250. The pilot fee can be credited toward an annual conversion under the written agreement. Existing free resident pilots retain their agreed arrangements.

Next step: a focused program demonstration

Tell us your cohort, intended curriculum use and planned practice frequency. We will walk through a case and the program report, then prepare a scoped proposal.

[Request a program demo](#) → · [Explore program pricing](#)

SigVy Rapid Response Sim · Reviewed September 15, 2026 · Educational simulation. Clinical judgment and institutional protocols remain essential. This brief describes an educational offer and a budget example, not a purchase agreement.