

More practice for the decisions that come first.

Recognize deterioration. Prioritize care. Reassess the response. Know when to escalate.

When an inpatient deteriorates, the learner has to bring information and action together. SigVvy Rapid Response Sim gives residents a place to rehearse that sequence in interactive cases, then review the reasoning behind their decisions.

The program value: a repeatable practice activity you can place in the curriculum, with participation reporting and pooled learning patterns to inform faculty teaching.

Who it serves

- Internal medicine residents.
- Family medicine residents with inpatient responsibilities.
- Senior students preparing for residency.
- Hospital-medicine NP/PA training and onboarding.

Where it fits

- Intern preparation and boot camp.
- Preparation for night-float responsibility.
- Longitudinal acute-care teaching.
- Targeted practice after a faculty discussion.

What makes the experience useful

The learner asks for findings, chooses actions and follows the clinical course. Case teaching and personalized feedback provide material for reflection and another practice session. An AI-mediated environment builds on a physician-led case bank and review process.

Current phase: residents are piloting the program while clinical review continues. We will confirm the available case scope and modes for your cohort. This educational tool complements supervised care and hands-on/team simulation. No CME credit is currently offered.

[Arrange a program demonstration →](#)

Work through the case. Learn from the decisions.

Practice the sequence of care in an evolving inpatient scenario.

- 1 Assess.** Start with a deteriorating inpatient. Ask for the history, bedside findings and studies needed to understand the problem.
- 2 Prioritize and act.** Interpret available information, choose initial management and request appropriate help.
- 3 Reassess and escalate.** Follow the clinical course, reconsider the plan and communicate the need for a higher level of care.
- 4 Reflect and repeat.** Review the diagnosis, authored teaching points and personalized feedback. Bring questions to faculty and revisit a learning need.

Example practice prompt: the nurse calls about a newly hypoxic inpatient. The learner decides which findings to obtain, what needs immediate attention, and how to reassess after acting. This is an illustrative teaching situation, not a treatment protocol or customer result.

Clinical themes

Hypoxia, shock, arrhythmias, sepsis and altered mental status are among the scenarios. Available ECG and chest-film cases add study interpretation to the decision process.

A faculty demonstration

We can show a synthetic case, its completed feedback and a sample program report. This lets you evaluate the workflow before choosing a cohort or practice plan.

AI responses and grading can require clinical correction. Authored content review does not mean every live model response has been clinician-approved. Use the experience for formative learning; it does not teach hands-on procedural technique or certify independent practice.

Turn practice into a teaching conversation.

Choose a manageable routine and a faculty owner who will use what the program learns.

Illustrative four-week introduction — adapt to your curriculum

When	Activity	Faculty follow-up
Before launch	Confirm access, scope and reporting choices.	Name a sponsor and agree the practice expectation.
Week 1	Orientation and one introductory case.	Check who could access and complete the activity.
Weeks 2–3	One case each week, if appropriate.	Discuss learner questions and material clinical concerns.
Week 4	Short learner/faculty feedback review.	Decide whether and how to continue.

This is a proposed onboarding example, not a proven optimal dose or an additional free-access offer. Case starts consume the agreed allowance. It differs from the three-cases-per-month annual budget example below.

Named participation

Faculty can follow who practiced, completed cases and returned, and export participation. Main participation counts exclude retries; billed case starts and report completion counts are different measures.

Pooled learning patterns

Skill and condition summaries can help identify teaching topics when enough data are available. A small or lightly used cohort may not have publishable performance rows.

Explain the reporting choices at onboarding

Named aggregate mean-score sharing is a separate, revocable learner opt-in. Participation CSVs exclude scores. Default pooled safeguards require at least five learners, with at least five distinct learners and 20 scored opportunities for a category row; additional checks apply to some reports. These safeguards do not guarantee anonymity.

[Explore the illustrated program-report walkthrough](#) → Synthetic examples from a prior build.

A supported approach. A product to evaluate in your setting.

Virtual-patient studies report benefits in some assessed skills, with mixed findings across populations and designs.*

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

Kononowicz et al., 2019 · JMIR

Review of 51 randomized trials: assessed skills favored virtual-patient learning. Evidence was generally low quality and highly variable; systems largely predated modern LLMs.

Luo et al., 2025 · npj Digital Medicine

A single-center randomized trial of 84 students found better ophthalmology history-taking assessment scores with an LLM patient system. Specialty and task differ from inpatient stabilization.

Liaw et al., 2014 · JMIR

Fifty-seven nursing students received virtual or manikin deterioration refreshers. Both improved from baseline; virtual-group performance later declined. The design did not establish superiority or patient-outcome effects.

Brügge et al., 2024 · BMC Medical Education

In a small randomized study with 21 students in the final analysis, structured AI feedback improved rated history-taking performance over AI patient conversations alone. Assessment remained simulated.

Junior-doctor trial, 2024 · JEEHP

Forty junior doctors practiced sepsis/trauma virtually or in person. Assessment differences were not statistically significant; satisfaction favored in-person training. This does not establish equivalence.

Infectious-disease trial, 2022 · Frontiers in Medicine

Among 100 students analyzed, greater virtual-case exposure did not improve the relevant clinical examination scores. More repetitions alone did not ensure assessment transfer.

Targeted selection, reviewed September 15, 2026; not an exhaustive systematic review. For a local evaluation, agree the cohort, exposure, feedback and continuation measures. A stronger learning-effect study would use unseen cases, independent raters and an appropriate comparison.

Budget around the practice you intend to provide.

Annual programs combine an enrolled-seat limit with a shared case pool. All amounts below are USD. Discuss your cohort, cadence and contract dates before choosing capacity.

Current annual program catalog

Seats	Annual price	Included cases
Up to 15	\$1,800	350
Up to 30	\$3,000	600
Up to 50	\$4,500	900
Up to 150	\$9,000	1,800
Up to 300	\$15,000	3,000
300+	Custom	Custom

A concrete example: 25 residents × three starts a month × 12 months = 900 starts.

Small team includes 600 cases for \$3,000. Add 300 cases at signup for \$1,200. Total: **\$4,200 annually**, or \$168 per participating resident in this example.

Additional capacity: \$4.00 per case committed at signup or renewal; \$5.50 per case added mid-term. Starts include retries and abandoned attempts, so a completion target may require a cushion. Case capacity expires with the term; unused cases do not roll over.

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

This is a catalog and illustration, not a binding quote. Your proposal specifies taxes, seats, dates, case capacity, payment, support and renewal/cancellation terms. Shared program cases are distinct from the Personal plan's monthly allowance.

Use the program case calculator →

Start with a faculty conversation.

Tell us who will practice, where it fits and what would make it worth continuing.

- 1 See the experience.** Walk through a synthetic case, feedback and program report with the faculty sponsor.
- 2 Scope the offer.** Agree the cohort, frequency, capacity, available content and budget/procurement path.
- 3 Prepare to onboard.** Confirm the agreement, payment route, network access, roster/admin setup and reporting choices.
- 4 Review local value.** Assess participation, return use, learner/faculty feedback, material clinical issues and support effort at an agreed date.

Questions worth bringing to the demo

“We have a simulation center.”

Use individual case practice between facilitated sessions. Keep hands-on procedures and team training in their appropriate setting.

“Will residents use it?”

Choose its place in the curriculum and measure return use. Faculty ownership and a realistic schedule belong in the plan.

“Can our hospital access it?”

Test the actual network, device and sign-in process. We will discuss your vendor and IT requirements before onboarding.

“What evidence can we take internally?”

Use this packet, the linked studies, the reporting walkthrough and a tailored quote. Label pilot opinions separately from independently measured learning.

A purchase rationale your sponsor can adapt

We propose adding repeatable inpatient decision practice for [cohort] in [curriculum]. [Faculty role] will review participation and teaching needs. The offer specifies [seats, dates, capacity and cost]. We will assess access, use, educational usefulness and support needs on [date] before deciding whether to continue.

Request a program demo or tailored proposal →

SigVy Rapid Response Sim · Program information · September 15, 2026
Product page · Full PDF packet · Two-page overview