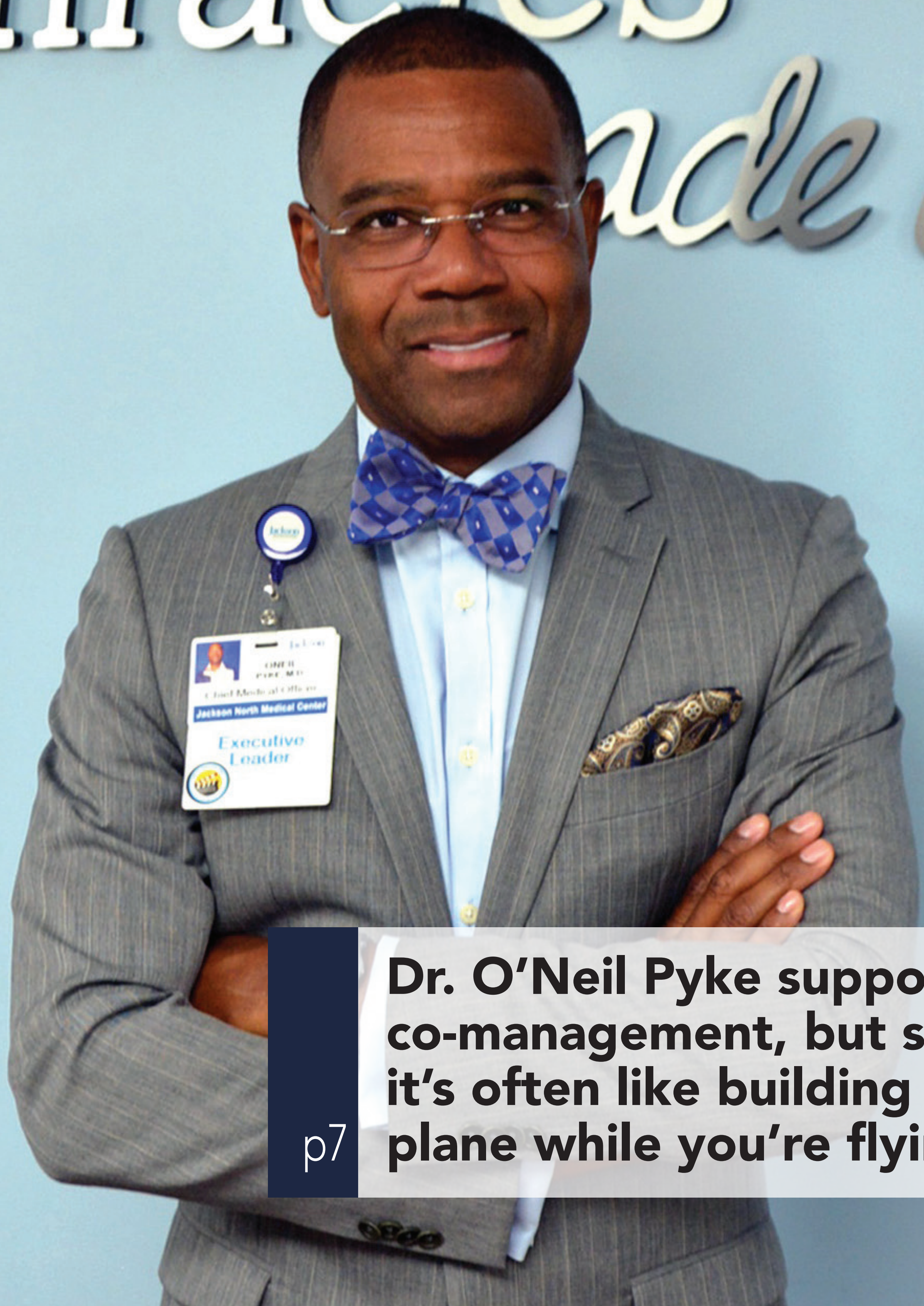
October 2024
Vol. 28 | No. 10

THE Hospitalist®

p10 PRACTICE MANAGEMENT
Ins and outs of POLST

p14 ADVOCACY
Helping hospitalized patients access voting

p19 DIVERSITY
Helpful roadmap for DEI officers in HM



Dr. O'Neil Pyke supports co-management, but says it's often like building the plane while you're flying

p7

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IN THE LITERATURE
Stanford Health Care, Part 2

p4 Gegg-Mitchell, Jang, Chen, Dam, Parikh, and Boyle's med-lit reviews

EDUCATION
SUD in physicians

p12 Drs. Faulk, Patel, Chang, Dao, and Wenzinger discuss a compassionate approach to the issue

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IN THE NEXT ISSUE...
Getting to know VA hospitalists

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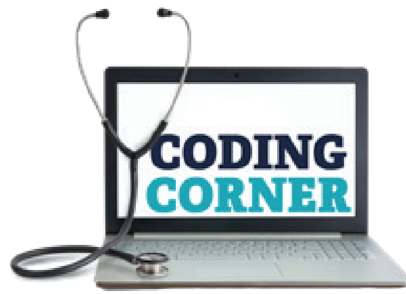
Coding Corner: Spoonful of Sugar

By Jeremy Gentile, DO, FACP, FHM



A 46-year-old woman is admitted to the hospital with an exacerbation of chronic obstructive pulmonary disease (COPD) requiring intensification of her inhaler regimen, initiation of corticosteroids, and initiation of 4 L/min oxygen support via nasal cannula. She does not require oxygen at baseline and has a history of diabetes mellitus for which she takes metformin and glipizide. On day two, her blood sugar is noted to be consistently above 300 mg/dL since admission and requires the initiation of weight-based basal-bolus insulin along with frequent glucose checks.

What level of billing does this qualify for?

This would qualify for level 3 (99233). This patient has respiratory failure due to an exacerbation of COPD. This would be considered evidence of a severe exacerbation of an underlying chronic condition and, if documented as such, would meet the criteria for a high-complexity medical problem. The patient's elevated blood sugar requiring the initiation of basal-bolus insulin is likely secondary to the initiation of steroids and even in the absence of hyperglycemia, increased vigilance is warranted. Thus, this could be documented as drug therapy requiring intensive monitoring for toxicity. The drug is corticosteroids (regardless of route, enteral or parenteral) and the toxicity requiring specific laboratory monitoring is severe hyperglycemia.

Tip

Patients with an acutely decompensated chronic medical condition or acute threat to life will often meet the criteria for level 3 billing (99223) if you are performing increased monitoring for toxicity. Common medications that would meet this criterion include diuretics, anticoagulants, antiarrhythmics, extended IV electrolyte replacement, and antibiotics (especially those requiring level monitoring such as vancomycin). ■

Dr. Gentile is an internal medicine hospitalist, section chief for acute care medicine, and associate program director for internal medicine at Corewell Health Western Michigan, and assistant professor in the department of medicine at Michigan State University College of Human Medicine, all in Grand Rapids, Mich.

Accepting Applications for Editorial Positions

The Hospitalist is now accepting applications for the position of pediatrics editor and the newly created position of associate editor.

You should apply if you're an SHM member interested in becoming more involved in guiding the editorial direction of the magazine, communicating with readers through your writing, and ensuring our content is both accurate and relevant. The pediatrics and associate editor terms are for three years. The application deadline is October 15, 2024, followed by a selection process, and interview.

Scan the QR code for more information. ■

From *JHM*

The *Journal of Hospital Medicine* Editor's Pick this month is Enhancing belonging and other stay factors to improve physician retention. The article discusses the physician attrition crisis, explains the push and pull factors, and suggests strategies healthcare systems can employ to help alleviate the issue. Scan the QR code to read the full article. ■

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Hospitalists are charged with treating individuals at their most vulnerable moments, when being respected as a whole person is crucial to advancing patients' healing and wellness. Within our workforce, diversity is a strength in all its forms, which helps us learn about the human experience, grow as leaders, and ultimately create a respectful environment for all regardless of age, race, religion, national origin, gender identity, sexual orientation, socioeconomic status, appearance, or ability. To this end, the Society of Hospital Medicine will work to eliminate health disparities for our patients and foster inclusive and equitable cultures across our care teams and institutions with the goal of moving medicine and humanity forward.

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The Hospitalist is the official newspaper of the Society of Hospital Medicine, reporting on issues and trends in hospital medicine. The Hospitalist reaches more than 35,000 hospitalists, physician assistants, nurse practitioners, medical residents, and health care administrators interested in the practice and business of hospital medicine.

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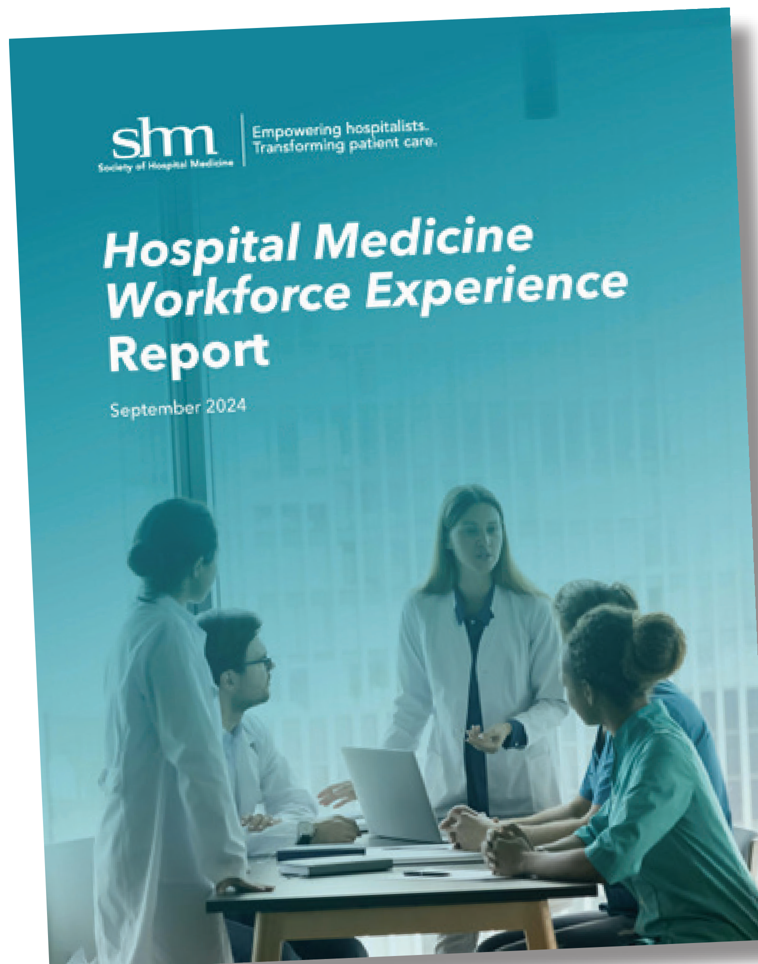
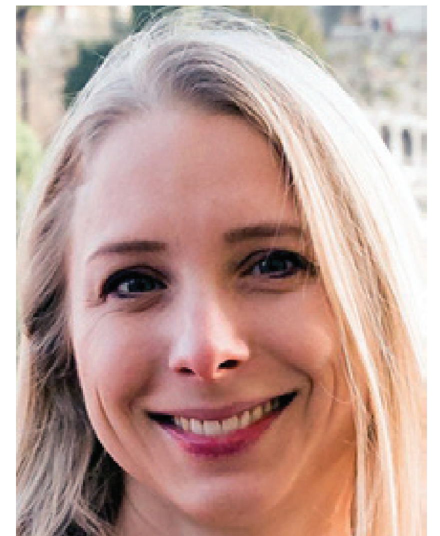
SHM's 2024 Hospital Medicine Workforce Experience Report Provides Insight into the Perceptions of Hospitalists

Dig deeper into the data

By Teresa Caponiti




Ms. Caponiti

Ms. Caponiti is SHM's practice management manager.

SHM is excited to announce the publication of the 2024 Hospital Medicine Workforce Experience Report. The 2024 Report, based on data collected in the Hospital Medicine Workforce Experience Survey conducted this spring, explores the perceptions of hospitalists on issues such as well-being, patient volumes, and workplace structures.

This report builds off the Hospital Medicine Workforce Experience survey data released last year as part of the 2023 State of Hospital Medicine Report. For the 2024 survey, we updated the survey instrument by adding a validated tool for measuring burnout and professional fulfillment, new questions about practice structures and clinician perceptions, and more. We received 904 responses to the survey, notably more than the 562 responses we received in 2023.

Professional fulfillment and burnout continue to present challenges in hospital medicine

Burnout, which peaked during the COVID-19 pandemic but is still very much an issue, has been the focus of many conversations and interventions. We continue to believe that burnout alone is an incomplete picture of assessing the health of the specialty. To that end, we used the Stanford Professional Fulfillment Index (PFI) to evaluate both burnout and professional fulfillment, hoping to get a more holistic picture of the field. The top-line picture is sobering: 45.4% of hospitalists were burned out and only 24.3% were professionally fulfilled.

The Stanford PFI uses responses on a set of indicators for burnout (10 indicators) and professional fulfillment (six indicators) to assess respondents. For professional fulfillment, the worst performing indicator was feeling in control when dealing with difficult problems at work and the best was feeling that work was meaningful. For burnout, the worst performing indicators were feeling emotionally and physically exhausted, while all six indicators relating to relationships with patients rated similarly well.

We suspected we would see a connection between professional satisfaction and burnout, but the overall low rates of professional fulfillment are surprising. These results highlight that only measuring and acting on burnout is an incomplete approach to addressing workforce well-being.

Differences in professional fulfillment and burnout scores

The structure and operations of hospitalist groups vary across sites, so we wanted to explore how demographic differences, workplace structures, and hospitalists' feelings about their workplace are tied to professional fulfillment and burnout scores. Hospitalists' role, age, gender, employment model, team structure, and other demographic differences led to differences in professional fulfillment and burnout rates.

We also asked participants to report how much of their job was spent dedicated to clinical work, as opposed to administrative or other tasks. The average percentage of clinical work was almost 10% higher with physicians who met the criteria for being burned out and professionally unfulfilled. This highlights how non-clinical time can play an important role in the professional fulfillment of hospitalists.

While our results did not show patient census having a direct impact on professional fulfillment and burnout scores, we did find that scores improved when participants perceived that their average patient census was safe. This highlights the role that chaos in the workplace and lack of control have on hospitalist wellness.

Additionally, our data highlighted how work/life balance plays a role in physician wellness. Physicians with access to paid time off (PTO) have 6% higher rates of fulfillment and 10% lower rates of burnout. However, if participants were required to pay their PTO back in shifts, that improvement would be essentially wiped away.

Supportive leadership is key

While many of the contributing factors related to lower rates of professional fulfillment and burnout may be challenging to mitigate, we were encouraged to find that supportive leadership substantially improves scores. Survey participants who strongly viewed their leaders as taking staff suggestions and taking action to improve provider well-being saw almost 20% higher rates of professional fulfillment and almost 20% lower rates of burnout than the average respondent.

These results are striking. While the report surfaces many vulnerabilities in the field, leaders have the power to address them. It is crucial that hospital medicine leaders focus on the professional experience and well-being of hospitalists, solicit feedback, and take action to promote their well-being. In the 2023 State of Hospital Medicine Report, only 20.9% of groups reported they had an employee with a non-clinical focus dedicated to addressing burnout and wellness, and we call on groups to remedy that. SHM will continue to prioritize the training, support, and growth of leaders who embrace this call to action.

SHM encourages all hospitalists, regardless of their role, to dig deeper into the data, and join us on this journey toward creating more sustainability and fulfillment in hospital medicine. There is much to unpack in the data, but the signal is clear—feeling burned out and unfulfilled professionally is common in hospital medicine. We must all do more to address these challenges.

Scan the QR code for more information about the 2024 Hospital Medicine Workforce Experience Report, including a detailed analysis of the findings described above. To learn more about how hospitalists and hospitalist leaders can address well-being, please visit SHM's website, hospitalmedicine.org. ■

In the Literature

Stanford Health Med Research Reviews, Part 2

By Jevon Gegg-Mitchell, MS, RN, NP-C, PA-C, Jessica Jang, ACNP-BC, Kelly Chen, AGACNP-BC, Nhi Thuy Dam, PA-C, Nisha Parikh, PA-C, MMSc, Rebecca Boyle, PA-C, CAQ-Nephrology

Stanford Health Care, Palo Alto, Calif.

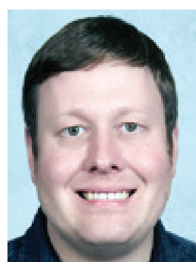
IN THIS ISSUE

1. Early Versus Later Anticoagulation for Stroke with Atrial Fibrillation
2. Comparing Outcomes of Targeted Reperfusion Therapy Versus Anticoagulation in Patients with Acute Intermediate-high-risk PE
3. To RAASi or Not to RAASi, That is the Question
4. Lactated Ringers in the First 24 Hours of Hospitalization May Improve Acute Pancreatitis Severity
5. ASCO Guideline for the Use of Opioids for Adults with Cancer or Cancer Treatment
6. ACLF Grade 3 Predicts Risk of Respiratory Failure with Terlipressin Use

By Jevon Gegg-Mitchell, MS, RN, NP-C, PA-C

1 Early Versus Later Anticoagulation for Stroke with Atrial Fibrillation

CLINICAL QUESTION: What is the safety and efficacy of early compared with later initiation of direct oral anticoagulants (DOACs) in patients with atrial fibrillation and ischemic stroke?


Mr. Gegg-Mitchell

BACKGROUND: There is a paucity of high-quality evidence regarding the timing of initiating anticoagulation in patients with atrial fibrillation and ischemic stroke. Clinical approaches focus on balancing concerns for bleeding with early initiation of anticoagulation and concerns for recurrent stroke with later initiation.

STUDY DESIGN: Multi-center, open-label, randomized trial

SETTING: Stroke centers in Asia, Europe, and the Middle East

SYNOPSIS: Patients were randomized to one of two groups. In the early-treatment group (n=1,006), DOACs were started within 48 hours of a minor or moderate stroke, and on day 6 or 7 after a major stroke. In the later-treatment group (n=1,007), DOACs were started on day 3 or 4 after a minor stroke, on day 6 or 7 after a moderate stroke, and on day 12, 13, or 14 after a major stroke. The primary outcome included the following components as a composite (with occurrence within 30 days of randomization): symptomatic intracranial bleeding, major extracranial bleeding, recurrent ischemic stroke, systemic embolism, and vascular death. In the early-treatment group, 2.9% of participants experienced a primary-outcome event within 30 days of randomization, and in the later-treatment group, 4.1% of participants experienced a primary-outcome event within 30 days of randomization. Upon analysis, the incidence of a primary-outcome event at 30 days was estimated to occur between 2.8 percentage points lower and 0.5 percentage points higher for early rather than later DOAC initiation (95% confidence interval).

BOTTOM LINE: Despite the lack of testing for superiority or non-inferiority, findings (based on estimated treatment effects) support early initiation of DOACs in patients with atrial fibrillation and ischemic stroke.

CITATION: Fischer U, Koga M, et al. Early versus later anticoagulation for stroke with atrial fibrillation. *N Engl J Med.* 2023;388(26):2411-21.

Mr. Gegg-Mitchell is the lead advanced practice provider for inpatient hematology/oncology at Stanford Health Care in Palo Alto, Calif.

By Jessica Jang, ACNP-BC

2 Comparing Outcomes of Targeted Reperfusion Therapy Versus Anticoagulation in Patients with Acute Intermediate-High-risk PE

CLINICAL QUESTION: Do patients with acute intermediate-high-risk pulmonary embolism (PE) benefit more in terms of cardiac function from reperfusion therapy with conventional catheter-directed thrombolysis (cCDT) plus anticoagulation, or does monotherapy anticoagulation have the similar outcomes?

Ms. Jang

BACKGROUND: The role of reperfusion therapy in intermediate-high-risk PE is still debated. Rather than full-dose systemic fibrinolytic therapy, which raises concerns for increased bleeding events, this study explores whether a smaller-dose catheter-directed approach (cCDT) delivered into the pulmonary arteries, followed by anticoagulation therapy, can reduce bleeding events caused by systemic therapy and provide overall improved cardiac function. However, there is little existing evidence to suggest that a combination of cCDT and anticoagulation therapy is superior to monotherapy anticoagulation.

STUDY DESIGN: Randomized clinical trial

SETTING: Two large cardiovascular centers in Tehran, Iran from December 22, 2018, through February 2, 2020.

SYNOPSIS: This was a randomized clinical trial of 94 patients called the CANARY Trial (Catheter-Directed Thrombolysis versus Anticoagulation Monotherapy in Patients With Acute Intermediate-High–Risk Pulmonary Embolism). Patients were randomly assigned to receive either cCDT (alteplase, 0.5 mg/catheter/h for 24 hours) plus heparin followed by anticoagulation therapy (n=48) or anticoagulation monotherapy (n=46). For both groups, anticoagulation was defined as twice-daily subcutaneous enoxaparin 1 mg/kg, and transition to oral anticoagulation was permissible at the discretion of treating clinicians. The primary endpoint was determined by achieving greater than a 0.9 right ventricle/left ventricle (RV/LV) ratio measured by transthoracic echocardiography at the three-month follow up. The outcomes of the trial were that numerically fewer cCDT patients (4.3%) had over a 0.9 RV/LV ratio than those in the monotherapy group (12.8%). Notably, all three deaths in the study occurred in the monotherapy group and one gastrointestinal (non-fatal) bleed occurred in the cCDT group. While treatment of intermediate-high-risk PE with cCDT did not achieve a statistically significant reduction in the percentage of patients with an RV/LV ratio greater than 0.9, it did improve echocardiographic markers of RV recovery.

LIMITATIONS: The trial ended prematurely due to the COVID-19 pandemic. Additionally, only 85 of the 94 enrolled participants returned for their three-month follow-up transthoracic echocardiogram. Also, women were underrepresented (30%).

BOTTOM LINE: Due to premature termination, the study was not able to decipher significant differences between cCDT and anticoagulation monotherapy. There does not appear to be a clear mortality benefit nor a high risk of bleeding with cCDT in this patient population. Larger studies with longer follow-ups will be needed to assess whether cCDT benefits long-term RV function in patients with intermediate-high-risk PE.

CITATION: Sadeghipour P, Jenab Y, et al. Catheter-directed thrombolysis vs anticoagulation in patients with acute intermediate-high–risk pulmonary embolism: the CANARY randomized clinical trial. *JAMA Cardiol.* 2022;7(12):1189-97.

Ms. Jang is a hospitalist nurse practitioner on an inpatient oncology/medicine primary team at Stanford Health Care in Palo Alto, Calif.

By Kelly Chen, AGACNP-BC

3 To RAASi or Not to RAASi, That is the Question

CLINICAL QUESTION: Should angiotensin-converting enzyme inhibitors (ACEi) or angiotensin receptor blockers (ARBs) be discontinued or continued in advanced chronic kidney disease (CKD) patients?

BACKGROUND: Guidelines do not provide specific guidance on continuing or stopping ACEi or ARB for advanced CKD.

Ms. Chen

STUDY DESIGN: Multi-center, randomized, open-label trial

SETTING: United Kingdom

SYNOPSIS: Randomizing 411 adult patients across 37 centers with stage 4 or 5 CKD (estimated glomerular filtration rate < 30 ml/min/1.73 m²), the STOP ACEi study demonstrated that at three years the discontinuation of renin-angiotensin-aldosterone system inhibitors (RAASi) was not associated with a significant difference in the rate of eGFR decreasing. Specifically, the investigators found the least-squares mean eGFR was 12.6 ±0.7 ml/min/1.73 m² in the discontinuation group and 13.3 ±0.6 ml/min/1.73 m² in the continuation group (-0.7 difference; 95% CI, -2.5–1.0), with the negative value favoring the outcome in the continuation arm.

BOTTOM LINE: Discontinuation of RAASi in advanced CKD patients does not cause a clinically relevant change in the eGFR or difference in the rate of eGFR decline. They should not be stopped purely based on a low eGFR.

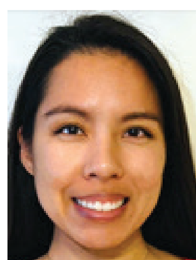
CITATION: Bhandari S, Mehta S, et al. Renin-angiotensin system inhibition in advanced chronic kidney disease. *N Engl J Med*. 2022;387(22):2021-32.

Ms. Chen is an outpatient nurse practitioner in the nephrology clinic at Stanford Medicine in Stanford, Calif.

By Nhi Thuy Dam, PA-C

4 Lactated Ringers in the First 24 Hours of Hospitalization May Improve Acute Pancreatitis Severity

CLINICAL QUESTION: Does the administration of lactated ringers (LR) in the first 24 hours of admission reduce the risk of more severe forms of acute pancreatitis compared to normal saline?


Ms. Thuy Dam

BACKGROUND: Current guidelines for the initial management of acute pancreatitis include fluid resuscitation, though the optimal fluid solution has not yet been established. This study primarily focused on generating more evidence to determine an association between the type of intravenous (IV) fluids and clinical outcomes of moderately severe to severe cases of acute pancreatitis.

STUDY DESIGN: Retrospective, observational, cohort study

SETTING: The patients from the APPRENTICE, an international multisite prospective study across four geographic regions of the world, conducted between August 2015 and January 2018 across 22 centers, were utilized for this study cohort. The data was managed at the University of Pittsburgh Medical Center.

SYNOPSIS: Data from 999 adult patients (18+ years old) who were directly admitted for acute pancreatitis within seven days of abdominal pain onset were analyzed for this study. Patients with chronic pancreatitis, pancreatic cancer, or any kind of cancer requiring chemotherapy or organ transplantation were excluded. Using a mixed-effects logistic regression model, patients receiving LR fluids compared to normal saline had a 48.2% decrease in their likelihood (aOR of 0.518) of developing moderately severe or severe acute pancreatitis. Secondary mixed-effects logistic regression models were used to exclude cases with organ failure within the first hour of admission to account for baseline severity, post-endoscopic retrograde cholangiopancreatography etiology, and aggressive fluid resuscitation greater than 4 L in 24 hours. Blood urea nitrogen and systemic inflammatory response syndrome were both found to be statistically significant in association with the development of moderately severe to severe pancreatitis. LR use varies widely across the world as there are currently no emergency medicine society-driven guidelines for the management of acute pancreatitis, compared to an already established gastrointestinal society recommendation.

BOTTOM LINE: LR usage, compared to normal saline, in the first 24 hours was associated with better outcomes for moderately severe to severe acute pancreatitis.

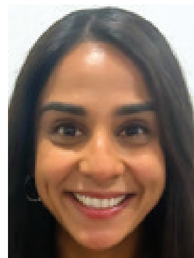
CITATION: Lee PJ, Culp S, et al. Lactated Ringers use in the first 24 hours of hospitalization is associated with improved outcomes in 999 patients with acute pancreatitis. *Am J Gastroenterol*. 2023;118(12):2258-66.

Ms. Thuy Dam is a hospital medicine physician assistant at Stanford Health Care in Palo Alto, Calif., and a faculty member at Stanford's School of Medicine in Stanford, Calif.

By Nisha Parikh, PA-C, MMSc

5 ASCO Guideline for the Use of Opioids for Adults with Cancer or Cancer Treatment

CLINICAL QUESTION: What are expert recommendations for the use of opioids for adults with pain from cancer?


Ms. Parikh

BACKGROUND: Pain is a common consequence of cancer and cancer treatment. There are limited guidelines focused *solely* on opioid use in a patient with cancer.

STUDY DESIGN: The evidence base included 31 systematic reviews and 16 randomized controlled trials published between January 1, 2010, and February 17, 2022.

SYNOPSIS: The American Society of Clinical Oncology convened a multidisciplinary expert panel to formulate clinical practice guidelines for opioid initiation, titration, prevention, and management of opioid adverse effects in people with cancer or treatment-related pain.

KEY POINTS:

- For patients with moderate to severe cancer pain, opioids should be initiated as an immediate release or as needed with ongoing assessment and frequent titration to establish an effective dose.
- Considerations of bioavailability, route of administration, and half-life should be made when selecting the initial opioid.
- Education and strategies should be provided to prevent known opioid-related adverse effects.
- Current evidence remains insufficient to recommend ranges for titrating opiates, specific short-acting opioids for breakthrough pain, and what to use in the setting of renal and hepatic impairment.

BOTTOM LINE: In patients with moderate to severe cancer pain, opioids effectively reduce pain and should be initiated as immediate release and titrated to establish an effective dose.

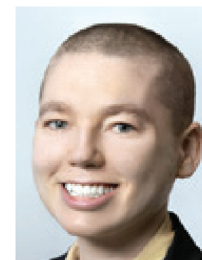
CITATION: Paice JA, Bohlke K, et al. Use of opioids for adults with pain from cancer or cancer treatment: ASCO guideline. *J Clin Oncol*. 2023;41(4):914-30.

Ms. Parikh is a physician assistant and hospitalist on inpatient hematology/oncology primary service at Stanford Hospital, and an instructional faculty member at Stanford University's School of Medicine's physician assistant program in Stanford, Calif.

By Rebecca Boyle, PA-C, CAQ-Nephrology

6 ACLF Grade 3 Predicts Risk of Respiratory Failure with Terlipressin Use

CLINICAL QUESTION: Which risk factors predict new-onset respiratory failure during terlipressin use for the treatment of patients with rapidly deteriorating kidney function attributed to type 1 hepatorenal syndrome (HRS-AKI)?


Ms. Boyle

BACKGROUND: Terlipressin, a synthetic vasopressin analog, has long been an international standard of care for HRS-AKI under the European Clinical Practice Guidelines. The agent offers two attractive advantages to norepinephrine, another vasoconstrictive agent employed for the treatment of HRS-AKI, in that terlipressin administration does not require central venous access or intensive care unit admission. The results of the CONFIRM trial demonstrated terlipressin's superiority in improving kidney function compared to placebo and were instrumental in terlipressin's approval for use in the U.S. in September 2022. However, the trial re-demonstrated the increased incidence of respiratory failure associated with terlipressin use seen in earlier, smaller trials. This post-hoc analysis of CONFIRM sought to identify risk factors for terlipressin-associated respiratory failure.

STUDY DESIGN: Post-hoc analysis of the randomized, double-blind, placebo-controlled CONFIRM trial

SETTING: 70 centers across the U.S. and Canada

SYNOPSIS: Acute on chronic liver failure (ACLF) grade is defined as the number of organ system failures under the Chronic Liver Failure-Sequential Organ Failure Assessment scoring system.

Significantly more patients developed respiratory failure under terlipressin treatment compared to placebo. Univariate logistic regression analysis revealed ACLF scores to be a predictor of respiratory failure. Patients with baseline ACLF grade 3 were significantly more likely to develop respiratory failure on terlipressin compared with those with ACLF grades 1–2 (30% for ACLF grade 3 versus 9.4% for grade 1–2, P=0.002). Patients with baseline ACLF grade 3 were also more likely to experience death attributed to respiratory failure on terlipressin as compared to those receiving placebo (22.5% versus 0%, P=0.05).

Multivariate logistic regression analysis identified baseline international normalized ratio, mean arterial pressure, and oxygen saturation as additional risk factors associated with the development of respiratory failure following terlipressin. Of note, the volume of albumin administration as a continuous variable was not found to be a predictor of respiratory failure in the terlipressin arm. No significant predictors of respiratory failure were identified among patients with HRS-AKI receiving a placebo.

Hospitalists can employ the ACLF scoring system to identify the subgroup of patients with HRS-AKI in whom the risks of terlipressin therapy may outweigh the benefits. For those patients with ACLF grade 3 in whom terlipressin is administered, hospitalists may wish to consider intensifying monitoring for respiratory compromise and have a lower threshold to discontinue therapeutic trials of terlipressin.

BOTTOM LINE: In contrast to patients with baseline ACLF grades 1–2, patients with ACLF grade 3 failed to achieve greater rates of hepatorenal syndrome reversal with terlipressin compared to placebo. Patients with baseline ACLF grade 3 were found to be at increased risk of respiratory failure and associated mortality following terlipressin therapy.

CITATION: Wong F, Pappas SC, et al. Terlipressin use and respiratory failure in patients with hepatorenal syndrome type 1 and severe acute-on-chronic liver failure. *Aliment Pharmacol Ther*. 2022;56(8):1284-93.

Ms. Boyle helped launch the first APP hospitalist service at Stanford Hospital where she works in inpatient transplant nephrology. ■

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Hospitalist Co-management Takes Practice But Can Enhance Patient Care

Clearly defined roles are crucial when establishing a co-management program

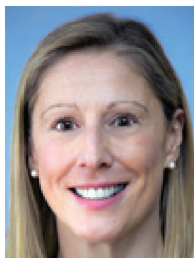
By Vanessa Caceres

Co-management continues to evolve as hospital leaders and hospitalists find the best ways to use skills and expertise from various specialties, including their own, to benefit patient care. Orthopedic surgery, neurosurgery, and other surgical specialties are commonly part of hospitalist co-management programs.

"These surgical specialty teams are often less familiar with managing medical complexity, and allowing the surgical team to provide excellent surgical care and the hospitalist to manage medical issues results in the best of both worlds," said Erin E. Shaughnessy MD, MSHCM, director and Beth Gordy Dubina Endowed Chair of pediatric hospital medicine in the department of pediatrics at the Heersink School of Medicine at the University of Alabama in Birmingham, Ala.

Dr. Shaughnessey

Co-management with these areas is common in pediatric medicine and adult medicine because evidence shows better outcomes when clinicians with varied experiences collaborate within these areas, said Mirna Giordano, MD, FHM, pediatric hospitalist and associate professor of pediatrics at Columbia University Medical Center in New York.



Dr. Giordano

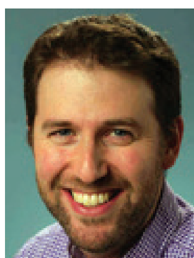
Yet other specialties can be part of a co-management agreement, said Nkemdilim Mgbojikwe, MD, SFHM, associate professor, department of medicine, and associate chief medical officer at Fox Chase Cancer Center in Philadelphia.

Dr. Mgbojikwe

At Dr. Shaughnessy's hospital, it's common for pediatric hospitalists to co-manage patients with significant medical needs with their pediatric physical medicine and rehabilitation partners, but infectious disease, dentistry, and ophthalmology often are in consultant roles. "The primary differentiation between a consultation and [a] co-management model is: a consultant makes recommendations and does not place orders, whereas co-managing services make decisions related to their practice area and enter orders," she explained.

Benefits and defining roles

Besides better patient care, potential benefits of co-management include increased professional satisfaction through collaborative working relationships and better allocation of medical staff expertise among patients, said Daniel A. Meyer, MD, vice chair for clinical affairs and quality in the department of medicine at Maine Medical Center in Portland.



Dr. Meyer

"The value proposition suggests that it is better for patients, providers, and healthcare systems alike to engage in these partnerships," Dr. Meyer said.

Dr. Meyer said that co-management within orthopedics may be so common and successful because there is easy delineation of roles. "The orthopedist can manage the surgery and the surgery-specific post-op care, and the hospitalist will typically manage everything else," he said. "This clear role definition allows the two groups to partner effectively and easily, in a sense because there is not a ton of partnership required to make it work."

He contrasts this with cardiology or oncology, where there may be more overlap in role definition. For instance, will the cardiologist or the hospitalist optimize hypertension? "It may be hard to define roles and responsibilities clearly ahead of time, but it is likely time well spent to iron out these questions as clearly as possible before entering into a co-management arrangement," he said.

When co-management arrangements happen organically due to staffing or resource limitations, hospitalists should still be deliberate in their role definition.

O'Neil J. Pyke, MD, MBA, SFHM, chief medical officer at Jackson North Medical Center, of Jackson Health System in Miami, supports more formal co-management arrangements but says it's common for them to develop organically. "Unfortunately, sometimes it's building the plane as we start flying," he said. One challenge he has seen is getting surgeons to take part in patient follow-ups postoperatively, especially on the weekends. "The hospitalist is left to guess or scramble to actually figure out what the surgeon is thinking because it's not adequately delineated in their progress notes," he said.

Dr. Pyke

This led to a pilot protocol at one of the hospitals in the Jackson system that says when a patient is admitted with a primary surgical issue, the surgeon is not allowed to sign off the case until they have a distinct conversation with the hospitalist team to confirm the patient is doing well and that the surgeon can be reached for any follow-up questions.

Co-management evolution

SHM published a White Paper on co-management in 2017, noting that co-management was associated with better patient care, improved patient safety, better pain scores, and lowered costs per patient hospitalization.[1]

The paper presented two possible models for co-management: one that assigns the hospitalist to be the patient's primary attending with the subspecialist as a consultant, and the second with the hospitalist as a consultant with the subspecialist as the patient's primary attending.

Although either model can work well with agreement and support from the involved parties, misinterpretations from other medical staff members and co-managers can occur if the co-management structure is not clearly defined.[1]

The report's content remains relevant today, hospitalists said—the only real change is an expanded role for co-management. "There is no doubt that we have moved away from the days where hospitalists only provided hospital coverage for primary care providers," Dr. Meyer said. "Today, hospitalists are managing or co-managing patients with a far wider range of medical and surgical conditions and medical complexity."

Dr. Pyke, one of the co-authors of the paper believes it reasonably states challenges with co-management and some possible solutions. What he's seen in recent years is hospitals trending toward specific co-management patterns based on the number of specialists available in a given area.

Best practices

Whether you're looking to start a co-management arrangement for the first time or want to maximize your current structure, here are a few tips for best practices:

Examine your current hospital dynamics. "The easiest place to start is by looking at your local environment to see where hospitalist partnerships can add the most value," Dr. Meyer said. "When in doubt, starting with an area like orthopedics or a similar surgical specialty may be the easiest way to go." However, examine your reasons for co-management. If your hospital orthopedic service's length of stay is longer than expected due to surgeons who are in the operating room and unable to address patient-flow needs, co-management may be useful. If orthopedic performance on length of stay already exceeds benchmarks, there may be fewer benefits of a co-management arrangement.

When getting started, make sure to discuss the financials of co-management with your chief executive officer and chief financial officer, to be clear on which type of practitioner is better to admit versus consult, Dr. Pyke advised.

Create detailed policies related to co-management. Although hospitalists acknowledge that co-management agreements sometimes happen organically, it's a better idea to have agreements in place. Be as detailed as possible so it's clear about who does what, where, and when. Make sure to outline any protocols used for shared decision-making as well, including medical and surgical checklists, Dr. Giordano recommended.

"One of the ways co-management programs break down is when a hospitalist or specialist feels they are being asked to practice out of scope, such as the hospitalist determining the timing of a surgery or a specialist needing to manage chronic medical condition outside of their training and experience," Dr. Mgbojikwe said. "The discussion about the scope of practice, including the level of engagement, cannot be emphasized enough in its importance for patients and medical teams." And, share these policies when onboarding new medical staff.

Vet your policies with members of surgical teams across the spectrum. "Even though the patient is at the center, we definitely want to make sure we hear all [clinician] voices," Dr. Pyke said. In a small hospital, that could mean speaking with every single proceduralist, but that also can help get support and feedback to create realistic co-management policies.

Link co-management to institutional or quality goals. For example, you could connect it with reaching a lower length of stay or improved patient experiences. "It still stands true from a quality perspective that the patient is getting the best care because you are structuring your co-management. It's making sure there are no gaps in the care that is delivered to the patient. Quality has to be at the top," Dr. Pyke said.

Have a plan in place to address conflict. Even with the best-laid policies, it still may happen. Plan to have a clearly identified individual or committee who can help handle conflict as well, Dr. Mgbojikwe recommended.

Aim for great communication and co-rounding when possible. "The best practice will always bring the two providers together to the bedside to make sure the patient perceives the togetherness of the service, and to feel more comfortable that no stones are left unturned in their care," Dr. Pyke said. In terms of better communication, that can be as simple as an exchange of phone numbers with fellow co-managers and having secure text messaging available, Dr. Shaughnessy said.

Foster a culture of mutual respect among specialties. "We are all professionals with important knowledge to contribute to patient care," Dr. Meyer said. "Respect each other's skills." One way to develop this is to have faculty who are active across divisions, he suggested.

Consider any special circumstances if you work in pediatrics. The American Academy of Pediatrics' section on hospital medicine, surgical care subcommittee, has a pediatric surgical co-management listserv that Dr. Giordano recommends to any practitioners who co-manage children and teenagers. If you're not sure how to join, she welcomes SHM members to contact her directly at mg2267@columbia.edu. This same subcommittee has several templates for clinicians who may want to start a co-management program, Dr. Giordano said. Another good resource for pediatric co-management is an article published earlier this year in *Pediatrics*.[2]

Vanessa Caceres is a medical writer in Bradenton, Fla.

SHM's Practice Management Team will debut additional co-management resources next month at hospitalmedicine.org/comanagement.

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SHM

Journal Series Aims to Demystify Publishing Process

JHM editors share their insights

By Thomas R. Collins

With a long-running sense that hospitalists often feel in the dark about how to get published, *Journal of Hospital Medicine (JHM)* editors decided it was time to tackle the topic seriously. They soon realized that the traditional avenue—pick a topic and write a single piece about it—would not be enough.

"At first, we envisioned this as a single paper, but the more and more we dug into it, we said, 'No way—there's no way all of this information is going to be able to fall into a single perspective,'" said Charlie Wray, DO, MS, senior deputy editor at *JHM*, and associate professor of medicine at the University of California, San Francisco. "So, we came up with the idea of, 'Why don't we break this apart?'"

Dr. Wray

The result is a three-article perspective series on the pre-publication process, the preparation process after a piece is submitted, and the post-publication process.

"Breaking it down into these three discrete parts, we thought, might be a better way of conveying all the important information that we thought the readers could use," Dr. Wray said.

The three papers—each written by a team of authors—are now available online and will be published in upcoming print editions of *JHM*.

Dr. Wray said there is no denying that getting published is an important part of the career trajectory of physicians—in addition to the value of producing new knowledge for the field. He called it "the gold coin of the realm."

"That's what academic institutions classically value and that's what people are oftentimes promoted on," he said.

Journal of Hospital Medicine®

Despite the importance of publishing—whether it's original research, case reports, or perspective pieces—hospitalists find themselves feeling unprepared, especially in their early attempts, he said.

"This process is so incredibly informal," he said. "It's never taught. And most of the time, people do it once or twice, find it incredibly frustrating or cumbersome, and then they never submit something again."

Once someone goes through the process five or six times— if they push through the frustrating initial efforts—the process becomes clearer and feels more manageable, he said.

"Part of our thinking was, 'Let's fast-track through those five or six times when it's really frustrating and difficult for people, and let's just tell people what it is that will help get their paper across the finish line.' We thought this series could accomplish that task."

He said that the advice contained in the three articles is applicable generally and valuable regardless of the kind of publication an author is trying to get published.

Many of the writers in the series were fellows in the *JHM's* editorial and digital media fellowship program, in which a handful of junior faculty throughout the U.S. join the editorial board for a year and get hands-on training and mentorship in the editorial and publication process. They are able to see "behind the curtain" into the

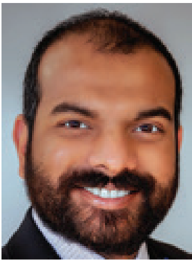
conversations when papers are adjudicated, reviewed, and slated for publication, or not. The fellows themselves have a range of publication history—some already with publications to their name, and some without.

Many of the fellows eagerly joined in when the editorial board introduced the idea of putting the series together, said Dr. Wray, who created the fellowship program eight years ago.

Since the fellows were learning about the publication process as they put together the series, they brought a freshness and immediacy to the articles about that process, he said.

"It was great because they were actively learning these things while they were writing about them," Dr. Wray said. "So, we thought those two aspects were really congruent in the fact that they could almost share their lived experience as editorial fellows and share what they were actually learning in the editorial and digital media fellowship programs."

Joseph Thomas, MD, a hospitalist at Buffalo Medical Group who was previously a fellow in the program and is now a deputy editor at *JHM*, said he wanted to participate in the series because there is a big need in the field for publishing guidance.


Dr. Thomas

"A lot of us go into it a little bit blindly," he said. "You can find mentorship, but sometimes it's difficult to know where to start. So, a series like that really appealed to me and to all of us to try to illuminate some of that."

Dr. Thomas led the perspective piece on the post-publication process, saying it dovetailed well with what was learned in his digital media fellowship.

"That was right up our alley because a lot of that involves digital media in today's publishing world," he said.

He said submitting a publication to a journal and then having it printed is only part of the process.

"With as much information as there is, you have to work actively to get that out in front of people and to help people engage with your work, which will lead to further engagement," he said. Engagement is no longer just about how many times an article is cited, but also about how many times it is clicked, viewed, and shared.

One piece of advice in his piece is to start at your own center when it comes to engaging readers.

"You always start where you're at," he said. "One of the first tips is to disseminate locally. Sometimes

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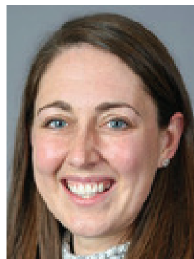
people will assume that if they put something out, that their section leaders, division leaders, department heads are kind of aware of all of the academic success that happens, but that's not always the case." So, circulating your work at your workplace, even just among your division heads, is important, he said.

The piece also delves into what goes into a good social media post in order to draw in people who live in the era of "constant scrolling," he said.

Furthermore, distributing quality work and data as widely as possible is imperative in today's world, Dr. Thomas said.

"I think it's really important if you've got good quality research or a perspective, or an educational aspect of medical care, it's important to get that out there because there is so much misinformation and disinformation out there. It's really easy to get lost in the weeds on that."

Rachel Peterson, MD, assistant professor of pediatrics at Cincinnati Children's Hospital, said the process of publishing is largely an unknown to many hospitalists.


Dr. Peterson

"It can just be kind of unclear what happens once you submit it, and how to make sure that your paper and what you've done is acceptable," she said.

The editorial fellowship at the journal was eye-opening for her and her group, she said, leaving them often saying, "Man, I wish I'd known this before." Realizing that sharing this information more widely would be beneficial, she decided to participate in the series and led the perspective piece on the pre-publication process.

"It's an evolving academic field, and so we want to make it approachable regardless of whether or not this is your first paper or your 51st," said Dr. Peterson, who got involved with publishing her work three years ago, after about three years as a practicing physician.

As she sat in on the editorial discussions about submissions, she saw that she had underestimated the importance of considering the audience and making sure that what is published is going to be of value to hospitalists in their everyday work.

"It was helpful to me to hear and understand from the editorial board just how dedicated those individuals are to making sure that they're publishing data that is relevant for hospitalists," she said. "In such a field that can be very generalist, it can be hard to make sure that you're being focused enough."

Dr. Peterson said that editorial board members "come at it with humility," and seek opinions from specialists when they might not have expertise to evaluate a submission in a particular area.

The thrust of her piece, she said, was "how do you get your idea from something in your head into a great piece on paper that you can submit with confidence?"

The piece discusses the importance of having a good team and a strong methodology, and underscores to readers the iterative nature of the process.

"There are going to be rounds and rounds and rounds of edits along the way and that is okay and that is a normal part of the publication creation process," she said.

"I think the biggest part is helping individuals see that it doesn't necessarily have to be perfect, but that having different eyes, different perspectives, looking at your paper—hopefully those are the members on your team—will help make your paper a lot better."

She said her deeper involvement in the editorial and publishing process has reinforced her appreciation for sharing knowledge.

"I wouldn't say I got the research bug—I'm not going to do research for the rest of my life—but I started to see the utility in asking scholarly questions and then getting it to published form," Dr. Peterson said. "Because I don't think we know how to improve what we're doing if we aren't learning from others. If I have a question or a concern about the way we do things in hospital medicine, someone else might also have that concern or question somewhere else." ■

Tom Collins is a medical writer in South Florida who has written about everything from lethal infections to thorny ethical dilemmas, runaway tumors to tornado-chasing doctors. He gathers health news from around the globe and lives in West Palm Beach.

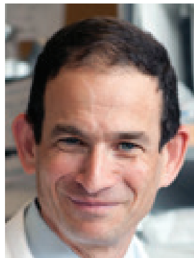
Hospitalists Use POLST to Initiate Patient Conversations About Care Goals

Defining life-sustaining preferences

By Larry Beresford

Physician orders for life-sustaining treatment (POLST) is a single-page medical order form, typically printed on bright pink paper, and signed by a physician, nurse practitioner, or physician assistant to spell out treatment preferences for a seriously ill or frail patient. It is also a process for exploring those preferences in conversation with patients and then communicating them to those who might need to know, such as EMS personnel, in some future medical emergency when the patients can no longer speak for themselves.

And, said Steven Pantilat, MD, FAAHPM, MHM, a former clinical hospitalist and the inaugural chief of the division of palliative medicine at the University of California San Francisco, it is "solidly within what hospitalists can and should be doing." That may involve meeting and talking with patients and their families about their values and treatment preferences, reviewing any existing POLST forms, and even filling out and signing a form.



Dr. Pantilat

When a patient completes a POLST form at UCSF, Dr. Pantilat said, a ward clerk can upload it to the hospital's electronic health record (EHR). "An advantage of POLST in the hospital is that when I sign it and the patient signs it, it's done."

A legal medical order

POLST includes information and options regarding cardiopulmonary resuscitation, artificially administered nutrition, and several other medical options—with choices ranging from full treatment to comfort-focused treatment only—along with the necessary signatures. It is recognized as a legal, actionable medical order in many states, while most of the other states are developing policies and regulations to recognize an executed POLST form.

POLST was first implemented in Oregon in 1995 to address the common problem of not being able to locate and thereby honor the life-sustaining treatment preferences of patients. Originally named "Physician Orders for Life-Sustaining Treatment," today it's often called a "portable medical order," meaning it's valid in community settings, or just plain POLST. Some states use alternate terms like MOLST (Medical Orders for Life-Sustaining Treatment), or POST and MOST, for a similar document.

But POLST is not just a medical form. It is a tool that can help medical practitioners, including those working in hospitals, to provide individualized, compassionate care aimed at honoring patients' wishes and deeply held values in the context of what is medically achievable for them—while helping to prevent unwanted or inappropriate treatments.

"POLST complements patients' advance directives, although it is different than those. It is an actual physician order that is meant to guide care in the home or long-term care setting in specific ways," Dr. Pantilat said. "The way I think about it is that when POLST is most useful—and typically the only time I fill it out—is when someone wants a code status other than full code. If the patient's preference is full code, full treatment, then I'm not sure you have to document that (on a POLST form) unless you think there's some reason why it would not be respected in the setting in which the patient is located."

"When I'm seeing patients, as soon as I hear that they don't want to be full code, I'm already thinking I should pull out a POLST form and get it done before discharge. And then you can use it to guide a conversation that is specific to their circumstances." Hospitalists are concerned with the patient's care in the hospital but also about what happens after they go home, Dr. Pantilat said.

More than just checking boxes

"As hospitalists, we should be able to review the patient's care preferences upon their admission to the hospital. Are those consistent with what's going on medically and what's achievable?" said Rab Razzak (@rabrazzak), MD, a hospitalist and clinical director of palliative care at University Hospitals Cleveland Medical Center in Cleveland.

Dr. Razzak

Whatever the patient chooses is important, Dr. Razzak said. "We need to help them better understand what those choices mean. The problem is we sometimes just accept what the patient says, even when what they say may not be consistent with what is medically possible." When needed, he said, the hospitalist can offer patients more guidance on what is possible.

"We should be having conversations about what this all means to them, including prognosis and natural history of the disease, if they want to know," Dr. Razzak said. Fostering improved communication, asking what is most important to the patient, "This is the work we need to do in order to provide better and more personalized care. Our clinical institutions and groups should be supporting that. Obviously, it requires some time in order to a good job," he said. If hospitalists are seeing too many patients in a day, they won't do as good a job on these conversations.

Dr. Razzak serves on SHM's Palliative Care Task Force, led by Wendy Anderson, MD. This group helped to develop the "Hospital Prognosis and Goals of Care Communication Pathway" of key communication processes within the typical workflow of hospitalists and their teams.[1] One of its recommendations is for the hospitalist to review established care preferences, such as those captured in a POLST form, at the time of admission to the hospital. "If POLST is in the chart, does it still apply? Can we update their POLST form by the time of discharge?" Dr. Razzak said.

A 2020 study in *The Journal of the American Medical Association* examined the association between POLST orders specifying treatment limitations and admissions to the ICU for hospitalized patients nearing the end of life in a two-hospital academic healthcare system.[2] It found that treatment-limiting POLST orders were significantly associated with lower rates of ICU admission, compared with POLST orders specifying a full-treatment approach. However, 38% of patients with treatment-limiting POLST preferences still received intensive care that was potentially discordant with their care preferences.

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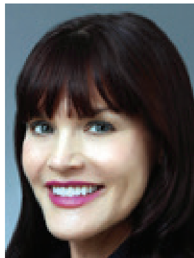
Meeting the patient and family

Elizabeth Gundersen (@top_gundersen), MD, FAAHPM, FHM, a former hospitalist and associate professor of hospice and palliative medicine at the University of Colorado's Anschutz Medical Campus in Aurora, Colo., said she is sometimes asked what "serious illness," a common indicator for POLST appropriateness, means.


Dr. Gundersen

"I say a serious illness is one that has a high probability of morbidity or mortality for the patient—with a high likelihood of complications and of coming back to the hospital," she said. She adds that a useful question for the clinician to ask is, "'Would I be surprised if this patient died in the next year?'"

One of the barriers to hospitalists using the POLST form with their patients is their limited time, Dr. Gundersen said. "But if you have a patient that you're seeing who has a serious illness and has been in the hospital frequently, and your intuition is telling you they are at risk of showing up in the hospital again in the not-too-distant future, those are patients for whom it would be worth sitting down and having a full goals-of-care conversation," she said.

"I did this recently with a family. We had a family meeting and they decided to shift the focus of care for their loved one to comfort. Our hope was that we would be able to send the patient home on hospice care. And we established all of that in a big, emotional family meeting," Dr. Gundersen said. "Then, at the meeting's end, I said, 'We have this form that we use to document everything that we just talked about, so that your loved one will be protected (from unwanted medical care) when she goes home with hospice.'" It applies, she adds, even for what might happen en route to her home.

As a hospitalist, introducing goals-of-care conversations during the initial encounter can be challenging and requires a certain level of sensitivity, empathy, and effective communication, said Salonie Pereira, MD, associate site director of the division of hospital medicine at Long Island Jewish Medical Center and assistant professor of internal medicine at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell in New Hyde Park, N.Y.

Dr. Pereira

"I often aim to establish at least a day or two, if possible, to introduce myself, get to know the patient and their caregivers, provide information on the diagnosis and care plan, and reinforce my role in their care. I then ask all my patients with advanced illness about their advanced directives, their healthcare proxy, and their preferences for medical interventions so as to align their values with the medical plan," she said.

In certain situations, a member of the palliative care team will accompany the hospitalist for a joint family meeting offering enhanced support and expertise in shared decision making, she said. The Advanced Illness Team at Northwell Health also conducts a three-hour training program for its clinicians, using simulated patients to offer experience in goals-of-care conversations.

Incorporating POLST into the EHR

Mihir H. Patel (@mhp0023), MD, MPH, MBA, FACP, CLHM, SFHM, medical director of virtual medicine and chair of the inpatient clinical informatics council at Ballad Health in Tennessee and Virginia, chair of SHM's Health Information Technology Special Interest Group, and a practicing hospitalist, said hospitalists are the primary point of contact for patients in the hospital and can facilitate the communication of patient preferences and values by initiating conversations about POLST.

Dr. Patel

"Verifying that the patient and family understand their choices and that the POLST form accurately reflects their wishes is essential," he said. "Hospitalists have the unique advantage of seeing the same patients daily, sometimes multiple times a day, during their hospital stay. This continuity allows for in-depth conversations and multiple touchpoints with the patient and family, which is typically not possible in an outpatient setting."

For Dr. Patel, incorporating digitalized POLST forms into a hospital's EHR ensures that patient preferences are accurately documented and easily accessible. "The digitalization of POLST forms involves transforming paper forms into electronic versions (ePOLST) that integrate seamlessly into EHRs," he said. There are two formats for integrating POLST within an EHR: paper POLST form upload and storage in the EHR, and an electronic POLST (ePOLST) completed electronically.

Implementation of ePOLST should follow document and messaging standards (e.g., HL7), Dr. Patel said. Depending on state laws, an ePOLST may still need to be printed, signed, and scanned into the EHR, with a copy given to the patient.

Technological solutions

There are other technological solutions such as mobile apps and electronic repositories for POLST documents, Dr. Patel said. Vynca and MyDirectives are examples of online repositories that allow online creation, signing, and storage of POLST forms, which can be integrated with healthcare or EHR systems.

Some hospitalists may not be fully familiar with the purpose or legal implications of POLST forms, leading to potential misinterpretations, educational gaps, communication breakdowns, or family conflicts, he said. Failure to update a patient's POLST form regularly may result in a document that no longer reflects the patient's current wishes. It is also important to make sure the family understands what's on the signed form.

For a hospital that does not have a formal program to encourage easy access and storage of POLST forms for its patients, the hospitalist may be the obvious choice to champion such a POLST initiative, he said. Start by reaching out to the C-suite, the medical executive committee, and the hospital's ethics committee for their support. Comprehensive staff training about POLST should target physicians—both hospitalists and intensivists—as well as primary care physicians in the clinic setting, nursing leadership, the emergency department, and long-term care facilities with working relationships.

Plan to collect data on usage, rate of adherence to patients' expressed wishes, and patient and clinician satisfaction. Make sure the forms are easily accessible, both electronically and on paper, throughout the hospital. Providing decision support tools within the system and ensuring interoperability are two other important goals.

Honoring patient values and preferences, with the help of POLST, could be an obvious target for quality improvement initiatives, experts interviewed for this article noted. "If you're looking at this from a practical standpoint, not only is it the right thing to do for patients, but it can impact quality metrics like ICU admission rates or in-hospital mortality," Dr. Gundersen said.

"I've always felt hospitalists are the 'home team' for both hospitalized patients and hospitals," she said. "Championing POLST is an excellent thing for hospitalists to do within their division. We want to see this form used more often because of the benefits it has for our patients. Work with your hospital leadership for system-wide buy-in. Talk to the leadership about how this is good for everyone." ■

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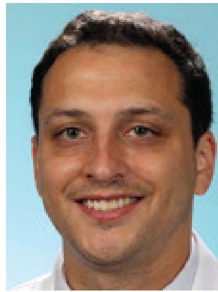
"First You Take a Drink, Then the Drink Takes a Drink, Then the Drink Takes You"

Substance use disorders in physicians

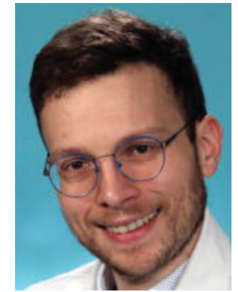
By Carol Faulk, MD, Kieran Patel, MD, Dennis Chang, MD, FHM, Anthony Dao, MD, and Michael Wenzinger, MD

Dr. Faulk


Dr. Patel

Dr. Chang

Dr. Dao


Dr. Wenzinger

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The title of this article, a quote by F. Scott Fitzgerald, illustrates the experience of alcohol use disorder. Although physicians are comfortable recognizing and treating substance use disorders (SUDs) in patients, we rarely discuss how to recognize SUDs in ourselves and our peers. This article will provide a compassionate approach to identifying SUDs in ourselves and our peers, discuss the stigma and other barriers to treatment for SUDs, and describe what practical help can look like.

Stats and diagnosis

Before starting medical school, future physicians have statistically significantly lower rates of depression and burnout and score higher on quality-of-life surveys compared to their college graduate peers.[1] During medical school and residency, this trend dramatically changes. Medical students and residents are more likely to be burned out and exhibit signs of depression compared to their age-matched college graduate peers. After completing training, physicians continue to have increased rates of burnout.[2] Like the general population, as many as 50% of physicians with SUDs have comorbid psychiatric disorders.[3] Previous cross-sectional surveys and review articles suggest that substances are often used by physicians for performance enhancement or as a treatment for pain, anxiety, or depression.[4] When identifying a SUD in ourselves or a physician peer, we recommend framing the diagnosis through this empathetic lens of how our mental health can be impacted by external stressors, rather than one of blame and personal choice.

Diagnosis of a SUD, whether that be alcohol, benzodiazepines, opiates, or others, can be made through the DSM V criteria for SUD, as illustrated in Table 1.[5] Although it's challenging to determine the exact prevalence of SUDs in physicians, studies suggest it ranges between 10 and 20%, similar to that of the general population.[6-8] Despite historical prejudice against physicians with SUDs, physicians with SUDs are not necessarily impaired physicians. An impaired physician, as defined by the American Medical Association, is a physician who is unable to deliver medical care to patients safely and with reasonable skill. Instead, like any physician with a psychological or medical disorder, physicians with SUDs are considered to have a potentially impairing condition.[8] Detecting signs of SUD and impairment in other physicians can be challenging. Table 2 includes common signs and symptoms.

Barriers to treatment

There are many barriers to treatment for physicians with SUDs, including stigma, denial, and fear of losing one's reputation, income, and license to practice medicine. The routine frustrations many physicians face in the management of SUD further add a unique, work-related source of both external and internal stigmatization. Emergency department (ED) physicians are one of the specialties that often manage acute presentations of patients with SUD. A 2018 study in the *Journal of Addiction Medicine* showed that since patients with SUDs typically have needs that far exceed what an ED can provide, it isn't surprising that only 8% of ED physicians said working with patients with SUDs who are in pain is "satisfying." More than half of the ED physicians in the same survey indicated irritation and preference to avoid working with these patients, and a further 72% reported these patients were particularly difficult to work with.[9] How this frustration may, along with the myriad other work-related stressors faced by this specialty, result in an increased avoidance and denial of one's own SUD is not difficult to imagine.

This stigma is thought to be part of the reason why only 10% of patients with SUDs seek treatment.[10] There is evidence that stigma is reduced when we avoid using terms like "substance abuser" and instead use "person with SUD." Physicians who avoid stigmatizing language are less likely to see patients as personally culpable for their pattern of use and instead more appropriately view the pattern of use as a dysregulated reward pathway in the brain. This leads us to see SUDs as a disease requiring medical treatment instead of a moral failing requiring punishment.[10,11] To foster more compassionate and effective discussions about SUDs among ourselves and our physician peers, it's essential to employ neutral language, as outlined in Table 3.

Despite physicians often having more insight into the diagnosis and treatment of SUDs compared to the general population, denial can often hinder treatment. Physicians are taught in training to be self-sufficient, and tireless, and to put patient care and their professional obligations before their own needs. One study of pediatric attending physicians and advanced practice clinicians showed that 83% of participants reported working while significantly ill in the last year, despite 95% of participants knowing that working while sick would put their patients at risk.[12] These healthcare professionals reported that they continued to work because they did not want to let their colleagues or patients down. Denial of one's own illness allows physicians to continue to work while knowing they shouldn't work while sick. Similarly, it's thought that denial of one's own SUD, due to years of putting our patients' and colleagues'

Table 1: DSM V Criteria for SUD[5]

12 MONTHS OF REPEATED SUBSTANCE USE RESULTING IN IMPAIRMENT OR DISTRESS LEADING TO TWO OR MORE OF THE FOLLOWING:
Taking more of the substance than intended
A persistent desire or unsuccessful effort to cut down
Spending a great deal of time obtaining, using, and recovering from the substance
Cravings
Use resulting in the inability to fulfill obligations at work or home
Continued use despite use causing interpersonal problems
Giving up or decreasing important activities due to use
Recurrent use when it is physically hazardous (e.g. driving while under the influence)
Continued use despite use causing physical or psychological problems
Tolerance
Withdrawal

2-3 criteria met is mild SUD, 4-5 is moderate, 6 or more is severe

Table 2: Signs of Possible SUD and/or Impairment[4]

BEHAVIORS	PSYCHOLOGICAL	PHYSICAL
Rounding on patients at odd hours	Tense interactions	Watery or blood-shot eyes
Often absent without reasonable explanations	Mood swings	Unkempt appearance
Consistently late	Withdrawal from family and social activities	Hand tremors
Conflicts with or avoidance of other colleagues	Personality changes	Dilated pupils
Heavy drinking at work functions	Defensiveness	Changes in speech patterns (i.e., slurred or pressured)
Multiple prescriptions for family members	Apathy	Weight loss or gain

Table 3: Avoiding stigmatizing language[11]

INSTEAD OF...	USE...	BECAUSE...
History of substance abuse or user	History of SUD	Using first-person language emphasizes the person has a problem, instead of the person *being* the problem
Alcoholic	Person with AUD	
Former addict	Person with SUD now in recovery	
Habit	SUD	Undermines the seriousness of SUD and implies that it is a choice
Clean	Testing negative, being in remission or recovery	Evokes implicit negative connotations for those who continue to use, i.e. "dirty"

needs before our own, leads to delay in diagnosis or treatment.[3,8]

Many review articles also describe a "conspiracy of silence" among physician peers. Physicians often explain away their peers' behavior or doubt their own observations due to concerns that they are overreacting. Furthermore, physicians also worry about damaging their colleagues' careers or their hospital's reputation by acknowledging the reality of an impaired physician. Despite clear guidelines from the American Medical Association mandating the reporting of impaired colleagues, some physicians still feel that it is the personal responsibility of the affected physician. Review articles suggest that physicians' personal lives are often first affected by SUDs as they are highly motivated to continue to fulfill their professional obligations.[3,4] However, family members of physicians may choose silence due to the loss of income that might occur if a SUD is diagnosed.[3] This can lead to a more widespread culture of denial both in the workplace and at home. Unfortunately, this short-term goal of saving face can lead to more substantial harm as delays to treatment for SUD can lead to worse outcomes.[10]

Physicians with SUDs often have concerns about the implications for their careers. As stated above, a physician with a SUD or any mental health diagnosis has historically been conflated with an impaired physician. One study showed that of the 5,000 actions that were taken against physician licenses between 2004 and 2020, more than 75% were due to impairment related to SUD.[13] This may lead to the belief that SUD is a career-ending diagnosis. However, physicians should instead be encouraged to seek timely help to continue practicing. In 2018, a report from the Federation of State Medical Boards recommended that state medical boards reconsider any probing questions about mental health or SUDs on license applications and renewals, as these questions were more likely to discourage physicians from seeking treatment than improve patient safety.[14] Despite this, these questions are still asked on yearly license renewals in many states.

Getting help

Once we have identified an SUD in ourselves or another physician, the next step is to seek assistance through an employee assistance program, counseling, medical care, and support groups. Caduceus groups are peer support groups that consist entirely of medical professionals and use a 12-step approach to encourage recovery from SUDs. These groups are often helpful because healthcare professionals can share their experiences with others. The state medical society and the associated physician health program (PHP) can be good resources when you or a colleague are struggling with an SUD. These entities are usually separate from the state medical board which is responsible for licensure.[4] If you or your colleague is unable to competently perform as a physician, the next step is to notify a supervisor to arrange for time off of work so a structured recovery plan can begin. Structured plans, called contingency contracts, can be provided by the state PHPs. These plans often involve a contract by which impaired physicians must participate in certain activities and document recovery from SUD to continue or return to practice, typically for five years.

If the physician does not comply with the contract, a common consequence is notification of the situation to the state medical board. Although there are valid criticisms of PHPs, studies show that physicians who participate in these programs have a much higher success rate (70%) than the general population does with usual treatment for SUDs.[6,15] Despite the possibility of loss of licensure, the 2001 Joint Commission on Accreditation of Healthcare Organizations standards state: "The purpose of the process [of identifying and treating impaired physicians] is assistance and rehabilitation rather than discipline, to aid a physician in retaining optimal professional functioning, consistent with protection of patients." It is in the best interests of physicians, patients, the government, and healthcare organizations for physicians with SUDs to recover and continue to practice.

Physicians with SUDs have made important contributions to healthcare. In Dr. William Osler's article "The Inner History of the Johns Hopkins Hospital," published in 1969, he describes the SUD of his friend William Halstead, the father of modern surgery. Dr. Osler states that Dr. Halstead's "proneness to seclusion, the slight peculiarities amounting to eccentricities...were the only outward traces of the daily battle through which this brave fellow lived for years."[4]

Like Dr. Osler, we need to approach SUD in ourselves and our fellow physicians with compassion. We should avoid dichotomizing physicians into either completely self-sufficient and infallible or weak and incompetent. We encourage you to avoid stigmatizing language, acknowledge that physicians like all humans are susceptible to disease, and break the conspiracy of silence to encourage timely diagnosis and treatment of physicians with SUDs. ■

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Election Day: The Votes of Hospitalized Patients Matter

Supporting the right to vote for hospitalized patients

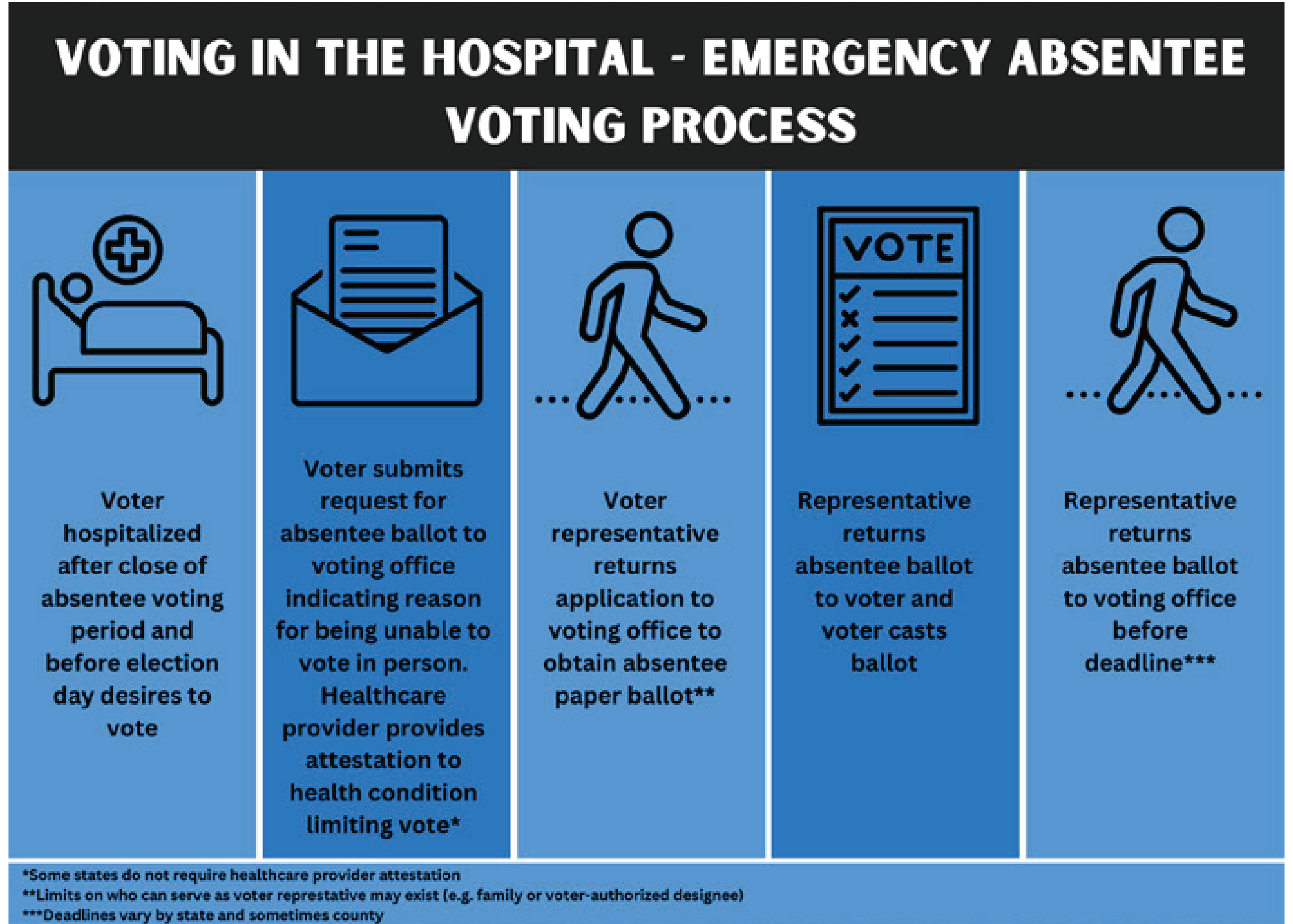
By Michelle Thomas, MD, and Charles Pizanis, MD, FHM

Election day—it's coming up. For many Americans, this is an opportunity to shape the future of our country, state, and local communities. Getting admitted to the hospital unexpectedly early this November—that's coming up too (for many voting Americans). So, what are those individuals to do if they want to vote?

The ability to vote is paramount and is now recognized as a social determinant of health. In 2022, the American Medical Association issued a resolution acknowledging the ability to vote as a social determinant of health and supported efforts that facilitate "safe and equitable access to voting."[1] The Health Resource & Services Administration released guidance for health systems to support non-partisan registration efforts for federally funded health centers, and many organizations, including the American College of Physicians, have called on healthcare practitioners to consider promoting voting access as a fundamental healthcare duty.[2,3]

Calls for hospitalists to participate in the electoral process and promote access to voting have been increasing.[4-6] Facilitating voting access for the tens of thousands of Americans on our inpatient teams in the immediate days leading up to November 5—now that sounds like something hospitalists might be masters at!

Figure 1: Typical State Emergency Absentee Voting Process



Emergency absentee voting—what is It?

Regular absentee ballots are available for those who know they won't be able to be present at the polls on Election Day. A majority of states, however, have absentee ballot deadlines which, in some cases, can be several days or even up to two weeks before Election Day. This allows for a period of vulnerability for individuals intending to vote in person who become hospitalized or otherwise experience a health barrier to making it to a voting location on November 5.

Enter the emergency absentee voting process. For those with unforeseen health circumstances who did not arrange in advance to vote by regular absentee ballot, many states' voting regulations include the provision of emergency absentee ballots. These regulations allow individuals hospitalized or in post-acute care facilities leading up to the election to vote without needing to be physically present at a voting location on Election Day.

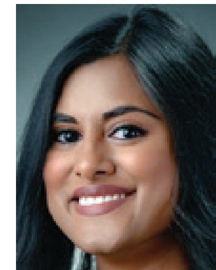
In a 2021 study assessing state voting laws, 39 states had emergency absentee voting processes allowing registered voters who couldn't make it to the polls for health-related reasons the chance to cast their ballots. The study revealed substantial differences in emergency absentee voting procedures among states, including variations in who could act as an "authorized agent" to assist with the ballot, whether a physician's signature or affidavit was necessary, and whether a notary or witness was required.[7] So how does a patient go about voting from the hospital?

Emergency absentee voting process

The general process for hospitalized patients to vote is the following: the patient (who must be a registered voter) completes the emergency ballot application which is then submitted to their Board of Elections (or other voting regulatory body). The Board of Elections then sends the ballot to the patient who fills it out, and it is then returned to the Board of Elections. Depending on the state in which the patient lives, the application and ballot can be sent electronically, by mail, in person, or through an authorized agent (Figure 1).

For example, the state of New Mexico requires a written request for an absentee ballot signed by the patient and the healthcare practitioner. The request and ballot itself can be delivered by a patient-designated authorized agent. However, the state of Kansas requires the patient to request the ballot from the County Election Office and an authorized agent cannot be used. For examples of a few additional states and elements of their processes, please see Table 1. For a list of other states' requirements, visit PatientVoting.com or your state's Board of Elections website.

Most states allow for an authorized messenger to take in-person trips to and from the election office to deliver the application, pick up the ballot, and deliver the bal-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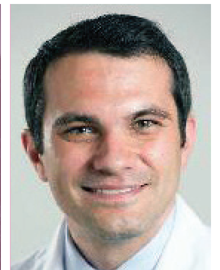

Dr. Pizanis

Dr. Thomas is a resident physician in internal medicine at the University of New Mexico in Albuquerque, N.M., where she is a member of the hospitalist training track. She plans to practice as a hospitalist in the state of New Mexico. Dr. Pizanis is an associate professor and co-director of the University of New Mexico's hospitalist training track, division of hospital medicine, department of internal medicine, at the University of New Mexico School of Medicine in Albuquerque, N.M.

Key Points

- Tens of thousands of registered voters will be hospitalized in the immediate days leading up to Election Day (November 5).
- Emergency absentee voting is available in many states to patients who are hospitalized on Election Day or are otherwise unable to make it to the polls for health-related reasons.
- Emergency absentee voting processes vary by state.
- PatientVoting.com is a nonpartisan group that facilitates emergency absentee voting. Its website has a state-by-state listing of emergency absentee voting processes with downloadable ballots in many cases.
- Hospitalists can help patients on our services vote by incorporating discussions on voting preferences into our rounds, completing any required documentation attesting to health-related reasons, and participating in system-wide efforts to increase voting in our hospitals.

Table 1: Select State-Specific Emergency Absentee Ballot Regulations

	REGULAR ABSENTEE BALLOT REQUEST DEADLINE	PHYSICIAN DOCUMENTATION REQUIRED FOR EMERGENCY BALLOT	ONLINE ABSENTEE BALLOT REQUEST	BALLOT RETURN DUE BY
California	7 days prior to Election Day	No	No	Postmarked by Election Day, received no longer than 7 days after Election Day
Florida	12 days prior to Election Day	No	No	7pm Election Day
Ohio	7 days prior to Election Day	No	No	Postmarked 1 day before Election Day, received no longer than 4 days after Election Day, or delivered in person by 7:30 pm on Election Day
New Mexico	7 days prior to Election Day	Yes	No	7pm Election Day
New York	In person: 1 day prior to Election Day; mail/online: 15 days prior to Election Day	No	Yes	9pm Election Day
Pennsylvania	In person/mail: 7 days prior to Election day; online: 5pm first Tuesday prior to Election Day	No	Yes	8pm Election Day
Texas	11 days prior to Election Day	Yes	No	Postmarked by 7pm Election Day, received no later than 5 pm day after Election Day

For a list of other state requirements, please visit PatientVoting.com or your state's board of elections website

lot. Some states have restrictions on who can help with which steps. However, it is encouraged to use case management team members and/or hospital-based volunteers to help patients with this process and ensure that they understand their voting options. Deadlines for when patients can request and submit ballots vary significantly by state. Additionally, some states send bipartisan, in-person teams to patients in their hospital rooms to complete their ballots.

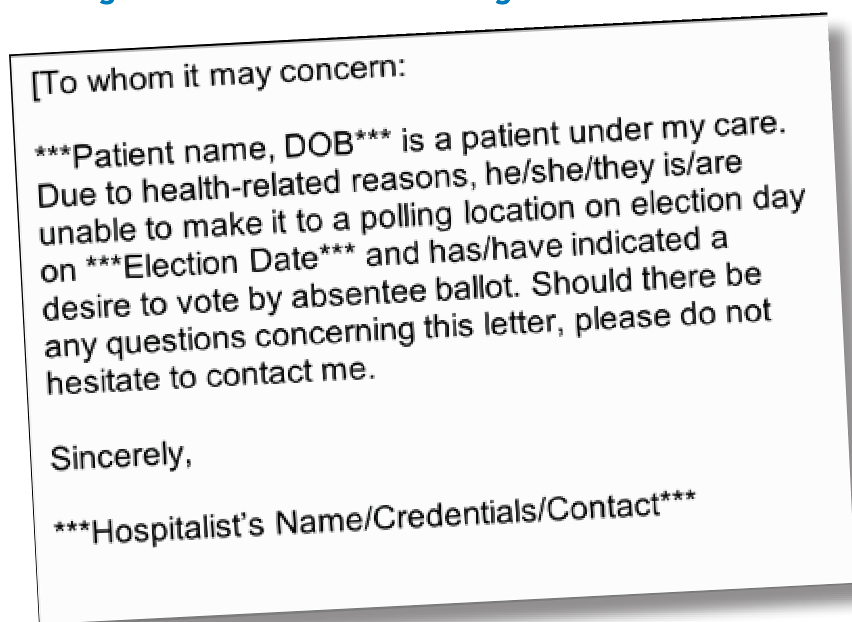
With the high variability in processes and how difficult it can be to find appropriate steps on some state-specific websites, Patient Voting, a non-partisan organization that seeks to increase voter turnout among registered hospitalized voters, contains a state-by-state summary of policies. Its site includes links to state commissioner websites detailing more specific language as well as emergency ballot applications for printing in the hospital in many cases.

What can hospitalists do to support patients who want to vote?

As hospitalists, there are a handful of ways we can facilitate voting for the patients who are under our care leading up to the election. At a minimum, we should become familiar with our state and county regulations on emergency absentee voting and be able to counsel our patients on the appropriate first steps for a patient to take. In the coming weeks, every hospitalist should take a look at PatientVoting.com to learn about their local processes.

Many states require a statement from a physician or healthcare practitioner verifying that a

Figure 2: Example Template for Electronic Records Attesting to Need for Absentee Voting


[To whom it may concern:

Patient name, DOB is a patient under my care. Due to health-related reasons, he/she/they is/are unable to make it to a polling location on election day on ***Election Date*** and has/have indicated a desire to vote by absentee ballot. Should there be any questions concerning this letter, please do not hesitate to contact me.

Sincerely,

Hospitalist's Name/Credentials/Contact

health-related condition exists which precludes a patient from making it to a voting location. As such, hospitalists should make themselves available for our patients in this regard if needed. Hospitalists can create templated language or dot phrases within our electronic medical records and share them with our colleagues. An example of some templated language is provided in Figure 2.

Hospitalists can also incorporate asking admitted patients in the emergency department or on the floor if they would like to know more about voting while hospitalized and provide the information on requesting and submitting absentee ballots. This aligns with our role in addressing social determinants of health and caring for patients in a holistic manner.[8,9]

At the health system level, hospitalists can also take lead roles at our institutions to improve voting awareness and engagement. Examples of such engagement have been reported with hospitalists taking roles in designing voting registration assessments as routine, healthcare-team member workflows, coordinating voter registration drives, and advocating for their hospitals to partner with nonpartisan civic engagement organizations.[4] Within the realm of emergency absentee voting, we can organize other hospitalists in our groups by sharing information on local voting policies and brainstorming ways to integrate facilitation of ballot requests within our workflows.

Final thoughts

Life itself can be unpredictable and undergoing a hospitalization is perhaps one of the most vulnerable and disrupting challenges one can experience. However, it should not stop those who desire to perform their civic duty from casting their ballots. As hospitalists, we have a unique vantage point and access to tens of thousands of voting Americans who, because of illness, find themselves in our wards and units leading up to the election. We can play a pivotal role in helping make our patients' voices heard. ■

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Finding Your Dream Job Out of Residency

By Philip Huang, MD

Since the role of a hospitalist was defined more than 25 years ago, hospital medicine has become an established and increasingly popular career choice for residency graduates. A recent report estimated that 71% of newly certified general internal medicine physicians choose hospital medicine over outpatient or hybrid positions.[1] Although the demand for hospitalists remains strong, with more than 2,500 new positions created each year, positions in well-established programs and desirable locations are becoming more competitive.[2] While everyone's path toward a dream job will be as unique as what makes up one's dream job, these are general steps and factors to consider in your journey.

Timing and preparation

In general, for most applicants, preparing a year before your expected start date will provide plenty of time. You may consider exploring positions earlier if you have special circumstances like coordinating a move with a spouse or securing a work visa. Gathering materials at this time mirrors the fellowship application cycle, which is beneficial given faculty are in a career mentorship mindset assisting your peers in applications as well. Applying early can be beneficial as many larger established hospitalist groups have a set number of new faculty that they are seeking to hire each year.

In preparing your application, a curriculum vitae should list major educational experiences and awards accrued during residency. Notable clinical experiences such as hospitalist electives, rural rotations, addiction medicine, perioperative consults, and critical care and procedural competence may demonstrate your ability to transition smoothly to independent practice.

Additional achievements such as research, teaching, leadership, and public service may also help demonstrate your potential to serve in non-clinical roles. As for clinical references, it's generally best to ask mentors early and to provide details about your career goals. Your mentors can then decide what qualifications to highlight to give the strongest overall impression to those reviewing your application.

The next step is to make contact. Recent residency graduates and early career faculty may be able to share their personal experiences and connections to hospitalist groups. Local career fairs and national conferences such as SHM Converge also provide a unique networking opportunity. If you have significant time constraints or find the process too complex, you could consider working with a recruiter. However, recruiters may only work with a few programs and their services do come at a cost. Moreover, your residency programs should be committed to your success and will be able to provide dedicated time for interviewing. Aiming to receive at least three to four job offers will then allow accurate comparison between positions and provide leverage in negotiation.

Practice setting

As you consider different opportunities, the practice setting is important to consider. Larger urban academic hospitals often have higher acuity but should offer more specialist support. Due to their size, these systems sometimes divide their services to focus on organ systems, such as cardiology, pulmonary, and cancer service lines. These centers may also offer more variety in practice settings, including intensive care units, long-term acute care hospitals, inpatient rehabilitation centers, and skilled nursing facilities. Some groups are exploring integrating more telemedicine and hospital at home services. In rural settings, some hospitalists find significant autonomy and a broad scope of practice including open intensive care units.

Another key decision is whether to practice in an academic setting. Academic centers often provide more flexibility to pursue interests outside of clinical medicine and usually have a decreased focus on volume. You should also consider opportunities for professional development in teaching, leadership, quality improvement, research, and procedures. When exploring positions, it is worth specifying the support and opportunities you will be given as well. Some academic systems have transitioned to having dedicated teaching faculty and may only offer very few opportunities to teach on the wards, especially to junior faculty.

Schedule

Regarding scheduling, most practices offer the traditional seven-days-on-seven-off model. Larger groups may have flexibility with admission, swing, and night shifts. Rural critical access hospitals may offer 24-hour shifts which can be manageable due to a low census and low acuity. Locum tenens work also offers flexibility in scheduling, although they generally also request seven-on-seven-off.

When considering a position that requires working evening and night shifts, be sure to clarify how many of these shifts are expected. It's common for junior physicians to cover more of these undesirable shifts, even while they are sometimes reimbursed at a higher rate. Understanding if internal or external moonlighting is permissible is important to discuss early.

Finally, understand the rules regarding time off for sick and vacation days, as junior faculty may be required to be on backup and work more vacations unless this is specifically stated.

Most shifts will be between eight and 12 hours, although requirements to be in-house may differ. Many programs now allow for remote coverage of routine issues from home after rounds are complete, with a rotating physician in-

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house who is then "on call" to respond to urgent issues requiring in-person assessments. Many of these details can be determined by asking what an average day on service may look like and by asking junior faculty about their experience.

Salary and benefits

After the above factors are considered, candidates should think about the importance of salary and benefits to them. The cost of living should be examined when reviewing salary. Comparing different positions allows you to have a good sense of the fair market rate for your services. Understanding bonus structures and group priorities is important, as groups may rate your performance based on RVU (relative value unit) production versus other quality metrics. Bonuses will typically be easier to negotiate than salary and might include some combination of payments for signing, relocation, production, and student loan repayment. Be aware, however, that some of the larger bonuses you encounter may have specific requirements or multiyear commitments.

Larger groups may also have opportunities to moonlight or add additional shifts, translating to a significant earning opportunity. If you have an entrepreneurial spirit, understanding the details of your contract's limitations on outside employment and ventures is important. Some university systems may also have strict regulations regarding your ability to create patents or other intellectual property as faculty.

The decision to work in private practice or be hospital-employed may also have significant implications. Private practice may offer financial benefits and autonomy, but there is associated risk and commitment as an owner. In addition, private groups must continue working hard to secure contracts at a time when many hospitals have been creating their own hospitalist groups. As a business partner, you will also be involved in business decisions such as hiring, contracts, and scheduling. If these additional responsibilities are attractive to you or at least tolerable, the financial benefit may be worth it.

Conclusion

Hospital medicine continues to be a growing field with significant variety in practice settings and responsibilities. This translates into many factors to consider as you search for that first dream job. Hopefully, this article gives you an idea of how to give yourself the best opportunity to find your dream job by preparing early, asking mentors for advice, determining your priorities, and comparing multiple offers. ■

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SIG Spotlight: Hospitalist Well-Being

A safe, compassionate space to address the systemic nature of the problem

By Richard Quinn

Well-being, at least in hospitalist circles, can't mean a once-a-year yoga session.

In the view of, Swati Mehta, MD, FACP, CPXP, SFHM, vice chair of SHM's Hospitalist Well-Being special interest group (SIG), it has to be making "compassion cool again."

Dr. Mehta

"It is a critical, critical foundation for any initiative you deploy/operationalize as a hospitalist leader," Dr. Mehta said. "Anything that you have to do, you have to make sure your team is ready, your team's cup is full."

That's where the SIG steps in.

"When the focus is on provider wellness and well-being in general for our teams, our HCAHPS [hospital consumer assessment of healthcare providers and systems] scores go up," Dr. Mehta said. "Our quality metrics are improved. Our medical errors go down and there is data to support that. I do believe strongly that this is a hard sign. This is not just 'Let's be nice to our team' and 'Let's do more yoga'. This is more, 'We have to be more intentional about it', and this is what I feel our SIG can provide to our hospitalists."

SIG chair Read Pierce, MD, says well-being and burnout remain a front-and-center issue four years after the onset of the COVID-19 pandemic exacerbated the feeling of overwork and under-appreciation for thousands of healthcare workers, hospitalists included.

"I can't think of a meeting I've been in, whether it's been related directly to burnout, or practice management, or quality and safety, or patient experience, or clinical operation, or the future of the field in education, where burnout doesn't come up in the first five minutes," said Dr. Pierce, chief quality, safety, and transformation officer for Denver Health. "So, this is an issue we need to keep talking about and working on."

Dr. Pierce

Dr. Pierce adds that while it feels like burnout, well-being, and physician resilience have long been talked about as a priority, it's really only in the last 10 years or so that the topic has received dedicated attention, a relatively short time in the slow-moving world of healthcare.

"I remember, even as recently as six or seven years ago, being in conversations with senior leaders of healthcare systems who said, 'Physicians are too well compensated to complain about their work,'" he said. "People were still saying, 'I don't believe that this burnout thing is a real issue.'"

Dr. Pierce sees the SIG's role as fourfold: First, it is a regular group where leaders can gather for conversations on what's working and, maybe more importantly, what's not. Second, the SIG brings forward specific tools or evidence-based interventions that can potentially solve member issues. Third, the SIG is a conduit to SHM for policy discussions, input on survey questions dealing with well-being, and shaping last year's inaugural SHM well-being and burnout survey. Lastly, it's a safe space for the kind of honest and open discussions necessary to truly address the systemic nature of the problem.

"We have created a space where we can ask people regularly, 'What else do we need to be thinking about?'" Dr. Pierce said. "Whether it's programming, advocacy, policy work. Whether it's more transparent resources."

"It's basically a community," said Dr. Mehta, national director of quality and performance for patient experience at Vituity and chair of SHM's Patient Experience Executive Council. "A commiseration community of learning that shows 'I am not alone in this.'"

Dr. Pierce acknowledges that "we don't have a perfect playbook yet. That's part of what this SIG has done, to try to pull together evidence-based interventions that people can use with relatively limited time and money."

But Dr. Mehta says it's a mistake not to try just because the problem feels too overwhelming.

"We can't wait for perfect to happen," she said. "That is what our SIG supports. What are the frontline hospitalists struggling with? What can they do instead of waiting for help to come from the leaders of the hospital? What can they do right now, for themselves and for their peers, if they witness this problem happening? If they see their peers struggling with burnout or having compassion fatigue? How can they help out right then?"

The SIG's offerings include Q&As, webinars, and other interactive events. Sometimes, the answer is as simple as the RISE program, which stands for Recharge, Introspect, Seek help, and Express yourself. The initiative aims for controllable steps — like a good night's sleep or asking "What am I grateful for?" — to ground oneself.

Like everything with well-being, it's just a start. Take the SIG itself, which had a half-dozen members a few years ago, but saw more than 100 people active at Converge 2024.

"To me, success looks like if we have accomplished more people being part of the group and realizing that we have value, and we learn from each other," Dr. Mehta said. "Success is when this feels like it is a value add for all of our hospitalists who are struggling." ■

Richard Quinn is a freelance writer in New Jersey.

Chapter Spotlight: Pittsburgh

Reimagining the chapter as members and their needs evolve

By Richard Quinn

In Pittsburgh, someone who identifies with the city is called a Yinzer. And Yinzers tend to stick around. That's as true in the old steel mills that defined this section of western Pennsylvania as it is in the hospitals that now help drive the local economy.

So how do hospitalists who identify with Pittsburgh commune? Well, that's the SHM Pittsburgh chapter's role, if you ask chapter president Eric Gardner MD, MBA.

Dr. Gardner

"People come to Pittsburgh from all over the world for the world-class medical training it offers. It's a very livable city, and trainees often choose to stay in the western Pennsylvania area after graduation," said Dr. Gardner, a hospitalist with Allegheny Health Network in Pittsburgh. "But many leave the major academic institutions and move on to different hospitals and health systems. This can lead to a sense of siloing among hospitalists at different programs, and hospitalists at smaller programs may have fewer opportunities for socializing and professional networking."

How can the chapter help?

"One of the main roles of the chapter is to bring the hospitalists of our region together to share their challenges, best practices, personal stories, and professional connections, Dr. Gardner says. "Chapter events are the perfect place to get to know one another. Who is the chief hospitalist over there? Who has graduating residents who are eyeing a career as a hospitalist?"

Dr. Gardner says he aims for six to eight chapter events annually. He views gatherings as integral to the fabric of a strong organization, especially one as geographically diverse as Pittsburgh, whose footprint covers all of western Pennsylvania, extending into eastern Ohio and parts of northern West Virginia.

"For many years, the bulk of our chapter events were held near the central Pittsburgh area," Dr. Gardner said. "When I came on as membership director, I was surprised to find that we had more than 200 members in the chapter. I was used to seeing the same 30 or 40 people at all of the events.

"I asked myself, 'Why aren't we reaching these people?' And then I saw, geographically, we're missing all kinds of people who want to be involved in SHM, who want to reach out, who want to make connections and colleagues and friends, but they're located further from the city, and getting to a chapter event far from home after a long day of work was a barrier. We'd have to bring a chapter event closer to home. And this began our idea to host 'regional' events throughout our chapter territory. Immediately, we began to see new faces at these events."

Dr. Gardner focuses as much as he can on in-person events to foster collaboration, camaraderie, and collegiality.

"We want our events to bring people together," he said. "We want our events to be exciting and engaging so people want to attend. We want our members to come to a chapter event and experience something they can't get somewhere else."

Take the annual Resident Abstract & Poster Competition, the chapter's largest event.

"We want this to be an SHM signature event," Dr. Gardner said. "We make it a gala event. We host it in the evening at a banquet hall. People dress up. We serve hors d'oeuvres during the judging and an upscale dinner during the awards presentation. We aim to be inclusive with as many residents presenting as we can accommodate. A few years ago, we expanded efforts to invite family practice residents to submit entries, and last year we added a pediatrics category. This event keeps growing and in 2023 we had more than 90 attendees."

And then there's the cooking class, where the chapter brings in a physician who is a specialist in wellness and lifestyle medicine, who teaches how to build a healthy diet, and attendees cook a vegan meal.

Why a cooking class, one might ask?

"When we do a cooking program, people are bumping elbows," Dr. Gardner said. "People are sharing. I am cutting what you're going to eat. When you've cooked something, you're going to hand the dessert back to me, and I'm going to taste it. There's a sharing aspect to it. And if there is anything that can bring people together, it's food. It's a way to break the ice when networking. We can laugh when someone grabs the wrong ingredient or causes a spill. The physical interaction of making a meal together is much more engaging than sitting and watching a lecture together."

Dr. Gardner says he was pleasantly surprised by the chapter earning a 2024 Platinum Excellence Award, as he notes the chapter isn't looking for accolades.

"We're always striving to push the chapter in more directions," he said. "Hospital medicine, over the last 20 years, has had to keep reinventing itself as the field has evolved. One of the things we do at the chapter level is to keep reimagining the chapter as our members and their needs evolve." ■

Richard Quinn is a freelance writer in New Jersey.

A Roadmap for New DEI Officers in Hospital Medicine Programs

By Keshav Khanijow, MD, and Uzoamaka Ofodu, MD

During my hospital medicine fellowship, I realized my interest in pursuing a leadership role. In July 2022, the opportunity came, and I was appointed as the division director of diversity, equity, and inclusion (DEI) at Johns Hopkins Bayview Medical Center in Baltimore. This was the first time this role had been established within the division with protected time, and I aimed to demonstrate my value in this position. Fortunately, our division recruited Dr. Uzoamaka Ofodu to collaborate with me on this endeavor. Despite this, I found myself asking, "What steps should I take to succeed as a director of DEI?"

In May 2020, the murder of George Floyd sparked a national call to action within the field of medicine. The goal was to promote diversity, truly include underrepresented populations in the workforce, and shift the focus from health equality to health equity. Studies have consistently demonstrated that diversity enhances the quality of patient care and financial outcomes.[1]

A year later in April 2021, the *Journal of Hospital Medicine* published an article titled Advancing Diversity, Equity, and Inclusion in Hospital Medicine that detailed a pre- and post-intervention focus on gender equity with salary and full-time equivalent allocation.[2] In this article, a framework for implementation of DEI projects was illustrated, with the following sequential components: establishing a director of DEI, performing a literature search, meeting with stakeholders, engaging faculty and staff, planning strategically, forming subcommittees, developing a DEI checklist, and observing possible outcomes.

A literature search on guidance for DEI directors in hospital medicine also yielded the September 2021 article from *The Hospitalist*, Embedding Diversity, Equity, Inclusion, and Justice in Hospital Medicine, which identified three domains for future DEI efforts to take place: recruitment and retention; scholarship, mentorship, and sponsorship; and community engagement and partnership.[3]

Armed with these seminal articles on DEI within hospital medicine, I sought to make sure our DEI program would be outstanding. However, I did not have the specifics to enact changes within my division. I was left with the questions "What can I do?" and "What are things I need to do to ensure our division is leading the way in DEI standards?"

During my first year, I was confused, trying to read the limited literature, and performing Google searches that mostly yielded consulting companies, advertising services, and mission statements from other divisions of hospital medicine. The next year, I was able to partner with Dr. Ofodu, and finally create a roadmap for our division. Even though this process takes time, it is a luxury that not everyone in DEI positions is afforded. Historically these positions have been underfunded, and they are under attack in recent years, with employment implications for those involved in DEI work. In this article, I aim to offer specific recommendations for individuals starting DEI work in hospital medicine.

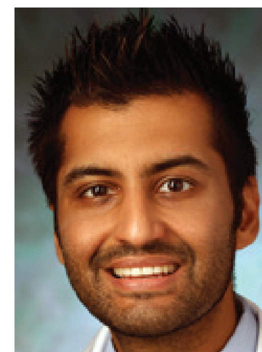
Hospital policies

First, a DEI director should look at institutional policies surrounding underrepresented populations. These could include salary parity, evaluation of diversity in leadership positions, coverage of family planning for those of advanced maternal age and LGBTQIA+ individuals, coverage of gender-affirming treatment for transgender and non-binary individuals, safe and private places for individuals who breast pump, and safe spaces to observe daily religious practices. These are starting points, but each division may need different adjustments. The mission statement and non-discrimination statement of both the hospital and division of hospital medicine should be evaluated for inclusivity. If groups have been excluded, there should be action to obtain equal protection.

The workforce

In an ideal world with equal opportunity for all, the makeup of the workforce within a field would be proportional to the makeup of the population. However, due to a history of institutional racism, intentional sexism, political discrimination, and social stigma, this is often not the case. If the data do not exist, the division should be surveyed (provided it's cleared by human resources) voluntarily, with the option to decline participation, to see which races or ethnicities, gender identities, sexual orientations, religions, and disability statuses people identify with. In addition, the division's comfort and need for further education on DEI concepts (e.g., implicit bias, bystander training) should be evaluated in a short digestible survey. This will identify both the diversity of the division, to see if it matches the patient population, and knowledge gaps for future educational efforts.

Qualified practitioners from underrepresented communities should be a target for recruitment and retention efforts. To eliminate bias from the recruitment process, previous articles have suggested using unbiased and ungendered language in job descriptions, having balanced recruitment committees, and screening letters of recommendation for potential bias from the recommendation writer.[3] If there is a problem with recruitment and retention, a focus group should be created to evaluate what aspects of the division are driving people away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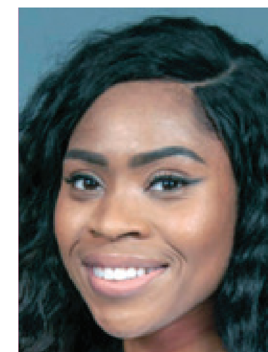
Dr. Ofodu

Dr. Khanijow (@gayhospitalist) is a hospitalist and assistant professor of medicine at Johns Hopkins Bayview Medical Center in Baltimore. He co-found SHM's LGBTQIA+ Health Task Force, which created the SHM LGBTQIA+ health series learning modules. In 2020, he led authorship efforts for the SHM DEI Statement. Since then, he has served as an inaugural member of the SHM DEI Committee, was appointed the chair of the SHM DEI Special Interest Group, and lectured internationally about culturally affirming care for hospitalized LGBTQIA+ individuals. Dr. Ofodu is a med-peds hospitalist at Bayview Medical Center and a clinical instructor for hospital medicine and pediatrics at Johns Hopkins School of Medicine, both in Baltimore.

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(e.g., non-discrimination protections, unequal salary, implicit or explicit bias within the culture of the institution).

Practitioner education

After knowledge gaps have been identified, practitioner education at all levels should be performed. Hospital medicine grand rounds occur monthly in our division, and through coordination with the organizer, two of the monthly lectures were reserved for DEI concepts for continuing medical education credit. Topics included a history of racism in medicine against African Americans, and trauma-informed care for populations, including the LGBTQIA+ population.

With Dr. Ofodu's help, approval was received to include 10-minute diversity segments during each division meeting, ranging from a colleague's experience raising a transgender child to cultural competence in caring for patients during Ramadan. This keeps DEI education at the forefront of the hospital medicine division's educational mission.

Implicit-bias training is a part of the core lecture series that new hospitalists receive, and the hope was to make this count twice. A one-hour online module that counts towards Maryland licensure credit is used, with a subsequent discussion of microaggressions, upstander training, and bias mitigation strategies for both practitioner-practitioner and patient-practitioner interactions. Another workshop that has shown promise in increasing awareness of personal bias vulnerability and taking action to reduce bias is the Bias Reduction in Internal Medicine initiative at of the University of Wisconsin.[4]

Practitioner wellness

Although practitioner education is a cornerstone of DEI efforts nationally, practitioner wellness within the division is important too. This article previously discussed examining non-discrimination policies and DEI educational needs, however, part of the DEI acronym is inclusion, and efforts should be made to have practitioners feel included. In the past, our division created affinity groups: Women in Medicine, Underrepresented in Medicine, and LGBTQIA+. However, engagement with the affinity groups was low, in part because the positions for leading the groups were volunteer. As a DEI officer, one's role should be to create safe spaces, and not force others to create them on personal time. Activities were created for the affinity groups which were well received and increased participation. Examples included online confidential chat sessions and in-person mixers with a neighboring medical campus to create a larger safe space with a larger community of practitioners.

Inclusivity is also displayed by considering kosher, vegetarian, halal, and other diets in the observation of religious practices for event food catering. In addition, there should be at least email recognition of holidays celebrated by members of the division.

Community engagement

While DEI efforts should create a safe space for clinicians, they should be paid forward using knowledge to create a healthier community. Part of this is performing a needs assessment. This coming year, our division will be evaluating the hospital medicine group's admission diagnoses, the need for upgrade to the intensive care unit, and length of stay by patient-identified race or ethnicity, gender identity, primary spoken language, and zip code. The hope is that this data will uncover diagnoses and utilization measures to help target interventions in specific populations. For example, we may discover diabetes and uncontrolled blood sugar have a higher prevalence in a group we serve. The information can then be used for targeted interventions during hospitalization to create system programming that ensures adequate culturally appropriate information during hospitalization. Providing patients with the same level of care is equality, but working towards patients all having an equally healthy future is how we get to health equity.

Conclusion

There is still more to be done to create an environment where DEI is at the forefront, especially at a time when legislation in certain states is decreasing or banning the teaching of concepts within DEI.[5] It is simply not enough to have DEI in one's mission statement, there must be action to show an organization's commitment to espousing the values of DEI. Concrete examples, like those men-

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tioned earlier, can be used by new DEI officers of hospital medicine divisions. It must be noted that these interventions help to create an environment with respect for DEI concepts. However, there will be work that needs to get done for a more inclusive and equitable future. It takes time, but steps can be taken now. I look forward to continuing to figure out the next steps in my role, having been re-appointed as the division's DEI director next year. ■

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At Core Clinical Partners, we believe in doing things better. As a physician-led company, we provide personalized care with the support and resources of a national group—all while staying debt-free to stay true to our mission. We empower our clinicians and ensure that the needs of each physician, hospital, and community are met.

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HOSPITALIST OPENING!

FAIRVIEW HOSPITAL

Great Barrington, Massachusetts

Are you ready for a change? Picture yourself in the Berkshires MA, where you can change people's lives, including your own. Fairview Hospital, a top 20 Critical Access Hospital in 2022, serves a small New England town with strong community support and exceptional quality of life. The 25-bed facility includes a medical/surgical unit, maternity unit, 3-bed ICU, and has received multiple quality awards.

RESPONSIBILITIES:

- Manage general medical admissions and inpatient rounding, including low-acuity critical care unit.
- Must be comfortable working without sub-specialty consultative services (cardiology available on weekdays).

WORK SCHEDULE OPTIONS:

- 18-week or 24-week annual commitment.
- 7-day cycles (126 or 168 shifts per year).
- 12-hour shifts, equally divided between days (7 am - 7 pm) and nights (7 pm - 7 am).

PATIENT LOAD:

- Average census: 10 patients.
- 2-3 admissions per 24 hours, on average.

FOR MORE INFORMATION PLEASE CONTACT:

Cody Emond, Physician Recruiter
Phone: (413) 447-2448
Email: cemond@bhs1.org
Website: berkshirehealthsystems.org/careers

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