Charting a new course in sepsis management

‘Motivated and multidisciplinary’ team critical to improving sepsis care

By Bryn Nelson, PhD

A drug overdose victim is admitted to a hospital. Providers focus on treating the overdose and blame it for some of the patient’s troubling vital signs, including low blood pressure and increased heart rate. Prior to admission, however, the patient had vomited and aspirated, leading to an infection. In fact, the patient is developing sepsis. This real-world incident is but one of many ways that sepsis can fool hospitalists and other providers, often with rapidly deteriorating and deadly consequences. A range of quality improvement (QI) projects, however, are demonstrating how earlier identification and treatment may help to set a new course for addressing a condition that has remained stubbornly difficult to manage.

Every year, more than 1.5 million Americans develop sepsis – arising from the body’s overwhelming and self-destructive response to infection – and roughly 250,000 die from it. According to the Centers for Disease Control and Prevention, about one in three hospital

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Dr. Kencee K. Graves
and Dr. Devin J. Horton

MEMBER SPOTLIGHT

Amith Skandhan, MD, FHM

Young hospitalists don’t realize the potential influence they hold within their own institutions.

ON HOSPITALIST BURNOUT

John Nelson, MD, MHM

Ensuring that you have some work-related interest outside of direct patient care can be really valuable.
By Matt Pesyna

Michael Rader, MD, has been named the chief medical officer of the Department of Veterans Affairs New York/New Jersey Health Care Network. The network serves upward of a half-million veterans in 76 counties in New York, New Jersey, and Pennsylvania. Dr. Rader’s appointment began on Oct. 15, 2017.

Previously, Dr. Rader was chief medical officer at Prospect East Orange (N.J.) General. In his new position, the 35-year veteran will be charged with overseeing care at VA facilities in Albany Stratton, Bath, Canandaigua, and Syracuse in New York, as well as the VA Western New York Health System, the New York Harbor Health System, the New Jersey Health Care System, Hudson Valley Healthcare System, the James J. Peters and Northport VA Medical Centers, as well as 66 community-based outpatient clinics.

The Rhode Island Medical Society has elected Bradley Collins, MD, as its new president. An internist and hospitalist, Dr. Collins practices at Miriam Hospital in Providence, R.I., where he started in 2006 as a staff hospitalist. He’s now the medical director of appeals for Lifespan at Miriam.

Dr. Collins is an assistant professor of clinical medicine at Brown University’s Alpert Medical School, while also serving as a fellow for the Society of Hospital Medicine.

Tracy Cardin, ACNP, SFHM, has been named associate director of clinical integration at Adfinitas Health, a private hospitalist company based in Maryland that serves more than 50 hospitals and post-acute care centers across the Mid-Atlantic region. Cardin is responsible for advancing the company’s training and onboarding infrastructure to support the full integration of physicians, nurse practitioners, and physician assistants into the Adfinitas care delivery model.

Jeffrey Millard, MD, has been named Patient Experience Provider of the Year by the employees and staff at Hardin Memorial Health (Elizabethown, Ky.). Dr. Millard has been a hospitalist at Hardin Memorial Hospital since 2012. The Patient Experience Provider of the Year award recognizes a provider who exceeds the company’s mission and vision with patients and their families, as well as with the hospital’s staff. Dr. Millard was chosen from a list of more than 800 nominations.

Benjamin Keidan, MD, has been appointed as chief medical officer for Boulder (Colo.) Community Health. Dr. Keidan advances from his previous role as medical director of quality and population health for outpatient primary care and specialty clinics. Dr. Keidan is a former internist and hospitalist for BCH and has worked in Boulder County for the past 12 years. He is only the second CMO in BCH’s history.

Dinesh Bande, MD, has been selected as the new chair of the department of internal medicine at the University of North Dakota, Grand Forks. Dr. Bande is a clinical associate professor at the school and a hospitalist with Sanford Health.

Dr. Bande has been the clerkship director for third-year medical students at UND for the past 2 years. As chair of internal medicine, he will oversee education, research, clinical care, training, and service programs within the department.

Business Moves

Management Service Organization Continuum Health (Marlton, N.J.) has signed an agreement with the Mid-Atlantic region’s largest private hospitalist group, Adfinitas Health (Hanover, Md.), to be its revenue management cycle partner. Founded in 1999, Continuum Health now serves more than 1,500 providers in more than 400 locations.

Colquitt Regional Medical Center in Moultrie, Ga., has expanded its hospitalist program, adding 5 physicians to increase its total to 10 on-staff hospitalists. Colquitt Regional’s program began in 2012.
Is it time for health policy M&Ms?

Preparing hospitalists to effectively advocate for specific policy changes

By Kelly April Tyrrell

What would happen if hospitalists began to incorporate health policy into morbidity and mortality (M&M) conferences? That was a question Christopher Moriates, MD, explored in an entry for SHM’s The Hospital Leader blog1 and an idea that caused a minor stir on Twitter when he proposed it last summer.

In late July 2017, the U.S. Senate was debating a bill to repeal the Affordable Care Act, without a clear vision for replacing it. In response, physicians around the country took to Twitter to share their sentiments about repeal under the hashtag #DoctorsSpeakOut. In one such tweet, Dr. Moriates, assistant dean for health care value and an associate professor of internal medicine at Dell Medical School at the University of Texas, Austin, said this, in 140 characters: “We recently had an idea: health policy M&Ms for residents to discuss adverse outcomes we see as a result of lack of access.”

Would this lead to more informed physicians? Improved patient advocacy? Increased understanding of the socioeconomic determinants of health? Better hospital performance? So far, the idea remains untested, but Dr. Moriates and some of his colleagues seem optimistic it could work.

The idea began with a conversation. Dr. Moriates had with Beth Miller, MD, program director for the Dell Medical School Internal Medicine Residency Program. “We were meeting and talking about revamping the [resident] M&M conference to have more learning objectives and put in place best practices,” Dr. Moriates said. “Dr. Miller suggested it could be a good forum [for health policy] because it’s an area where we all come together and there’s a natural hook to it. We can use it to recognize the drivers within the system that lead to bad outcomes.”

In his SHM blog post, Dr. Moriates said he has increasingly observed adverse events that result from issues related to health policy. He provided an example: “A patient I admitted for expedited work-up for rectal bleeding after he told me he had been trying to get a recommended colonoscopy for many months but could not get it scheduled due to his lack of insurance. He had colon cancer that had spread.”

In another example, he conjured a hypothetical case where a patient prescribed blood thinners upon hospital discharge returns to the hospital soon after with a blood clot. Unable to afford the medication, or seek primary care follow-up, the patient is readmitted through no direct fault of his physicians. Yet, the patient is worse off and the hospital receives readmissions penalties. Dr. Moriates believes that viewing a case like this through a health policy lens is critical to better understanding health care delivery, particularly in an environment where physician performance is measured, in part, by outcomes. He now believes health policy M&Ms would be valuable to all hospital-based physicians, not just residents.

“Hospitalists are being asked to hit these value-based performance metrics, like readmissions and length of stay, and while we deal with the consequences, we are not always the best informed” with respect to policy, he said. “We could use this forum to teach health policy topics and contribute to different discussions and understand how things are changing and impact our patients.”

Keeping up with rapidly changing health policy is a full-time job and few physicians have time to do it, said Nadereh Pourat, PhD, director of research at the University of California, Los Angeles Center for Health Policy Research. “Doctors get almost all of their training on clinical practice with little on policy and its impact of their practice,” she said. “Health policy M&Ms could provide a way for more policy-engaged physicians to educate and inform their less-engaged colleagues.”

“It’s important for physicians to know the policies that are aligned with, and the policies that may undermine, what they’re doing in their practice to improve their patients’ health,” Pourat said.

This knowledge can benefit physicians, too, Pourat added, because health policy M&Ms could help providers understand policy goals and in turn adjust their own behaviors and expectations.

“Physicians could discuss, what are the underlying issues or root causes, like the decision not to expand Medicaid here in Texas,” Dr. Moriates said. “Not all of these things you can fix, but you’re exposing those stories and perhaps we can come up with some actionable steps. How do we ensure in the future that our patients are able to fulfill their prescription so we’re not just sending someone out assuming they will but not knowing they’re unable to afford it?”

Similar to other domains in which physician leaders become champions, such as antibiotic stewardship, Dr. Pourat suggested that hospitalists could champion policy awareness through the kind of M&Ms Dr. Moriates proposed.

While journal clubs and lectures are great ways for hospitalists to learn more about health policy, the emotionally gripping nature of M&Ms could inspire more physicians to act in favor of policies that benefit their patients and themselves, Dr. Moriates said.

For example, physicians may write to or visit legislative offices, or author op-eds in their local newspapers. This collective action carries the potential to effect change. And it need not be partisan.

“I believe that if health policy issues were more explicitly integrated into M&Ms then clinicians would be more inclined and prepared to effectively advocate for specific policy changes,” he wrote in his blog post. “On Twitter, even before Dr. Moriates’ first tweet about health policy M&Ms, New Jersey–based Jennifer Chuang, MD, an adolescent medicine physician, wrote: ‘M&M is heart-wrenching in academic hospitals. I dare @SenateGOP to present their role in M&Ms to come if ACA is repealed.’

While Dr. Moriates believes the chances are quite small that legislators and policymakers would attend health policy M&Ms, he called the notion ‘provocative and intriguing.’

In his blog post, Dr. Moriates invites state legislators and local members of Congress to join him in reviewing M&M cases where patients have been negatively affected by policy. He also emphasized that, like most modern M&Ms, the point should not be finger-pointing, but an opportunity to learn how policy translates into practice.

Physicians may learn from legislators, too, he said in his blog post. “Just as policymakers could see legislation through the eyes of practitioners and their patients, this is where we as physicians could possibly learn from our legislators,” he wrote. “We may recognize the potential trade-offs, downsides, and barriers to proposals that to us may have seemed like no-brainers.”

Reference


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Making hospital medicine a lifelong, enjoyable, and engaging career

Amith Skandhan, MD, FHM, wants young hospitalists to realize the potential influence they hold.

By Felicia Steele

Editor’s note: Each month, the Society of Hospital Medicine puts the spotlight on some of our most active members who are making substantial contributions to hospital medicine. Visit www.hospitalmedicine.org for more information on how you can lend your expertise to help SHM improve the care of hospitalized patients.

This month, THE HOSPITALIST spotlights Amith Skandhan, MD, FHM, a hospitalist, a director/physician liaison for clinical documentation improvement, and core faculty member in the Internal Medicine Residency Program at Southeast Alabama Medical Center in Dothan, Ala., and clinical faculty member at the Alabama College of Osteopathic Medicine also in Dothan. Dr. Skandhan is the cofounder and current president of the SHM Wiregrass Chapter and is an active member of SHM’s Annual Conference and Performance Measurement Reporting Committees.

When did you join SHM, and what prompted you to apply for your current committee roles?

When I did my residency and chief residency at University of Pittsburgh Medical Center Mercy, I was fascinated by my faculty hospitalists — they seemed to have mastered a balance of managing acute, high intensity care with a lifestyle that encouraged exploring personal hobbies. But as I started my new role as a hospitalist at Southeast Alabama Medical Center, I discovered nuances to the profession that I had not seen during my graduate medical education.

There were many things that were not sufficiently taught during clinical training that were required in my day-to-day practice, like clinical documentation improvement, practice management, billing, coding, and so forth. I also quickly understood how vast and dynamic hospital medicine really was. While looking for an outlet to voice my questions, concerns, and curiosity, I decided to join SHM, which has helped me find and apply the techniques I’d been looking for to further my career as a hospitalist.

I’m now fortunate to be a part of SHM’s national committees, which involve hospitalists of various backgrounds and experiences, who work together to improve the overall quality of inpatient medicine. I currently serve on the Performance Reporting Measurement Committee and the Annual Conference Committee. My interests in reviewing the ever-evolving policies of health care made me apply to be a part of the Performance Reporting Measurement Committee. We work very closely with the Public Policy Committee, analyzing written policies and subsequently offering our recommendations. It’s been fulfilling to be a part of a committee that works toward developing policies that support a good quality of care on such a large scale.

My penchant for organizing events and bringing people together based on common ground led me to apply for the Annual Conference Committee. We meet every week to discuss various topics, choose and invite speakers, and help organize the entire event, which will host close to 5,000 hospitalists later this year. It has made me appreciate being a member of an organization that provides hospitalists with opportunities for education and growth. I’m hopeful that the attendees next year will find the conference to be a worthwhile experience.

As the president of SHM’s Wiregrass Chapter, how has the chapter grown since its establishment in May 2015?

Our chapter is based in Dothan, a small, rural Alabama town where Southeast Alabama Medical Center is located. The chapter covers the counties of lower Alabama and the panhandle of Florida. We named the chapter after a special species of grass that grows in this region.

When we started the chapter, our goal was to bring the best and brightest of hospital medicine to our region to give talks on hot topics in the field and also to use their expertise to guide inpatient care in our hospital system. We aggressively marketed the events to bring in large crowds of medical professionals, and we consistently average around 70-80 attendees in our meetings. Bringing in leaders from the field helped create an atmosphere of learning and inspired us to grow and develop our hospitalist program. We now closely work with hospital medicine groups in surrounding rural areas toward improving inpatient hospital care.

During these past years, we also realized that, for the further growth of our chapter, we would need to nurture an interest in hospital medicine among future generations of doctors, and this realization led to the creation of our medical student and resident wing. So far, the students have been very enthusiastic about participating in SHM-related events, and I hope that continues. We also developed a mentor-mentee program, in which we paired select medical students with hospitalists to help guide future careers in acute care medicine. This year, we have also been helping the hospital medicine division at Southeast Alabama Medical Center create a research track for medical students. To that end, we have just completed our second annual poster competition where we presented around 50 posters in the areas of clinical vignettes, quality improvement, and original research.

In addition, the chapter is very active with community activities. We took notice of the fact that many of our patients and community members were unaware of what hospitalists did because they could not understand how our work was different from that of primary care physicians. Our members have therefore participated in TV, radio, and newspaper interviews to help elucidate the role of hospitalists in patient care. We have also periodically visited primary care physician offices, nursing homes, senior citizen groups, and cancer support groups to educate these patients on various facets of health care and how hospitalists influence these areas.

In 2014, we organized a “walk with a hospitalist” event, for which...
Typical in-patient dosing is 1-4 packets/day BID. Typical out-patient dosing is 1-2 packets/day BID.

Which SHM conferences have you attended? Tell TH about your most memorable highlights or takeaways.

When I started out as a hospitalist in 2014, I decided to attend the annual conference in Las Vegas, and I can honestly say that conference changed the course of my career. I can still remember listening to the opening speech and realizing that I was surrounded by more than 3,000 hospitalists who understood the power we had to influence in-patient care. I attended all the national conferences since then and am grateful that I now get to help organize the Hospital Medicine 2018 annual conference, also known as HM18.

I had been working to find a way to improve documentation within my group, as well as change the culture and perception toward billing and coding practices, which prompted me to attend the Quality and Safety Educators Academy. During one of the problem-solving sessions, I explained the challenges that I faced to my conference group. The exercise required me to explain the problem at hand, and the players of my group then discussed their thoughts while I took notes. It was a fantastic experience, as the participants at my table offered strong solutions to my problems within a matter of minutes. Their advice led to meaningful changes in our group’s hospital documentation practices, and in turn, I’ve been promoted to physician adviser in Southeast Alabama Medical Center.

After such a great experience at Quality and Safety Educators Academy, I went on to attend SHM’s Leadership Academy, where I had the opportunity to meet some of the top leaders and pioneers in the field of hospital medicine. It’s empowering to be mentored by the very people you look up to and aspire to be like. Not only was I able to bring ideas home to my institution, but I was able to reflect and improve my own professional and personal growth. I’m happy to say that I’ve completed all three levels of Leadership Academy.

As I’ve become involved with the medical student and residency programs at my medical center, I recently attended the Academic Hospi-talist Academy to help my transition into academic hospital medicine. Meeting and spending time with the faculty at Academic Hospitalist Academy made me further realize the roles that academic hospitalists play in the education of future physicians, emphasizing the idea that we can all be champions in quality and patient safety.

If you’re looking to advance your career as a hospitalist, take advantage of the conferences that SHM offers. I’ve gained so much from each experience, and I’m looking forward to returning to these conferences as a potential facilitator, in hopes of offering what I’ve learned to hospitalists looking to bring about change in their fields and careers.

What can attendees at HM18 expect to see in the area of career development, and how is this different than previous years?

Hospital medicine is only about 2 decades old, making it one of the youngest branches in medicine today. Given this fact, the Annual Conference Committee feels that it is paramount to focus on career development for both new and midcareer hospitalists alike.

One question that we wish to explore and answer this year is: “How do you make hospital medicine a life-long, enjoyable, and engaging career?” In turn, our committee has created several new additions to HM18. This includes a “Seasoning Your Career” track, which will provide ideas on how to advance in leadership, use emotional intelligence to achieve success, change your roles midcareer, and change hospitalist schedules. Another unique addition this year is career development workshops, which will aim to develop various aspects of a hospitalist’s career, such as working on leadership skills, refining presentation and communication skills, providing constructive feedback, promoting women in hospital medicine, preventing burnout, and turning ideas into clinical research. We also plan to incorporate an education track, which will focus on how hospitalists can expand their careers toward educational leadership.

Given your involvement in SHM at both the local and national levels, do you have any advice for young hospital medicine professionals looking to build their professional profiles?

I’ve frequently noticed that young hospitalists don’t realize the potential influence they hold within their own institutions or the power they have to elicit change in health care at the national level.

Though we don’t often admit it, some hospitalists feel like they are glorified residents, which definitely is not the case. As a provider on the front lines, you have the unique opportunity to implement changes pertaining to issues of cost, utilization of resources, process management, quality and patient safety, and bottlenecks in care, to name a few. These are issues that keep the administrators of your organization and leaders of hospital medicine up at night. Don’t sit around and complain about how things could be or should be; look toward creating change. Bring up possible solutions to these problems with your leaders. They will appreciate the effort, and hopefully together you can find ways to tackle these problems.

I will conclude by saying this: Hospital medicine is such a unique specialty in that it’s constantly evolving, and the pioneers of this field are still alive and practicing medicine. You can meet and interact with them during the SHM conferences and look to them as sources of inspiration or guidance. Meeting people you look up to and having them as your mentors can take you places.

Ms. Steele is the marketing communications specialist at the Society of Hospital Medicine.
By Leonard J. Marcus, PhD

I had the privilege of teaching two seminars at the recent Society of Hospital Medicine Leadership Academy in Scottsdale, Ariz. The theme of my second seminar was “Swarm Leadership,” the topic of my September column. Participants were intrigued at the notion of leveraging instinctual responses to encourage team spirit and collective outcomes.

The key principles of these swarm-like behaviors are: 1) unity of mission, 2) generosity of spirit, 3) staying in lanes and helping others succeed in theirs, 4) no ego/no blame, and 5) a foundation of trust among those working together. Leaders create the conditions in which these behaviors are more likely to emerge. The resulting team spirit and productivity raise morale and increase the sense of work-related purpose and mission.

Despite the interest in the topic, an underlying objection arose in questions and comments. These remarks countered the intentions and opportunities for swarm-like connectivity.

People expressed their sense of being burned out and overworked, even to the extent of being exploited. Not everyone spoke though many people identified with the theme.

What I heard was enough to raise the question here: For hospitalist leaders, to what extent is burnout significant enough to give it serious attention? (I report observations as anecdotal. There is no implied critique of hospitalists on the whole nor any individual or groups.)

Burnout includes sensations of being exhausted, overburdened, underappreciated, undercompensated, cynical, and depressed. These phenomena together can affect your productivity, the quality of your work, and your endurance when the workload gets tough.

By contrast, the opposite of burnout is balance, including sensations of being engaged, enthusiastic, energetic, absorbed, challenged, and dedicated. Work is part of the equilibrium you establish in your life.

Ideal balance would have all the different parts of your life – from family to hobbies to work – in perfect synergy with one another. Complete burnout would have all parts of your life imploding on one another, with little room for joy, personal contentment, and professional satisfaction.

How do you assess the differences between burnout and balance? First, this is a very individual metric. What one person might consider challenging and engaging another would experience as overwhelming and alienating. When you assess a group of people, these differences are important and could inform how work assignments and heavy lifting are assigned.

During the SHM session and in private comments, people described this rise in burnout not as a personal phenomena. Rather, it results from the health system expecting more of hospitalists than they can reasonably and reliably produce. People described hospitalists getting to the breaking point with no relief in sight. What can be done about this phenomenon?

First, hold a mirror up to yourself. You cannot help others as a leader if you are not clear with your own state of burnout and balance. The questions for you – a leader of other hospitalists – include: To what extent are you burned out? If so, why? If not, why not? If you were to draw a continuum between burnout and balanced, where on that range would you place yourself? Where would others in your group pinpoint themselves, relative to one another, on this continuum?

How might burnout develop for hospitalist leaders? Like a car, even a high performance vehicle, you can go only so fast and so far. If your system is expecting the pace and productivity to outstrip what you consider reasonable, your performance, job satisfaction, and morale drops. Impose those demands upon a group of people and the unhappiness can become infectious.

With a decline in performance comes a decline in confidence. You and your colleagues strive for top-rate outcomes. Fatigue, pressure, and unreasonable expectations challenge your ability to feel good about what you are doing. That dissatisfaction is part of why you chose hospital medicine and without it, you wonder about what you are doing and why you are doing it.

When you and your colleagues sense that you are unappreciated, it can spark a profound sense of disappointment. That realization could express itself in many forms, including unhappiness about pay and workload to dissatisfaction with professional support or acknowledgment.

When I first began teaching at SHM conferences and had hospitalists in my classes at the Harvard School of Public Health, the field was novel, revolutionary, and striving to establish a newly effective and efficient way to provide patient services. It is useful to keep these roots in perspective – hospital medicine over the arc of time – from what WAS, to what IS and eventually what WILL BE. The cleverness of hospitalist leaders has been their capacity to understand this evolution and work with it. Hospital medicine built opportunities in response to high costs, the lack of continuity of care, and problems of communication. It was a solution.

How might you diagnose your burnout – and that of others – in order to build solutions? Is it a phenomenon that involves just several individuals or is it characteristic of your group as a whole? What are the causes? What are the symptoms, and what are the core issues? Some system problems in which expectations for performance – and the resources to meet those objectives – are not reasonably aligned. There is a cost for trying to reduce costs on the backs of overworked clinicians.

If this is more than an individual problem, systematically ask the question and seek systematic answers. The better you document root causes and implications, the better you are able to make a data-driven case for change.

Showing that you care about the professional and personal well-being and balance of your workforce, in and of itself, is the beginning of an intervention. Be honest with yourself about your own experience. And then be open to the experiences of others. As a leader, your colleagues may suggest changes you make in your own leadership that could ameliorate some of that burnout. Better communication? Improved organization? Enhanced flexibility as appropriate? These are problems you can fix.

Other solutions must be negotiated with others on the systems level. With documentation in hand, build your case for the necessary changes, whatever that might entail. Hospitalist leaders negotiated their way into respected and productive positions in the health care system. Similarly, they must negotiate the right balance now to ensure the quality, morale, and reasonable productivity of their departments and workforce.

As a hospitalist leader, you know that each day will bring its complexities, its challenges, and its burdens. Your objective is to encourage – for yourself, your colleagues, and your system – both personal and organizational resilience. That resilience – the ability to take a hit and bounce back – is an encouraging signal of hope and recovery, for your workforce as well as the people for whom you care.

Are you burned out? Are you resilient?

Demonstrate care about the professional and personal well-being of your team.
Special interest groups drive SHM engagement

New governance model encourages volunteer group interaction

By Ethan Gray

As a professional society supporting an increasingly diverse membership base, SHM is perpetually challenged to create an environment that offers relevance and community to all. While the broad hospital medicine population and SHM are focused on the same goals, there are nuances within membership that require specific networks and platforms to build this environment of community.

SHM relies on both staff and volunteers to be an engine for leadership, innovation, and labor. Over the last year, SHM has attempted to expand the infrastructure and opportunity for volunteer leadership by examining new approaches to allow pockets of membership to have their own voice. In 2018, members will continue to help staff forge a new landscape for constituency engagement.

If you are a current volunteer leader, or are interested in pursuing volunteer opportunities, you may be aware that the Committee structure has changed. There is also new publicity for things called “Special Interest Groups.” Many of our constituency-based Committees are in the process of transforming into SIGs, which will be officially launched during HM18 in Orlando in April. They are adopting a more visible charge to create the most accessible and influence-able environment for the SHM community.

Committee-to-SIG transition is about both philosophy and mechanics. It aims to ensure that each constituency group can be shaped by the entire population it represents, and will work to create the infrastructure to facilitate that. SHM envisions SIGs being primary influencers over future content-development and policy objectives; their online communities serving as the principal means for socialization and dialogue around proposed ideas and initiatives. To that end, SHM invested in an entirely new platform for Hospital Medicine Exchange. To explore the new HMX and opportunities for niche networking, visit www.hmxchange.org.

We have also developed a new governance model to encourage interactions between volunteer groups. While there is overlap within Committee and SIG constructs and likely many volunteers serving in both spheres, it is important to create parallel environments with discrete charges around function and membership engagement.

During this transformation, existing volunteers are working with staff to determine the future. There will be some differences in the way Committees and SIGs function. There will also be consistent communication between SIGs and strategic and functional Committees with ongoing charges and oversight of existing SHM programs.

SIGs will have dedicated staff liaisons and volunteer leadership councils. Transforming Committees current volunteers will serve as inaugural council leaders with the process for future election being developed over the next several months. SIG membership is open and free to all active SHM members. All current SIGs will facilitate live Special Interest Forums during SHM’s Annual Conference.

Summaries of the live forums will be posted on corresponding HMX communities after the conference. There will be an open application period during summer 2018 for SIGs not yet defined. The SHM Board will review applications in September 2018, and new groups will be convened in October to begin building HMX communities, confirming leader councils, and charting their course with a dedicated staff liaison.

To offer your thoughts and ideas about SIGs or anything else related to membership, please email membership@hospitalmedicine.org.

Mr. Gray is vice president of membership at the Society of Hospital Medicine.

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By Zahir Kanjee, MD, MPH

1 Hospitalist empathy associated with reduced patient anxiety

CLINICAL QUESTION: What effect does hospitalist empathy have on patient anxiety, ratings of physician communication, and duration of encounter?

BACKGROUND: Physician empathy is associated with better patient-reported and medical outcomes in a number of settings. The effects of hospitalist empathy have been less well studied.

STUDY DESIGN: Observational study of audio recordings of hospitalist admission encounters.

SETTING: General medical service at two urban hospitals within an academic medical center from August 2008 to March 2009.

SYNOPSIS: Admission encounters (76 patients, 27 hospitalists) were recorded. Researchers detected negative emotional expressions from patients and characterized resultant physician replies as either empathic (“focuses toward further expression of emotion”), neutral (“focuses neither toward nor away from emotion”), or nonempathic (“focuses away from emotion”). Through use of regression models, response frequency was compared with change in pre/post-encounter patient anxiety, patient ratings of physician communication, and duration of encounter. Every additional empathic response was associated with a small decrease in anxiety, better ratings of physician communication, and no change in encounter duration. Nonempathic responses were associated with worse communication ratings. Limitations of the study include its observational nature, small sample size, exclusion of non–English-speaking patients, absence of data on nonverbal communication, and exclusively urban academic setting.

BOTTOM LINE: Empathic hospitalist responses during admission encounters are associated with reductions in patient anxiety and better ratings of physician communication without increases in encounter duration.

2 Rivaroxaban versus warfarin in mild acute ischemic stroke secondary to atrial fibrillation

CLINICAL QUESTION: Is rivaroxaban as effective and safe as warfarin immediately following minor acute ischemic stroke from atrial fibrillation?

BACKGROUND: There is uncertainty regarding the best approach to anticoagulation acutely after ischemic stroke secondary to atrial fibrillation. To reduce the risk of intracranial hemorrhage, many physicians start aspirin immediately and delay initiating warfarin until days to weeks later. With their more predictable and rapid anticoagulant effect with potentially lower risk of intracranial hemorrhage, direct oral anticoagulants such as rivaroxaban are an attractive possible alternative to warfarin in the acute setting.

STUDY DESIGN: Multicenter, randomized, open-label superiority trial with blinded outcome assessment.

SETTING: Fourteen academic hospitals in South Korea.

SYNOPSIS: One hundred eighty-three patients with mild acute ischemic stroke secondary to nonvalvular atrial fibrillation were randomized to immediately initiate either rivaroxaban or warfarin. The primary outcome (composite of new ischemic lesion or new intracranial hemorrhage on MRI at 4 weeks) occurred at similar frequency between groups (49.5% versus 54.5%; P = .49). Rates of adverse events were comparable in each group. Median hospitalization length was shorter in those randomized to rivaroxaban (4.0 versus 6.0 days,
Fluoroquinolone use tied to higher risk of aortic dissection and aneurysm

A meta-analysis of two observational studies found that current fluoroquinolone use was associated with modestly higher risk of aortic dissection (odds ratio, 2.79, 95% confidence interval, 2.31-3.37) and aortic aneurysm (OR, 2.25, 95% CI, 2.03-2.49). (OR, 2.25, 95% CI, 2.03-2.49).

**Bottom Line:** The use of evidence-based care processes (appropriate antibiotic use, echocardiography, and infectious disease consultation) was associated with decreased SAB mortality.


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**By Jorge Rodriguez, MD**

3 Evidence-based care processes decrease mortality in *Staphylococcus aureus* bacteremia

**Clinical Questions:** What are the trends in patient outcome for *Staphylococcus aureus* bacteremia (SAB)? Does the use of evidence-based care processes decrease mortality in SAB?

**Background:** SAB is associated with poor clinical outcomes. Prior research has demonstrated that several evidence-based interventions, namely appropriate antibiotics, echocardiography, and infectious disease consults, have been associated with improved outcomes. The use of these interventions in clinical practice and their large-scale impact on SAB mortality is unknown.

**Study Design:** Retrospective observational cohort study.

**Setting:** Veterans Health Administration acute care hospitals in the continental United States from January 1, 2003, to Dec. 31, 2014.

**Synopsis:** This study used the Veterans Affairs Informatics and Computing Infrastructure to identify 36,868 patients across 124 acute care hospitals with a first episode of SAB. Use of evidence-based care processes (specifically appropriate antibiotic use, echocardiography, and infectious disease consults) and patient mortality were recorded.

All-cause 30-day mortality decreased 25.7% in 2003 to 16.5% in 2014. Concurrently, the rate of evidence-based care processes increased from 2003 to 2014. There was lower risk-adjusted mortality when patients received all three evidence-based care processes compared to those who received none, with an odds ratio of 0.33 (95% confidence interval, 0.30-0.37; 57.3% of the decrease in mortality was attributable to use of all three evidence-based care processes.

Given the observational nature of the study, unmeasured confounders were not considered. Generalizability of the study is limited since the patients were primarily men.

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5 Anticoagulation use in new-onset secondary atrial fibrillation

**Clinical Question:** Is anticoagulant use in patients with new-onset atrial fibrillation secondary to acute coronary syndrome, acute pulmonary disease, or sepsis associated with a reduction in ischemic stroke or an increase in bleeding risk?

**Background:** Data on the efficacy of anticoagulation to reduce stroke risk in patients with new-onset atrial fibrillation due to acute coronary syndrome (ACS), acute pulmonary disease (APD), and sepsis are limited.

**Study Design:** Retrospective cohort study.

**Setting:** All hospitals in Quebec.

**Synopsis:** Authors included 2,304 patients aged 65 and older with new atrial fibrillation secondary to ACS, APD, and sepsis. Anticoagulation was started for 38.4%, 34.1%, and 27.7% of these patients and the incidence of stroke was 5.4%, 3.9%, and 5.8% in the ACS, APD, and sepsis populations, respectively. After 3 years, anticoagulation use was not associated with a lower risk of ischemic stroke in any cohort. In a multivariate analysis adjusted for the HAS-BLED score, anticoagulation was associated with a higher risk of bleeding in patients with APD (odds ratio, 1.72; 95% confidence interval, 1.23-2.39) but not in ACS or sepsis.

The major limitation of this study was the reliance on administrative data alone, making it difficult to confirm and capture all patients with transient atrial fibrillation.

**Bottom Line:** Anticoagulation use in patients with secondary atrial fibrillation may not be associated with a reduction in ischemic strokes, but may be associated with an increased bleeding risk in patients with atrial fibrillation secondary to acute pulmonary disease.

**Diagnostic delays, morbidity, and epidural abscesses**

**CLINICAL QUESTION:** What is the frequency of diagnostic delays in epidural abscesses, and what factors may contribute to these delays?

**BACKGROUND:** Diagnostic evaluation of back pain can be challenging. Missed diagnosis of serious conditions such as epidural abscesses can lead to significant morbidity.

**STUDY DESIGN:** Retrospective chart review.

**SETTING:** Veterans Affairs Electronic Medical Record database from more than 1,700 VA outpatient and inpatient facilities in the United States.

**SYNOPSIS:** Of the 119 patients with a new diagnosis of spinal epidural abscess, 55.5% were felt to have experienced a diagnostic error, defined by the study authors as a missed opportunity to evaluate a red flag (e.g., weight loss, neurologic deficit, fever) in a timely or appropriate manner. There was a significant difference in the time to diagnosis between patients with and without a diagnostic error (4 versus 12 days, P less than .01). Of those cases involving diagnostic error, 60.6% were felt to have resulted in serious patient harm and 12.1% in patient death. The most commonly missed red flags were fever, focal neurologic deficits, and signs of active infection.

Based on these findings, the authors suggest that future intervention focus on improving information gathering during patient-physician encounter and physician education about existing guidelines. The limitations of this study include its use of data from a single health system, and the employment of chart reviews instead of a root cause analysis based on provider and patient interviews.

**BOTTOM LINE:** A delay in diagnosis resulting in patient harm or death may occur frequently in cases of epidural abscesses. Further work on targeted interventions to reduce error and prevent harm are needed.


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**A simplified risk prediction model for patients presenting with acute pulmonary embolism**

**CLINICAL QUESTION:** Is there a simplified risk prediction model to identify those with low risk pulmonary embolism (PE) who can be treated as outpatients?

**BACKGROUND:** Existing prognostic models for patients with acute PE are dependent on comorbidities, which can be challenging to use in a scoring system. Models that make use of acute clinical variables to predict morbidity or mortality may be of greater clinical utility.

**STUDY DESIGN:** Retrospective chart review with derivation and validation analysis.

**SYNOPSIS:** Authors included 6,629 patients aged 30 and older who presented with symptoms suggestive of acute pulmonary disease, or sepsis. The authors identified 400 patients with acute PE who met inclusion criteria. Using logistic regression and readily accessible clinical variables previously shown to be associated with acute PE mortality, the authors created the HOPPE prediction score: heart rate, PaO₂, systolic blood pressure, diastolic blood pressure, and ECG score. Each variable was classified into three groups and assigned a point value that could be summed to a cumulative 30-day mortality risk score. In the derivation and validation cohorts, the low, intermediate, and high HOPPE scores were associated with a 30-day mortality of 0%, 7.5-8.5%, and 18.2-18.8%, respectively, with similar trends for secondary outcomes including right ventricular dysfunction, nonfatal cardiogenic shock, and cardiorespiratory arrest.

In comparison with the previously validated PESI score, the HOPPE score had significantly higher sensitivity, specificity, and discriminative power. The conclusions from this study were limited by its single institutional design.


Dr. Pizza is a hospitalist, Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, Boston.

By Jessica Berwick, MD, MPH

9 Transfusion threshold and bleeding risk in malignancy-related thrombocytopenia

CLINICAL QUESTION: What are laboratory predictors of bleeding in patients with thrombocytopenia, and what is the effect of platelet or RBC transfusion on actively bleeding patients?

BACKGROUND: The association between platelet counts, risk of bleeding, and transfusions in patients with thrombocytopenia related to stem cell transplant (SCT) or chemotherapy is not clear, except at very low platelet counts.

STUDY DESIGN: Secondary analysis of a multicenter, randomized controlled trial, stratified by cause of thrombocytopenia: autologous or syngeneic SCT (AUTO), allogeneic SCT (ALLO), or chemotherapy for hematologic malignancy without SCT (CHEMO).


SYNOPSIS: The PLADO trial enrolled more than 1,200 patients aged 18 years and older expected to experience a period of hypoproliferative thrombocytopenia as a result of chemotherapy or SCT, and randomized them to low, medium, or high doses of prophylactic platelets. This secondary analysis assessed laboratory predictors of bleeding, and the effect of transfusion.

Of 1,077 patients who received platelet transfusions, there were no differences between dose groups for any bleeding outcomes. Over a wide range of platelet counts, the ALLO stratum had a higher risk of bleeding than other strata, with clinically significant bleeding on 21% of patient-days in the ALLO stratum, compared with 19% in the AUTO stratum and 11% in the CHEMO stratum (P < .001). Risk for bleeding was significantly higher at platelet counts of equal to or less than 5 x 10⁹/L, compared with platelet counts greater than or equal to 8 x 10⁹/L. Higher aPTT and INR were also associated with higher risk of clinically significant bleeding. In a multipredictor model, only hematocrit was significantly associated with more severe bleeding. Neither platelet transfusion nor RBC transfusion reduced the risk of bleeding on the following day, although the authors note some possibility of confounding by indication.

BOTTOM LINE: Predictors of overall increased risk for bleeding in patients with secondary hypoproliferative thrombocytopenia were treatment stratum, platelet counts less than or equal to 5 x 10⁹/L, hematocrit less than or equal to 25%, INR greater than 1.2, and aPTT greater than 30 seconds. This study challenges the conventional wisdom that transfusions reduce bleeding risk in patients with secondary hypoproliferative thrombocytopenia.


10 PFO closure reduces the risk of recurrent stroke compared to antiplatelet therapy alone

CLINICAL QUESTION: Does closure of a patent foramen ovale (PFO) reduce the risk of recurrent ischemic stroke?

BACKGROUND: Previous research on the use of PFO closure to prevent recurrent stroke has yielded mixed results.

STUDY DESIGN: Gore REDUCE, CLOSE, and RESPECT were all multicenter, randomized, open-label superiority trials, with blinded adjudication of endpoint events. RESPECT data reflected an exploratory analysis of an extended follow-up period.

SETTING: Gore REDUCE was a multinational study conducted at 63 sites in Europe and North America, from 2008-2015. CLOSE was conducted at 34 sites in France and Germany, from 2007 to 2016. RESPECT was conducted at 69 sites in the United States and Canada, from 2003 to 2011.

SYNOPSIS: Three trials reexamined the impact of PFO closure with standard antiplatelet treatment, with a total of 2,307 patients between the ages of 16 and 60 years. CLOSE included only patients with a PFO and an associated atrial septal aneurysm or a large interatrial shunt. Gore REDUCE and RESPECT were both industry funded. All three trials found a statistically significant reduction in risk of recurrent ischemic stroke associated with PFO closure and antiplatelet therapy compared to antiplatelet therapy alone (CLOSE: hazard ratio, 0.03; 95% confidence interval, 0.00-0.26; P < .001), (RESPECT: HR, 0.55; 95% CI, 0.31-0.99; P = .046), (Gore REDUCE: HR, 0.23; 95% CI, 0.09-0.62; P = .002). Gore REDUCE and CLOSE identified increased rates of post-procedural atrial fibrillation or Flutter (Gore REDUCE: 6.6% vs. 0.4%; P < .001; CLOSE: 4.6% vs. 0.9%; P = .02). Serious adverse events related to the procedure or device ranged from 3.9% to 5.9%.

BOTTOM LINE: PFO closure combined with antiplatelet therapy in patients aged 60 years or younger, particularly in those with significant right-to-left shunts and atrial septal aneurysms, reduced the risk of recurrent ischemic stroke, compared with antiplatelet therapy alone.


Dr. Berwick is a hospitalist, Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, Boston.
Charting a new course

Continued from page 1

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January 2018  16  The Hospitalist
As part of a QI effort led by an interdepartmental task force, the hospital first updated its inpatient and ED sepsis pathways to incorporate the Surviving Sepsis Campaign’s 2012 guidelines. “We continued to tweak our pathways, so they’ve now embedded other infection pathways into the sepsis pathway to make sure that we’re not missing anybody,” Ms. Savino said. The hospital also launched an early recognition and treatment educational effort targeting all health care staff and rolled out a new electronic early warning system in February 2014.

In 2013, the hospital documented three serious safety events related to a delay in diagnosis and treatment of sepsis. In 2014, it recorded only one event and has had none since then. From 2014 to 2015, sepsis-related mortality fell by more than 20%, saving an estimated 25 lives. Sepsis length of stay also declined. “We’re identifying them sooner and treating them sooner so they’re not getting as sick or requiring critical care and longer length of stays,” Ms. Savino said.

Dr. Odden also participated in a national project sponsored by the Surviving Sepsis Campaign that focused on developing protocols for nurse-led screening processes in hospital wards. Within a pilot unit of each participating hospital, bedside nurses screened every patient for sepsis during every shift. For positive screens, the hospitals then developed protocols for order sets, like blood work and fluids.

The initiative suggested that a nurse-based, every-shift screening method might be one feasible way to identify sick patients as early as possible. “Going through the screening process really seemed to empower the nurses to take a much more active role in partnering with the physicians and in recognizing some of the early warning signs,” Dr. Odden said. The project led to other benefits as well, including improved identification of strokes, delirium, and even a gastrointestinal bleed because the “barriers in communication had been broken down,” he said.

To help medical providers recognize sepsis earlier, Dr. Shieh and her colleagues created a free game called Sepris as an adjunctive teaching tool. Based on a player’s diagnosis and treatment decisions, patient outcomes either improve or worsen. Ms. Savino and Dr. Umscheid have also been impressed by the “screening process really seemed to empower the nurses to take a much more active role in partnering with the physicians and in recognizing some of the early warning signs,” Dr. Odden said. The project led to other benefits as well, including improved identification of strokes, delirium, and even a gastrointestinal bleed because the “barriers in communication had been broken down,” he said.

Dr. Odden has participated in two multicenter QI initiatives on sepsis. One, a partnership led by the Institute for Healthcare Improvement in Cambridge, Mass., and New York’s North Shore-LIJ Health System, focused on how to diagnose sepsis in hospital ward patients as quickly as possible and how to successfully deliver the 3-hour sepsis bundle. Beyond getting everyone on the same page regarding definitions, he said, the collaborators discussed and shared strategies for identifying patients. “One hospital would often have a solution for a problem that other hospitals could either take directly or modify based on their own understanding of their own processes,” he said.

Dr. Odden also participated in a national project sponsored by the Surviving Sepsis Campaign that focused on developing protocols for nurse-led screening processes in hospital wards. Within a pilot unit of each participating hospital, bedside nurses screened every patient for sepsis during every shift. For positive screens, the hospitals then developed protocols for order sets, like blood work and fluids.

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To help medical providers recognize sepsis earlier, Dr. Shieh and her colleagues created a free game called Sepris as an adjunctive teaching tool. Based on a player’s diagnosis and treatment decisions, patient outcomes either improve or worsen.
O yielding disease specialist and pharmacist J. Horton, MD, designed the hospital’s QI project. Kencee K. Graves, MD, also took several precautions to lessen the risk of antibiotic resistance.

“Lake City, the hospitalist co-leaders took initiative at the University of Utah, Salt Lake City, and included an educational effort to get pharmacists in the habit of prompting antibiotic de-escalation whenever possible. The project also included an educational effort to get pharmacists in the habit of prompting antibiotic de-escalation whenever possible. The project also included an educational effort to get pharmacists in the habit of prompting antibiotic de-escalation whenever possible. The project also included an educational effort to get pharmacists in the habit of prompting antibiotic de-escalation whenever possible. The project also included an educational effort to get pharmacists in the habit of prompting antibiotic de-escalation whenever possible. The project also included an educational effort to get pharmacists in the habit of prompting antibiotic de-escalation whenever possible.

By Bryn Nelson, PhD

One unintended consequence of the increased attention to early sepsis identification and intervention can be unnecessary or excessive antibiotic use. Overuse of broad-spectrum antibiotics, in turn, can fuel the emergence of life-threatening infections such as antibiotic-resistant *Clostridium difficile*, a scourge in many hospitals.

For a sepsis quality improvement (QI) initiative at the University of Utah, Salt Lake City, the hospitalist co-leaders took several precautions to lessen the risk of antibiotic overuse. Kencee K. Graves, MD, said she and her colleague Devin J. Horton, MD, designed the hospital’s order sets in collaboration with an infectious disease specialist and pharmacist. Thus, they could avoid overly broad antibiotics whenever possible. The project also included an educational effort to get pharmacists in the habit of prompting medical providers to initiate antibiotic de-escalation at 48 hours. The hospital had an antibiotic stewardship program that helped as well, she said. As a result of their precautions, the team found no significant difference in the amount of broad-spectrum antibiotics doled out before and after their QI pilot project.

Infection control and antimicrobial specialists also can help; they can monitor an area’s resistance profile, create an antibiogram, and reevaluate sepsis pathways and order sets to adjust the recommended antibiotics as the resistance profile changes.
Key Clinical Question

How to manage a patient presenting with syncope

Proper treatment of syncope will depend on its etiology

By Michael Roberts, MD; David Krason, MD; and Farrin A. Manian, MD, MPH
Massachusetts General Hospital in Boston

Brief overview

When evaluating a patient admitted for syncope or falls, the hospitalist must address a number of questions: a) Did the patient actually have syncope?; b) What factor(s) precipitated the syncope?; c) How might similar events be prevented or mitigated in the future?; and d) Is the patient at high risk for a serious adverse outcome (for example, ventricular dysrythmia, cardiac arrest, intracranial bleed, or death) and, therefore, in need of more immediate or intensive work-up?

The American College of Cardiology, American Heart Association, and Heart Rhythm Society guidelines define syncope as “a symptom that presents with an abrupt, transient, complete loss of consciousness, associated with inability to maintain postural tone, with rapid and spontaneous recovery” with cerebral hypoperfusion as the presumed mechanism.1 Furthermore, “there should not be clinical features of other nonsyncope causes of loss of consciousness, such as seizure, antecedent head trauma, or apparent loss of consciousness (that is, pseudosyncope).”1

A careful history revolving around the patient’s behavior prior to, during, and following the event, a thorough past medical history, and a review of current medications are essential. Potential obstacles in obtaining details of the event include lack of witnesses, patient’s inability to recall the experience, and inaccurate description of convulsive syncope as a “seizure” by bystanders.2

Certain characteristics may help identify types of syncope based on clinical presentation. Major categories of syncope include neurally mediated syncope (that is, vasovagal, situational, and carotid sinus hypersensitivity), orthostatic hypotension, and cardiac syncope – which may occur in the setting of acute events such as myocardial infarction, cardiac tamponade, aortic dissection, or pulmonary embolism (PE).

Continued on following page
Overview of data
Obtaining a detailed history is crucial to understanding both the etiology of the syncopal event and determining which patients are at high risk for adverse outcomes. The etiology of syncope can be determined by history alone in 26% of patients younger than 65 years. Data on the prevalence of syncope by cause vary widely. As a general rule, in younger patients, especially those under 40 years of age, neurally mediated syncope is most common. As patients age, orthostatic hypotension and cardiac causes (including arrhythmias and structural diseases) occur more frequently, though neurally mediated syncope is still the most common.

Hospitalists should bear in mind that clear categorization of syncope is often challenging in the elderly. Retrograde amnesia can be seen following syncope in the aged, and even patients who can provide a history may not necessarily provide an accurate account of the event. For example, up to one-half of patients who undergo tilt-table testing and have an observed episode of syncope deny that loss of consciousness ever occurred. Repeated falls in an elderly patient may also require an evaluation for syncope. The typical prodromal symptoms and characteristics of cardiac and neurally mediated syncope also tend to overlap in elderly patients. In a study that examined 46 variables in various age groups, only myoclonic study that examined 46 variables in rally mediated syncope also tend characteristic of cardiac and neurally mediated syncope, where the Risk Stratification of Syncope in the Emergency Department rule, to name a few). Unfortunately, the definition of and the timing of the adverse outcomes related to syncope often vary among studies, with reported risk factors ranging from anemia to hypotension on presentation to positive fecal occult blood testing, elevated brain natriuretic peptide, and various ECG findings. Nevertheless, several consistent predictors of serious adverse outcomes tend to emerge, such as hemodynamic instability, anemia, abnormal ECG, evidence of heart failure or structural heart disease, and acute coronary syndrome or its attendant symptoms. Many of these predictors, however, would raise the clinical suspicion of most hospitalists for adverse outcomes in their hospitalized patients independent of the presence or absence of syncope. In fact, a meta-analysis has concluded that “None of the evaluated prediction tools (SFSR, EGSSS) performed better than clinical judgment in identifying serious outcomes during emergency department stay, and at 10 and 30 days after syncope.”

Once the patient is hospitalized, further evaluation should be based on a careful history and physical examination. Standard evaluation also includes careful review of medications, an ECG to exclude findings suggestive of arrhythmias as well as structural or coronary artery disease, and orthostatic blood pressure measurements. Additional tests should be considered as deemed appropriate. For example, in patients over 40 years of age without history of cardiac artery disease or stroke and in whom no carotid artery bruit is appreciated, a carotid sinus massage may be considered. The correct technique is to massage the sinus on the right then left, each for 5 seconds in both supine and standing positions with continuous heart rate and frequent blood pressure monitoring. Reproduction of syncope, especially concurrent with a cardiac pause of greater than 3 seconds and a systolic blood pressure drop of greater than 50 mm Hg, is considered a positive test. Tilt-table testing should be considered in those for whom neurally mediated syncope is suspected but not confirmed, or in patients who might benefit from further elucidation of their prodromal symptoms.

If the patient’s history is concerning for arrhythmia but without supportive ECG findings, ECG monitoring should be considered. The type of monitoring will depend on the frequency of the patient’s symptoms, with consideration given to Holter monitors for more frequent events and external patch or implantable loop recorders considered.
in more sporadic events. An echocardiogram can be useful in those suspected of having structural heart disease. Although the overall yield of echocardiography is elucidating the cause of syncope is low, it may help further risk stratify those patients with suspected cardiac syncope and, in some cases, help with consideration of implantable cardioverter defibrillator placement. Cardiac stress testing may be considered for exercise-related syncope or patients suspected of having cardiac ischemia. Head imaging, EEG, and carotid ultrasounds are generally considered very low-yield in patients whose history suggests true syncope.

Of note, a study recently published in the New England Journal of Medicine suggests that the prevalence of PE in patients (median age, 80 years) presenting with a first episode of syncope, 17% were found to have PE. Acute coronary syndrome and aortic dissection are less frequent causes of syncope and supraventricular tachycardia is generally not associated with syncope.

Dr. Roberts

Quiz

Which of the following conditions was recently found to occur in about 1 in 6 patients presenting to the hospital with syncope?

A. Acute coronary syndrome
B. Aortic dissection
C. PE
D. Supraventricular tachycardia
E. None of the above

Answer: C, PE. In a study of patients presenting with a first episode of syncope, 17% were found to have PE. Acute coronary syndrome and aortic dissection are less frequent causes of syncope and supraventricular tachycardia is generally not associated with syncope.

Features of syncope that should prompt admission or early intensive evaluation

Canadian Cardiac Society guidelines
- Abnormal ECG: Tachyarrhythmia, bradycardia, conduction disease, new ischemia, or old myocardial infarct.
- History of cardiac disease: Ischemia; arrhythmia; and structural, obstructive, or valvular disease.
- Hypotension: Systolic BP less than 90 mm Hg.
- Heart failure: Current or past history.
- Minor risk factors: Age more than 60 years, dyspnea, anemia (hemocrit less than 30%), hypertension, cerebrovascular disease, family history of sudden cardiac death (SCD) (age less than 50 years), and specific situations (for example, syncope during exertion, while supine, or without prodrome).

European Society of Cardiology guidelines
- Severe structural or coronary artery disease: Heart failure, previous myocardial infarction, low left ventricular ejection fraction.
- ECG features of arrhythmic syncope: Bifascicular block (complete left bundle branch block, right bundle branch block with left hemifascicular block) or other interventricular conduction delay with QRS duration 120 ms or greater, nonsustained ventricular tachycardia, inadequate sinus bradycardia (less than 50 bpm) or sinoatrial block in absence of negative chronotropic medications or physical training, pre-excited QRS complex, prolonged or short QT interval, Brugada pattern, negative T waves in right precordial leads, epsilon waves and ventricular late potentials suggestive of arrhythmogenic right ventricular cardiomyopathy.
- Clinical features of arrhythmic syncope: Syncope during exertion, palpitations at the time of syncope, or family history of SCD.
- Important comorbidities: Severe anemia or electrolyte disturbance.

Convulsive syncope vs. seizure

Distinguishing characteristics

Convulsive syncope
- Prodrome of diaphoresis, warmth, abdominal discomfort
- Pallor
- Fixed or upward eye deviation
- Myoclonic jerks
- Postdromal nausea, fatigue, brief disorientation

Seizure
- Prodromal cry
- Tongue biting
- Lateral eye deviation
- Rhythmic, generalized movements
- Prolonged postdotal confusional period

Source: Adapted from reference.

Diagnostic work-up for syncope

Standard work-up
- Detailed history
- Physical examination
- ECG
- Orthostatic blood pressure measurement
- Review of medications

Additional work-up if needed
- Targeted blood testing (for example, D-dimer, CBC, BMP, troponin, NT-proBNP, based on history.)
- Carotid sinus massage
- ECG monitoring
- Echocardiography
- Tilt-table testing
- Electrophysiologic testing
- Exercise stress testing
- Fetal occult blood testing
- Radiographic evaluation for pulmonary embolism

Convulsive syncope

Differential diagnoses

Convulsive syncope

- Seizure
- Convulsive syncope
- Seizure equivalents

Diagnostic work-up

- Electrophysiologic testing
- Neurophysiologic testing
- Rhythms, conduction, seizures, symptomatic

Syncope

- » Syncope
- » 24h Holter monitoring
- » Event-related monitoring

Treatment

- Continue anticonvulsants
- Maximize anticonvulsants
- Maximize anticonvulsants

References

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• Lead the recruitment and retention of physicians and advanced practitioners.
• In collaboration with administrative and finance staff, develop and manage to the annual budget for the Division.
• Actively support the educational mission of the Division in the teaching of medical students and residents, and in Lahey’s CME programs.
• Develop a program of research which is inclusive and aligned with the clinical and quality improvement mission of the Division.

Candidates for this position:

• Must be Board Certified in Internal Medicine and eligible for licensure in Massachusetts.
• Should have a minimum of 5 years’ experience working as a hospitalist, and at least 2 years’ experience in a leadership role.
• Should have attained fellowship in the Society of Hospital Medicine and/or fellowship of the American College of Physicians.
• Should possess strong clinical, managerial and leadership skills, and demonstrate a high level of emotional and social intelligence.

For consideration and/or additional details, please contact:

David T Martin, MD, FRCP, MACP
Chair, Department of Medicine Lahey Hospital & Medical Center
41 Mall Road, Burlington, MA 01805
Email: david.t.martin@lahey.org

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Joan Humphries
Director, Physician Recruitment
p 314.364.3891 | f 314.364.2597
Joan.Humphries@mercy.net

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- Board eligible/certified in Internal Medicine
- No J-1 visa waiver sponsorships available

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Reference # SHM2017.

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Please email a letter of interest and curriculum vitae to:
- Gabriel J. Escobar, MD
  Email: gabriel.escobar@kp.org
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More thoughts about hospitalist burnout

Increasing attention, resources directed at wellness initiatives

By John Nelson, MD, MHM

I wrote about physician burnout and well-being in the July 2017 version of this column, and am still thinking a great deal about those issues. In the past 6 months, I can’t identify anything that strikes me as a real breakthrough in addressing these issues. However, the ever-increasing attention and resources directed at physician burnout and wellness, on both a local and national level, strike me as reason for cautious optimism.

A chief wellness officer

In summer 2017, Stanford (Calif.) University created a new physician executive role called chief wellness officer (CWO). As far as I am aware, this is the first such position connected with a hospital or medical school. It will be interesting to see if other organizations create similar positions, although I suspect that, in places where it is explicitly recognized as a priority, responsibility for this work will be one of the many duties of a chief medical officer or other such executive, and not a position devoted solely to wellness. Interestingly, an Internet search revealed that some non–health care businesses have executive positions with that title, though the role seems focused more on physical health — as in exercise and smoking cessation — than emotional well-being and burnout.

According to a statement on the Stanford Medicine website, the new CWO will work with colleagues to continue “building on its innovative WellMD Center, which was established in 2016. The center has engaged more than 200 physicians through programs focusing on peer support, stress reduction, and ways to cultivate compassion and resilience, as well as a literature and a dinner series in which physicians explore the challenges and rewards of being a doctor. The center also aims to relieve some of the burden on physicians by improving efficiency and simplifying workplace systems, such as electronic medical records.”

A national conference

Over the last 2 or 3 years many, if not most, physician conferences, including the SHM annual conference, have added some content around physician burnout and well-being. But for the first time I’m aware of, an entire conference, the American Conference on Physician Health, addressed these topics in San Francisco in October 2017, and attracted 425 attendees along with an all-star faculty. I couldn’t attend myself, but found a reporter’s summary informative and I recommend it.

While the summary didn’t suggest the conference provided a cure or simple path to improvement, I’m encouraged that the topic has attracted the attention of some pretty smart people. If there is a second edition of this conference, I’ll try hard to attend.

Worthwhile web resources

The home page of Stanford’s WellMD Center provides a continuously updated list of recent research publications on physician health and links to many other resources, and is worth bookmarking.

Another great educational resource for physician wellness is the AMAs STEPS Forward, a site devoted to practice improvement that provides guidance on patient care, work flow and process, leading change, technology and finance, as well as professional well-being. Of the five separate education modules in the latter category, I found the one on “Preventing Physician Burnout” especially informative. The site is free, doesn’t require an AMA membership, and can provide CME credit.

Making a difference locally: Individuals

Surveys, research, and the experience of experts available via the above resources and others are very valuable, but may be hard to translate into action for you and your fellow local caregivers. My sense is that many hospitalists address their own work-related distress by simply working less in total — reducing their full-time equivalents. That may be the most tangible and accessible intervention, and undeniably the right thing to do in some cases. But it isn’t an ideal approach for our field, which faces chronic staffing shortages. And it doesn’t do much to change the average level of distress of a day of work. I worry that many people will find disappointment if working fewer shifts is their only burnout mitigation strategy.

I’m ensuring that you have some work-related interest outside of direct patient care, such as being the local electronic health record expert, or even the person leading formation of a support committee, can be really valuable. I first addressed this topic in the June 2011 issue of THE HOSPITALIST, and there is a long list of things to consider: mindfulness, practicing “self-compassion,” cultivating deeper social connections in and out of the workplace, and ultimately, each of us will have to choose our own path, and for some that should include professional help, e.g., from a mental health care provider.

But as a colleague once put it, a focus on changing ourselves is akin to just learning to take a punch better. A worthwhile endeavor, but it’s also necessary to try to decrease the number of punches thrown our way.

Making a difference locally: Medical staff

I’m part of the Provider Support Committee at my hospital, and I have concluded that nearly every hospital should have a group like this. Our own committee was modeled after the support committee at a hospital 5 miles away, and both groups see value in collaborating in our efforts. In fact, a person from each hospital’s committee serves on the committee at the other hospital.

These committees have popped up in other institutions, and many have been at it longer than at my hospital. But they all seem to share a mission of developing and implementing programs to position caregivers to thrive in their work, increase resilience, and reduce their risk of burnout. Some interventions are focused on making changes to an EHR, work schedules, work flows, or even staffing levels (i.e., reducing the “number of punches”). Other efforts are directed toward establishing groups that support personal reflection and/or social connections among providers.

A review of activities undertaken by seven different organizations is available at the AMA STEPS Forward Preventing Physician Burnout website (click on “STEPS in practice”).
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