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IN THE NEXT ISSUE...
Celebrating volunteers, hospitalists as leaders, and SHM's Rhode Island chapter

A VICIOUS CYCLE WITH SIGNIFICANT BURDEN

WHAT COULD BE THE CONSEQUENCES OF RECURRENT *C. DIFFICILE* INFECTION?

Learn why it requires aggressive action

THE CDC ACKNOWLEDGES *C. DIFFICILE* INFECTION AS A MAJOR AND **URGENT THREAT.**[1]

IT **RECURS IN UP TO 35%** OF CASES WITHIN 8 WEEKS AFTER INITIAL DIAGNOSIS.[2,3]

THE CONSEQUENCES OF RECURRENCE ARE SIGNIFICANT, **POTENTIALLY DEADLY.**[2]

Now is the time to learn how Ferring is shedding light on the link between disease and disruptions in the gut microbiome, exploring the potential for repopulating its diversity and restoring hope to patients.

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March 2022
Volume 26 | No. 3

Movers and Shakers

Chang B. Choi, MD, FHM has been named to the board of directors at CalvertHealth, Prince Frederick, Md. Dr. Choi leads the adult-hospitalist team at CalvertHealth Medical Center. Since joining the staff in 2013, he's served as the medical director and served on the committees for quality improvement, hospital-acquired conditions, sepsis, medication safety, informatics, and critical care.


Dr. Choi

Dr. Choi is board certified in internal medicine. He earned his medical degree from the University of Maryland School of Medicine, Baltimore, and completed his residency at the University of North Carolina, Chapel Hill, N.C. He is currently a physician partner with Adfinitas Health, Hanover, Md.

Central Vermont Medical Center (CVMC) in Berlin, Vt. hired **Nejat Zeyneloglu, MD MBA, FHM** as its chief medical officer.

Dr. Zeyneloglu has held various leadership positions for more than a decade, most recently as department chair of medicine at Woodhull Medical Center, a 323-bed, community teaching hospital in Brooklyn, N.Y.


Dr. Zeyneloglu

At Woodhull, he managed all aspects of pandemic response including infection control, PPE allocation, surge planning, and staffing. He also implemented new telemedicine workflows for all medical-service lines, led the implementation of the Epic electronic medical system in his department, and achieved improvements in health and quality metrics during his tenure.

Dr. Zeyneloglu completed a quality and safety fellowship by the Greater New York Hospital Association/United Hospital Fund in 2014 and graduated from Columbia Business School's Executive MBA program in 2016. He earned his medical degree from Ege University School of Medicine in Izmir, Turkey, and completed his residency in internal medicine and pediatrics at Yale University/Bridgeport Hospital in Bridgeport, Conn.

Edmondo Robinson, MD, MBA, MS, FACP, SFHM has been appointed to the board of directors for Ardent Health Services, Nashville, Tenn., a leading provider of health care in communities across the country.

Dr. Robinson is the senior vice president and chief digital officer for Moffitt Cancer Center, Tampa, Florida's only National Cancer Institute-designated Comprehensive Cancer Center. A practicing hospital medicine physician, he leads Moffitt's Center for Digital Health, which leverages health data, information technology, and digital innovations to scale optimal care across thousands of interactions with the singular focus of preventing and curing cancer.


Dr. Robinson

Dr. Robinson earned his medical degree from the University of California, Los Angeles, an MBA from the Wharton School, Philadelphia, and a master's degree in health policy research from the University of Pennsylvania, Philadelphia.

Patrick J. Cawley, MD, MBA, MHM was named one of *Charleston Business Magazine's* 50 most influential people for 2021.


Dr. Cawley

Dr. Cawley is the chief executive officer of MUSC Health and vice president for health affairs of the Medical University of South Carolina, in Charleston, S.C. In this role, he oversees all clinical matters related to MUSC.

During his leadership, MUSC has significantly expanded its clinical enterprise with a new children's hospital, multiple ambulatory sites, the development of additional clinical affiliates, and numerous novel joint ventures. MUSC has also become a national leader in telehealth and has continued as South Carolina's number 1 hospital/health system according to *U.S. News & World Report*.

Dr. Cawley is a certified physician executive through the American College of Physician Executives, a fellow of the American College of Healthcare Executives, a fellow in the Liberty Fellowship Program, a member of the Aspen Global Leadership Network, a past president of SHM, and was awarded an MHM from SHM.

Dr. Cawley graduated from the University of Scranton, Scranton, Pa. He earned his medical degree from Georgetown University, Washington, D.C. before completing an internal-medicine residency at Duke University, Durham, N.C. He holds an MBA from the University of Massachusetts-Amherst, and he is board certified in internal medicine with focused recognition in hospital medicine. ■

Top 10 leadership tips from Dr. Eric Howell

By Eric Howell
MD, MHM, SHM CEO

While preparing for National Hospitalist Day, I began reflecting on how fortunate I am to be a hospitalist and on the aspects of leadership that have allowed me to successfully navigate more than 20 years as a hospitalist leader. I thought I'd share them with you. Yours may vary!

10. Be a workhorse rather than a show horse.

I've found that being regularly reliable is more important than being sporadically spectacular. Being consistently reliable builds trust and a strong personal brand, which is especially important in our collaborative and relationship-based world of the hospital. I believe my reputation as a workhorse is one reason I was chosen to open the COVID-19 field hospital in March 2020 at the Baltimore Convention Center.

Dr. Howell

Even though I am a workhorse, I still stretch as a leader and have stretch goals. I occasionally go into show-horse mode when I give lectures or present important work. But in general, I favor the workhorse approach.

9. Hospital medicine is a team sport.

By definition, leaders work with others —and in hospital medicine, usually a lot of others. There's a difference between leading a group of individuals versus forging people into a team. A team works collaboratively to reach a unified goal, whereas groups are people who may have a common goal (or interest) but do not intentionally coordinate efforts. Teams are more productive in reaching shared goals, more resilient, and in my experience, more likely to open opportunities for me as their leader.

8. Invest in people.

This is the corollary to building a strong team. Mentorship and sponsorship help people grow as professionals and individuals and, in turn, have helped me grow immensely as a leader. I find it personally rewarding to see people succeed, but the return on investment in my professional career has been huge. Investing in others has allowed me to expand my professional network into new and high-impact ventures. When I invest in others, they also invest in me.

7. Take calculated risks.

I find it hard to grow as a leader if I don't venture out of my comfort zone. These are the stretch goals I talked about before. Some of the biggest leadership jumps came from taking some professional risks. For example, I had a very successful, single-hospital, hospitalist group. I could have stayed in that single hospital for the rest of my career, which was a common practice at my institution. Instead, I took a professional risk by opening a second hospitalist group in another hospital.

Fortunately, that second hospital medicine group was a huge success and paved the way for a much larger institutional role, overseeing eight physician groups in four hospitals. While not all risks pay off, when they do, they are well worth it!

6. Find a pathway to resilience.

Medicine can be stressful, and the pandemic has made the stressors worse both inside and outside of the hospital. Add leadership responsibilities, and I find I need to be very proactive in my self-care to avoid burnout. I work hard to exercise, eat well, and get sleep. The most important self-care activity for me is staying connected to my family. I make time for walks with my wife Heather every day (with our dogs Duffy and Sperry too!), and I strive to eat dinner with my kids frequently. I can't be home for dinner every day—after all, patient care is a round-the-clock vocation—but I still manage to eat with Heather and my children more days than not.

I also have hobbies. Many of you know I like boats and Jeeps, and I spend time tinkering on or exploring nature with both. Sometimes boats and Jeeps have to wait days or weeks to be revisited, but I can take a moment during a busy hospital (or SHM!) day to daydream about my next adventure.

5. Be grateful.

I am so very lucky that physicians are well respected by (most of) society. I'm grateful for the patience my family has for those late-night calls and missed events. I am especially grateful for the trust and close bond I've developed with many patients. Medicine is not easy, but I am thankful for the special role I'm allowed to play.

During my most recent ward-attending block, we helped a dying patient transition to hospice. It was extremely heart-wrenching. But I got a call from the patient's daughter, thanking us for supporting her mother and her siblings during those dark times. I am so thankful for those patients who validate that what we do is meaningful, even when all we can do is listen.

4. Manage conflict.

I don't like conflict. When a car wants to merge into my lane in front of me, I feel stressed! Who would have thought that much of my success as a hospitalist leader would be the result of effectively managing conflict? From negotiations where "everyone wins" to "playing hardball" and walking away, I have learned to flex my negotiation style. Because I am seen as an effective negotiator and manager of conflict, I've been tasked with managing partnerships with emergency departments (ED), hospital administrators, and more.

I knew I had managed the ED conflict well when the ED director at one point stood up in front of hospital administration to support our overworked hospitalists. He said, "I don't know how many hospitalists are too many, but I can assure you we are a long way from that today. I favor funding more hospitalists."

3. Give.

Give away authority, give away time, give away some of your opportunities to others. I've even given away my free parking to a colleague! What did I get in return? A whole lot more than parking. I got colleagues who have my back, I got introduced to opportunities that would have been invisible to me otherwise, and I got a network of people willing to share information because they knew I had their best interests at heart.

2. Be ethical and transparent.

This needs no explanation. Especially in these dark times, where trust is low and misinformation is high, being ethical and transparent is critical. Start early and build that trust. This is a core step to transforming a group of people into a unified team. They need to trust in you as a leader.

1. Find and live by your core values.

I've developed three fundamental core values that I live by:

- Make the world a better place.
- Be ethical and transparent.
- Invest in people.

You'll see two of those core values are also two of my top 10 leadership tips. They are so important they merit two mentions. When followed, they almost always create outcomes that lead to my first core value. It sounds corny, but I use these to guide difficult decisions frequently.

Here are a couple examples. Baltimore needed doctors to help hospitals during the omicron surge, so what did I do? "Get in there, Howell! You want to make the world a better place." So, I volunteered to see patients at my old hospital for seven days in early January.

There was a cushy lecture invite at a cool location. One of my colleagues might have been a better fit, but did I snap that up myself anyway? No, I wanted to invest in people, so I connected my colleague to the request. The result? She has become an international hospital medicine celebrity.

These are just two examples of how my core values played an active and important role in my leadership growth. I'm a strong advocate of finding one's core values, explicitly stating them, and then doing one's best to live by them. You'll find this not only makes you a stronger leader, but also a more compassionate, resilient human being. ■

Key Cinical Question

How should patients with eating disorders requiring acute medical stabilization be managed in the inpatient setting?

By Kate Wimberly, MD

Case

A 25-year-old female pharmacy student is brought to the emergency department by her parents after a presyncopal episode while at home for a school break. Her parents are concerned that she has lost quite a bit of weight over the last year. Initial vitals are notable for HR 38 and supine BP 110/70. Upon standing, BP decreases to 85/60 and HR increases to 115. Labs are notable for slightly low potassium and normal serum phosphorus. BMI is 15.2.

Background

Eating disorders (EDs) are serious psychiatric illnesses with significant morbidity and mortality. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) provides diagnostic criteria for six categories of feeding and eating disorders: anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), avoidant/restrictive food intake disorder (ARFID), pica, and rumination disorder.[1] Patients with AN are further categorized into restricting and binge-eating/purging subtypes. It is common for patients with symptoms of feeding and eating disorders to fall outside the strict diagnostic criteria for the disorders listed above. These patients may be diagnosed with other specified feeding or eating disorder (OSFED) or unspecified feeding or eating disorder (UFED). All eating disorders cause significant emotional and psychological distress and place patients at risk of serious medical complications. For simplicity, this article will focus on medical complications of AN and BN, but any patient with disordered eating behaviors may experience medical complications. The DSM-5 diagnostic criteria for AN and BN are listed in Table 1. Within each diagnosis, there are additional criteria to classify the severity of the disease.

Epidemiology

Eating disorders are relatively common. A 2019 systematic review reports a lifetime prevalence of ED of 8.4% in women and 2.2% in men. Of the EDs described in the DSM-5, OSFED has the highest lifetime prevalence, followed by AN, BN, and BED.[2] EDs can affect people of all ages, genders, and ethnicities, and are often present in adolescence or young adulthood. There is a strong association between EDs and other comorbid psychiatric diagnoses, especially mood and anxiety disorders.[3] Eating disorders can be deadly—other than substance-use disorders, EDs have the highest mortality rate of all mental illnesses.[4] Mortality in AN and BN is typically attributable to suicide or medical complications of malnutrition or purging behaviors.[3]

Medical complications

It is important to remember that patients with eating disorders can experience medical complications at any weight, not just extremely low weights. Medical complications of AN are typically due to weight loss and malnutrition, while complications of BN are due to malnutrition and/or purging behaviors, including self-induced vomiting, laxative, or diuretic use. Individuals do not need to be underweight to experience the effects of malnutrition. The complications of EDs can affect all body systems. Common complications of AN and BN in adults include, but are not limited to, the following:[3,5,6,7]

Cardiac: Bradycardia, myocardial atrophy, mitral valve prolapse, peripheral edema, orthostatic hypotension, sudden cardiac death

Gastrointestinal: Gastroparesis, constipation, superior mesenteric artery (SMA) syndrome (due to loss of fatty tissue surrounding the SMA, causing external compression of the duodenum as it passes between the SMA and aorta), elevated liver transaminases

Endocrine and metabolic: Hypokalemia, metabolic alkalosis (typically caused by self-induced vomiting), hyperchloremic metabolic acidosis (secondary to laxative abuse), amenorrhea, hypercortisolism, hypothermia, hypoglycemia, thyroid-function abnormalities resembling euthyroid sick syndrome

Hematologic: Anemia, leukopenia, thrombocytopenia

Musculoskeletal: Osteopenia/osteoporosis

Dermatologic: Lanugo, acrocyanosis, xerosis, Russell's sign (excoriation on knuckles due to repeated trauma from self-induced vomiting)

Neurologic: Brain atrophy

Most medical complications of EDs are treatable with early, effective psychotherapy and medical interventions.[3]

Levels of care

Eating disorders are best managed by a multidisciplinary team including a medical provider, a dietitian, and a psychiatrist or psychologist with experience treating EDs.[8] Patients with EDs may be managed in a variety of settings, including inpatient medical facilities (non-specialized acute-care hospitals), specialized intensive inpatient programs, residential and partial-hospitalization programs, and varying levels of outpatient care.[9] The level of care indicated for a given patient is determined based on the severity of physical and psychological symptoms, as well as the patient's geographic proximity to specialized treatment. In this review, we will focus on management in the inpatient acute-care setting. There are no standardized, evidence-based criteria indicating which patients should be admitted to an acute-care facility for medical stabilization, but several societies have published consensus guidelines. The Society for Adolescent Health and Medicine has published indications for hospitalization in adolescents and young adults with EDs (listed in Table 2).[10] These indications for hospitalization are often extrapolated to adult patients. It is also possible that patients with EDs may be admitted to the hospital for an apparently unrelated medical or psychiatric condition, and the ED is then identified on review of history, vital signs, exam, or labs.

Inpatient medical stabilization

The immediate goals of treatment for patients with eating disorders include the following: medical stabilization, nutritional rehabilitation to achieve weight restoration (if needed), management of refeeding and possible complications, and interruption of purging and other compensatory behaviors.[8] Medical stabilization during an acute hospitalization to a medical floor should involve a multidisciplinary, protocolized approach to nutritional rehabilitation.[11,12]

Patients requiring hospitalization for complications of malnutrition are at high risk for the development of refeeding syndrome with the initiation of nutritional rehabilitation. Refeeding syndrome is a serious condition characterized by fluid and electrolyte shifts in malnourished patients undergoing the initiation of feeding.[13] These fluid and electrolyte shifts can precipitate severe hypophosphatemia and other electrolyte abnormalities, which can cause arrhythmias, heart failure, or sudden death. Refeeding syndrome typically occurs within the first two weeks of nutritional rehabilitation and usually develops within the first three to four days after initiation of refeeding.[12,14]

Risk factors for refeeding syndrome in adult patients include:[8,11]

- Body mass index (BMI) <15; highest risk at BMI <13
- Recent rapid/profound weight loss (>10-15% of total body mass in three to six months)
- Chronic undernourishment with little to no intake for more than 10 days
- Significant alcohol intake
- History of bariatric surgery

Dr. Wimberly

Dr. Wimberly is an assistant professor in internal medicine and pediatrics, in the division of hospital medicine at the University of Kentucky, Lexington, Ky.

Table 1

DSM-5 DIAGNOSTIC CRITERIA: ANOREXIA NERVOSA
A. Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
SUBTYPES
Restricting type: During the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
Binge-eating/purging type: During the last three months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or misuse of laxatives, diuretics, or enemas).
DSM-5 DIAGNOSTIC CRITERIA: BULIMIA NERVOSA
A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: **1.** Eating, in a discrete period of time (e.g., within any two hours), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances. **2.** A lack of sense of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
B. Recurrent, inappropriate compensatory behaviors to prevent weight gain, such as: self-induced vomiting; misuse of laxatives, diuretics, or other medications; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Adapted from: American Psychiatric Association (2013). Feeding and eating disorders. In Diagnostic and Statistical Manual of Mental Disorders (5th ed.)

Table 2

INDICATIONS SUPPORTING HOSPITALIZATION IN AN ADOLESCENT WITH AN EATING DISORDER ONE OR MORE OF THE FOLLOWING JUSTIFY HOSPITALIZATION:
1. ≤75% median body mass index for age and sex
2. Dehydration
3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia)
4. EKG abnormalities (e.g., prolonged QTc or severe bradycardia)
5. Physiologic instability: » Severe bradycardia (HR <50 beats/min daytime, <45 beats/min at night) » Hypotension (<90/45 mmHg) » Hypothermia (body temperature <96°F, 35.6°C) » Orthostatic increase in pulse (>20 beats/min) or decrease in blood pressure (>20 mmHg systolic or >10 mmHg diastolic)
6. Arrested growth and development
7. Failure of outpatient treatment
8. Acute food refusal
9. Uncontrollable bingeing and purging
10. Acute medical complications of malnutrition (e.g., syncope, seizures, cardiac failure, pancreatitis, etc.)
11. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (e.g., severe depression, suicidal ideation, obsessive-compulsive disorder, type 1 diabetes mellitus)

Adapted from: Golden N, et. al. Position paper of the Society of Adolescent Health and Medicine: Medical management of restrictive eating disorders in adolescents and young adults. *J Adolesc Health.* 2015;56:121-125.

- Recent diuretic, laxative, or insulin misuse
- Abnormal electrolytes prior to initiation of refeeding
- History of refeeding syndrome

The risk of refeeding syndrome increases with rapid initiation of feeding. As a result, a conservative approach to nutritional rehabilitation has historically been recommended.[12] With this "start low, go slow" approach, patients were typically started on low-calorie diets (around 1200 calories/day) and calories were advanced slowly (often by around 200 calories every other day).[12,15] In recent years, the conservative approach to refeeding has been challenged—a number of recent studies have shown that starting mildly to moderately malnourished patients with AN on higher-calorie diets and advancing calories more aggressively does not increase the rate of refeeding syndrome or refeeding hypophosphatemia.[12,15] A more aggressive approach to nutritional rehabilitation may also decrease the length of hospitalization and promote faster weight restoration, which has been linked to improved outcomes in AN.[12] It is not yet clear if aggressive refeeding is safe in severely malnourished (BMI <15) or critically ill patients with AN.[15]

The goal of inpatient nutritional rehabilitation is to prevent refeeding syndrome proactively (rather than treat it reactively) while promoting weight gain to restore physiologic stability.[15] It is important to monitor electrolytes closely (at least daily) upon initiation of feeding and to replace electrolytes aggressively. Electrolytes may be normal on admission—phosphorus reaches its nadir three to seven days after initiation of nutritional rehabilitation.[8] Thiamine supplementation is recommended on initiation of feeding in adult patients to reduce the risk of Wernicke's encephalopathy.[11] Malnourished patients should also receive a daily multivitamin. Patients with severe bradycardia, arrhythmias, prolonged QTc, or severe electrolyte abnormalities should be monitored on telemetry until stabilized.[12] Target weight gain in the acute inpatient setting varies between patients but typically ranges from 0.5–2kg/week.

Oral feeding is generally the preferred method of nutritional rehabilitation, as refeeding orally avoids a potentially difficult future transition from enteral to oral feeds.[8,11] Oral feeds typically consist of meals and snacks with liquid supplementation (e.g., Boost or Ensure) as needed to provide additional calories or make up for uneaten portions of meals or snacks. However, in some situations, including acute food refusal and poor weight gain with oral refeeding, enteral nutrition via nasogastric (NG) tube is warranted. A recent systematic review determined that NG nutrition is safe, well-tolerated, and led to improved weight gain in inpatients with AN.[16] Fluid balance must be monitored carefully in patients undergoing nutritional rehabilitation. Because refeeding syndrome involves fluid shifts and can cause acute circulatory fluid overload, oral rehydration is preferred over the intravenous route whenever possible.[8]

While eating disorders may have profound physical consequences, EDs are psychiatric illnesses at their core. Patients with EDs may not acknowledge that they are ill and may be indifferent or even resistant toward treatment.[8] Treatment goals, including nutritional rehabilitation, are often in direct opposition to the wishes of a patient with an eating disorder.[17] As such, patients may attempt behaviors that do not align with the goals of hospitalization. Without appropriate supervision, inpatients may attempt compensatory behaviors such as purging (via self-induced vomiting or laxative

use), surreptitious exercise to burn calories, or may attempt to hide food. Patients may also artificially manipulate their weight by "water loading" (drinking copious amounts of water) or by placing objects under their clothes or gown while being weighed in an attempt to make their weight appear higher than it actually is (perhaps to avoid further treatment).[11]

In the inpatient setting, there must be protocols in place to provide structure for patients and interrupt these disordered behaviors. Specific protocols may vary between facilities, but generally involve 24-hour or mealtime supervision by nursing observers, bathroom supervision, exercise/movement limitations, and scheduled daily weights (typically performed in the morning, gowned, after the first void of the day). Blind weights are often performed.[7,11,12]

Discharge criteria may vary depending on a patient's discharge disposition, but patients typically need to have a resolution of any electrolyte, EKG, or vital-sign disturbances prior to discharge from the acute inpatient setting.[12] Many inpatients are discharged to residential, partial-hospitalization, or intensive-outpatient treatment programs for further weight restoration and psychotherapy once medically stabilized and out of the expected timeframe for the development of refeeding syndrome. Full recovery may take years and patients often require varying levels of care over time.[9]

Lastly, it is important to take a moment to discuss language that should be used when communicating with patients with EDs. As discussed, EDs are complex psychiatric disorders—it is important to remember that any physical manifestations of eating disorders are symptoms of the patient's underlying psychiatric process. Eating disorders are not choices, they are serious, biologically-influenced illnesses.[18] Patients with EDs often minimize or rationalize their ED symptoms or behaviors, but at the same time, may feel a great deal of guilt or shame regarding their disorder.[8] These patients have a skewed perception of food and weight and may perceive comments regarding these topics differently than they are intended and differently than the general population would perceive them. When communicating with patients with EDs, clinicians should address matters of food and body size in a straightforward, non-judgmental manner.[19] ■

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#HowWeHospitalist: A glimpse into six lives

By Robert Bell

They've been called heroes. They've been applauded. That respect and admiration was a balm to overworked hospitalists. Now many would gladly pass that up for a return to normalcy.

Normalcy. Remember that? Twelve-hour days? On-off shifts? Using the bathroom without a mask? Two years into the pandemic, hospitalists are tired. Many are burned out. Some have left the profession. Others are no longer alive. This is not another story on the emotional wreckage the pandemic has left in hospitalists' lives. This is the other kind.

Sure, the anxiety and stress remain, but there is also hope. And family. And compassion, and heaping doses of collegiality. To celebrate National Hospitalist Day, we spoke with six hospitalists in different stages of their careers and lives. All have experienced loss these past two years. Yet all can imagine no other calling they'd want to pursue.

Hotels for the healing

Looking back, there was no way Khaalisha Ajala, MD, MBA, FHM, would have ended up anywhere other than where she is today, which is to say a hospitalist and co-director of the division of hospital medicine's education council at Emory University School of Medicine, Atlanta. And looking back, there's nowhere else she'd want to be.


Dr. Ajala

Dr. Ajala remembers tagging along with her mother Brenda Austin, a registered nurse, when she went to work. She loved everything about her mom's job: parking herself at the nurse's station and taking it all in—the patients passing by in the hallways, the doctors and nurses darting in and out of rooms to help them.

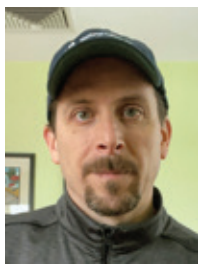
But it wasn't until later, during her residency, that Dr. Ajala realized she wanted to work in a hospital. "Clinical is important," she said, "but I really came alive when I was in the hospital."

Think about it, she said. For a hospital to operate at its best, everyone's job is critical. "The cafeteria lady, environmental services, records, customer service, doctors, nurses—we have to work together to pull it off, and we do, every day," said Dr. Ajala.

Dr. Ajala once had another name for hospitals. "Hotels for healing," she said. "So many people are working to make the patients comfortable. We have to be like a family to pull that off, to keep everyone's spirits up, and we do it every day. It's been a miracle, really."

Escaping to the court

First came the bed shortages. Then came the staff shortages. The vaccine shortages soon followed. In the hospitals across New York City where David Alfandre, MD, MSPH is a health care ethicist at the U.S. Department of Veterans Affairs National Center for Ethics in Health Care and an associate professor of medicine and population health at the NYU School of Medicine, the last two years have been a blur of shortages.


Dr. Alfandre

Months fighting a pandemic without end left Dr. Alfandre exhausted and anxious. His self-prescription? A tennis racket.

"Just being outdoors and seeing people in person was the best," said Dr. Alfandre, who until last summer had never played the sport. "Public tennis courts are great for social distancing, but they're also great for helping leave work behind. Seeing people and talking to them face-to-face—not on Zoom—is how I cope."

Dr. Alfandre suspects he's not alone. Last year, when the nation finally started to gain an upper hand on COVID-19, and family and other visitors were slowly allowed back into hospitals, he remembered what a powerful tool hospitalists and their patients had in friends and family.

"I'd forgotten what it's like having someone who knows the patient in the same room," he said. "So many people died alone. Now they've got someone by their side, and we've got someone who can help us with any medical questions or history. Are you kidding me? That's a gift."

So far in 2022, it's a gift without any shortages.

Graces abound

Can there be silver linings to a pandemic? If there are, Eileen Barrett, MD, MPH, MACP, SFHM hasn't come across any yet. But graces, the term a friend of Dr. Barrett's coined? They're everywhere.


Dr. Barrett

"The pandemic has helped a lot of people see the importance of hospitalists and our profession," said Dr. Barrett, a hospitalist in Albuquerque, N.M. "There's been a long-overdue conversation about professional sustainability. I worry about a lot of people—nurses, physicians assistants, doctors. It's been rough."

That assessment could apply to Dr. Barrett at times, but she won't allow it. Every night she texts a friend in Illinois three good things big or small that happened that day. Dr. Barrett's graces on a recent Wednesday: A nice walk to work … a meaningful palliative-care conversation with a nurse … a lovely walk home from work.

"Sometimes they are deep," she said. "Sometimes it's a good cup of coffee."

Sure, dinner out with her husband or friends helps, too, but the texts "are like a balm," said Dr. Barrett. "They keep me going."

A hospitalist at heart

John Bulger, DO, MBA hasn't practiced medicine in seven years, but the chief medical officer for Geisinger Health Plan in Danville, Pa. still has a soft spot for hospitalists—even more during this latest wave of the pandemic.


Dr. Bulger

"This might be the most difficult time to be a part of health care in my 25 years, but it's the hospitalists who are pulling us through," he said. "Obviously the clinical competencies are important, but the core competencies? The communication with the patients, the families? Helping with the difficult flow of people through care from admissions, to getting better, to post-acute care, to skilled nursing, and eventually getting them home? The hospitalists have gotten us through this."

And, Dr. Bulger said, they're the ones who will get us through 2022. "I think the biggest mistake we made in this pandemic was not relabeling it last summer. We need to start preaching that this is an endemic and no longer a pandemic if for no other reason than for people's mental health."

With a readily available vaccine and infection rates dropping over the summer, Dr. Bulger said many people saw a light at the end of the tunnel. "Turns out that light was a train coming at us," he said.

"This is going to be with us for some time," Dr. Bulger said. "That's why I'm proud of all the hospitalists who show up every day and never stop doing their job and caring for others. Some days I wish I were right there with them. I guess I'll always be a hospitalist at heart."

A support group at home. Work, too.

The hardest part of his job? That's easy. When the COVID-19 pandemic was at its worst, Harvir Singh Gambhir, MD, FACP, CPL, CPHQ, would pull into his driveway after a long day's—and frequently night's—work and not get out of his car. He knew his wife and then-9-year-old son were waiting inside. What he didn't know was what he might be carrying inside to them.


Dr. Gambhir

"That was my biggest fear," said Dr. Gambhir, an internist at Upstate University Hospital in Syracuse, N.Y. "Every night was the same. Every night I worried about what I might bring home to my family."

The best part of his job? That's easy, too. Throughout the last year, Dr. Gambhir has been supported emotionally at home, but also professionally at work. Both families have offered heavy doses of whatever he needed that day: advice, empathy, a smile.

"You hear stories, really horrible stories about what other people at hospitals are going through, but it was never that bad for me. I have such a strong team that is there for everyone. Great communication, everyone is willing to help each other. I like to think I'm there for them, too, because their support has made such a difference for me," he said.

A new beginning

Courtney Edgar-Zarate MD is a mother and an internal medicine/pediatric specialist in Little Rock, Ark. So, it's safe to say she knows children.

It's even safe to say she knows her children. It's also safe to say she knows how the pandemic has affected her work and family. "COVID made me think about what made me happy and what didn't," said Dr. Edgar-Zarate. "The past 18 months made me realize I didn't like my job and what it was doing to my family."

So she quit.

Well, sort of. Goodbye, Little Rock. The Zarates—Courtney, her physician husband Yuri, and two children—are moving. Hello, Lexington, Ky.

Dr. Edgar-Zarate is going to work part time at Baptist Health in Lexington. Less money? Absolutely. Less stress? You bet. More time with 10-year-old Leila and 7-year-old Bianca? Most definitely.

Just thinking about that makes Dr. Edgar-Zarate smile, something that's been missing the past 18 months. Summer's coming. There are boxes to be packed. "I still get a little tight thinking about it," she said. "But for our careers, our family, I'm happy. The kids will come around. It's a new beginning."

Here's to new beginnings for Dr. Edgar-Zarate—and all hospitalists. ■

Robert Bell is a freelance writer in Greensboro, N.C.

SHUTTERSTOCK.COM

Must-attend Converge sessions

SHM editorial board members share their picks

Each year, hospitalists, clinicians, and frontline workers come together for SHM's annual conference—Converge. They come for education, engagement, and networking. It's been two years since the last in-person event, but this April in Nashville, Tenn. you'll find all that, and more—in person.

As a sneak peek, *The Hospitalist's* editorial board members share the sessions at the top of their must-attend lists.

Tiffani Panek, MA, CLHM, SFHM, division administrator, division of hospital medicine, Johns Hopkins Bayview Medical Center, Baltimore

The first session I'm really looking forward to is "Finding Calm in the Storm: Building Resilience & Strengthening Emotional Intelligence". It's been a tough few years for everyone, and now more than ever, learning how to be more resilient in the face of the world around us is so important.

Ms. Panek

I'm also looking forward to the session on the leadership track, "Immigrant Hospitalists: Our Stories and Paths to Success". Any time you get to hear personal stories from your fellow hospitalists it's so impactful and learning how people have grown and thrived should be very inspirational.

Then, especially considering some of the challenges the world and medicine are facing right now in terms of social justice, I am looking forward to "Rise Up: Challenging Microaggressions and Implicit Biases in Organizational Culture". It's vital that we understand the role our own systems play in these difficulties and better know how to combat those elements of our cultures.

Anika Kumar, MD, FAAP, FHM, staff physician, department of pediatric hospital medicine, assistant professor of pediatrics, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, Cleveland, and pediatric editor of The Hospitalist

Converge 2022 is filled with great content, especially on the pediatric track. As a pediatric hospitalist, I'm most excited to attend the "Transitions from Pediatric to Adult Care for Patients with Medical Complexity", and the "Mental Health Boarding on Inpatient Units" sessions. Both are hot topics and address different populations that often require unique care.

Dr. Kumar

James Soo Kim, MD, assistant professor of medicine, Emory University School of Medicine, and Emory University Hospital, Atlanta

"So You Want to be a Medical Director: Tips and Tricks for Securing and Thriving in Your Leadership Role" Speakers: Stephanie Halvorson, Dan Hunt, Chad Vokoun, and Rand Ladkany. I think the members of the panel have a great amount of experience concerning the topic, and this session will hopefully be useful for audience members, no matter whether they're just starting their careers or have been in their positions for a while.

Dr. Kim

"Chart SMART: Using Documentation Wisely" Speakers: Nita Kulkarni, Matt Landler, Aziz Ansari, and Gopi Astik. I remember listening to Dr. Ansari several years ago and his lecture about documentation. I was surprised by how much I learned and how engaging it was. Even though the subject matter may seem a little dry, I think the panel will be able to elevate the topic.

P Dileep Kumar, MD, MBA, FACP, FAAPL, CPE, hospitalist, East Michigan Hospitalists, Port Huron, Mich.

I'm looking forward to several sessions in particular: "Perioperative Pitfalls—Overcoming Common Challenges in the Medical Care of Surgical Patients"; "Delirium Do Si Do: Literature and Best Practices"; and "How to Fund Your Research: Understanding and Navigating Funding Opportunities for Any Size Research Project".

Dr. Kumar

Venkataraman Palabindala, MD, FHM, hospitalist, University of Mississippi Medical Center, Jackson, Miss.

It's hard to pick which ones are the best to attend. I'm going to listen to almost all the talks during the coming months since I'll buy Converge On Demand. The annual meeting is one of the best collections of speakers you can ever have in the hospitalist world. This kind of summary and suggestions are not available anywhere else or at any other meeting.


Dr. Palabindala

Saying that, I still believe there are a few talks that are a must to attend. Of course, I will always promote my fun event, "Medical Jeopardy". This year it's going to be a challenge between four great attendings from four great organizations across the country vying to win the National Jeopardy competition. Not only will you learn a lot, but you'll also have a lot of fun. I'm sure it's going to be more entertaining this time given a combination of in-person and virtual play.

I also recommend the session by Dr. Ansari, "Chart Smart, Using Documentation Wisely". This one is going to be a very important talk for early-career hospitalists and physician advisors who are planning to become experts in utilization-management roles.

Since I'm a tech-savvy hospitalist, the whole TECHno track will be my favorite to attend, with the "BC and AC of Telehealth: Essential Telehealth Skills for the Hospitalist in the After COVID Era" workshop high on my list.

The workshop "So You Want to be a Medical Director: Tips and Tricks for Securing and Thriving in Your Leadership Role" is also going to be one heck of a talk.

Weijen W. Chang, MD, FAAP, SFHM, pediatric and adult hospitalist at Baystate Medical Center and Baystate Children's Hospital in Springfield, Mass., associate professor of pediatrics at the University of Massachusetts Medical School Baystate, chief of pediatric hospital medicine, vice-chair for clinical affairs at Baystate Children's Hospital, and physician editor of The Hospitalist

"So You Think You Can Scan: Integrating POCUS with Clinical Reasoning"—POCUS and engaging clinical reasoning are two of the really fun aspects of being a hospitalist, and you get both here!


Dr. Chang

"Getting Things Done: Principles for Successful and Effective Leadership"—Whether you're a newly-minted hospitalist or CEO of the hospital, you will be leading a team of individuals, and you can never get enough insights into effective leadership as a hospitalist.

"Approaches to Addressing Microaggressions and Mistreatment from Patients as a Provider and as a Supervisor to Learners"—The past few years have been eye-opening to the world but specifically to health care providers about how we often overlook microaggressions and outright mistreatment. I am very curious to get as many perspectives on this topic as possible since as an "older" hospitalist, I'm sure I have many ingrained biases that need to be addressed.

Lonika Sood, MD, MHPE, FACP, FHM, clinical education director for internal medicine, Elson S. Floyd College of Medicine, Washington State University, Spokane, Wash.

"Things We Do for No Reason"—This session will help hospitalists to continue being good stewards of appropriate and high-value care.

"The Need For Speed: Rapid Qualitative Methods for Real-World Operational and Quality Improvement And Yes!, Qualitative Research Can Be Rapid!"—Qualitative research gets a bad rap for being time-consuming. This session claims this is not the case. I would love to hear more!


Dr. Sood

"Cases from the Northwoods: Impact of Technology on Rural Medicine"—In resource-limited settings and in a pandemic, how can we leverage the use of technology? This is a timely topic!

Amith Skandhan, MD, FHM, medical director/physician liaison, physician advisor, core faculty, internal medicine residency program, internal medicine hospitalist, Southeast Alabama Medical Center, Dothan, Ala.

"Leveraging Diversity & Inclusion to Improve Outcomes"—Diversity, Equity, and Inclusion (DEI) has taken more prominence in our society and in workplace hiring. DEI programs help the employees have the freedom to participate in the workforce and contribute as their true selves. These DEI programs facilitate a platform of creativity, sharing new ideas, and improving production, all of which should contribute to increased revenue and better quality. However, there are still health systems that don't understand DEI.


Dr. Skandhan

I am looking forward to this talk to hear specifically about the outcomes and education provided to create meaningful change.

"BC and AC of Telehealth: Essential Telehealth Skills for the Hospitalist in the "After COVID Era"—The COVID-19 pandemic has highlighted health care discrepancies related to access to care. Telemedicine has been around in some form since the 1950s. The potential of telemedicine is realized during this pandemic. There is a significant opportunity to change the practice of medicine using this technology, even in the inpatient setting. We must understand the challenges and skills necessary to deal with this newer health care delivery model. The more we participate on this unique platform the more we can promote and influence a higher quality of care.

I am looking forward to learning the basic skills necessary to participate in a new culture in medicine.

"Redesigning Systems to Improve Teamwork and Quality for Hospitalized Patients: Lessons Learned"—Hospitalists often deal with issues related to system issues, whether it be readmission because of a transition to outpatient care which fell through, patient-safety issues due to diversion and emergency-department hold, or delay in care due to patient-flow challenges. Often departments work in silos. Improving care in their area of influence can create a more significant blockage in the downstream patient flow and affect the quality of care. It is essential for health care leaders to have an eagle-eye view of the entire health care system and how their department affects others. Health care system redesign makes systematic changes to improve the quality and efficiency of care rendered, leading to better patient outcomes and improved patient and provider satisfaction.

I am eager to learn what examples other institutions have incorporated to improve the teamwork and quality of hospitalized patients. ■

shm CONVERGE On Demand

Whether you attend SHM Converge in Nashville or not, Converge On Demand is the perfect option to soak up all the education and information at your own pace.

SHM Converge offers educational and networking opportunities designed specifically for the hospital medicine professional. Attendees can re-energize and focus their practice with the latest research, best practices, and newest innovations in the field that can immediately be applied to improving patient care.

Learning Objectives

- Describe current state-of-the-art, evidence-based, clinical practice for key topics in adult and pediatric hospital medicine
- Implement systemic changes to promote quality and improve patient safety
- Address current challenges in academic and educational systems for improving hospital medicine
- Discuss new policy, financial, ethical, legal, and management trends affecting inpatient care

SHM is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education (CME) for physicians. SHM designates this live activity for a maximum of 102.5 AMA PRA Category 1 Credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 31.5 Maintenance of Certification (MOC) points in the American Board of Internal Medicine's (ABIM) MOC program. Participants will earn MOC points equivalent to the number of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

Earn more than 100 CME credits and up to 31.5 MOC points. When you purchase SHM Converge On Demand, you'll have access until 2024. Learn more about SHM's annual conference and Converge on Demand at

https://shmconverge.hospitalmedicine.org/. ■

THINGS TO DO IN NASHVILLE

Sights, sounds, food, and fun!

You might know Nashville as the birthplace of country music and home to SHM's 2022 annual conference, Converge—but there's a lot more to see and do in Tennessee's capital than the Grand Ole Opry and the Country Music Hall of Fame.

History buffs

Check out the capitol (it's one of the oldest still in use) and Bicentennial Capitol Mall State Park. You might also enjoy:

- **Nashville Parthenon—**this full-scale replica is the centerpiece of Centennial Park. The park sits on 132 acres and has a one-mile walking trail, Lake Watauga, the Centennial Art Center, historical monuments, an arts activity center, a sunken garden, and more.
- **RCA Studio B**—where Elvis recorded more than 200 songs. It became part of the Country Music Hall of Fame and Museum in 1992.

Nature lovers

If you're drawn to the great outdoors, there are lots of opportunities for hiking, exploring, and wildlife viewing.

- **Radnor Lake State Natural Area**—this 1,300-acre park features more than six miles of trails, an aviary complex, and ranger-led programs.
- **Cheekwood Estate & Gardens**—this 55-acre, 1930s estate, listed in the National Register of Historic Places, was home to Leslie and Mabel Cheek. You might know one of the Cheek family businesses—Maxwell House Coffee. You can tour the home, botanical garden, arboretum, and museum.

Family fun

There's no shortage of family-friendly things to do in Nashville.

- **Adventure Science Center**—explore more than 175 hands-on exhibits and the Sudekum Planetarium.
- **Country Music Hall of Fame and Museum**—called the "Smithsonian of country music," this campus celebrates everything country music-related. The campus includes galleries, archives, stores, the CMA and Ford Theaters, and Historic RCA Studio B. It also includes the Taylor Swift Education Center, a space for hands-on experiences, youth art installations, and activities.

Culture aficionados

For those who prefer to soak in the arts and social aspects of the area, there's something for everyone in Nashville.

- **Marathon Village**—these re-purposed historic buildings are home to retail shops, restaurants, artist studios, offices, a comedy club, and the Marathon Motor Works Museum.
- **Frist Art Museum**—the museum, the former main post office building, is on the National Register of Historic Places. Aside from art exhibits, there's Martin ArtQuest, a hands-on gallery for drawing, animation, printmaking, and painting.
- **National Museum of African American Music**—this is the only museum of its kind, dedicated to celebrating the music genres created, influenced, and inspired by African Americans. The museum opened in 2020 and houses instruments, stage costumes, sheet music, recording equipment, and photographs. Visitors can explore more than 50 music genres throughout five different galleries.

Culinary delights

Don't leave Nashville without tasting hot chicken, biscuits, and Belle Meade Bourbon. A partial list of restaurants to try:

- Prince's Hot Chicken
- Hattie B's Hot Chicken
- Arnold's Country Kitchen
- Puckett's Restaurant and Grocery
- Bartaco
- Rooftop Lounge at the Bobby Hotel
- Margot Café and Bar
- Liberty Common
- Bourbon Steak
- Von Elrod's Beer Hall and Kitchen
- The Pharmacy

There are plenty of other sites to see and things to do in Nashville; this list is just the tip of the iceberg. Enjoy Converge and have fun exploring the city! ■

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Hospitalists stretch beyond their hospitals' four walls

By Larry Beresford

Praveen K. Vemula, MD, MPH, CPE, FACP, for the past decade a hospitalist and physician leader, currently with the 11-hospital WellStar Health System based in Atlanta, brought a master's degree and a personal interest in public health to his medical-school training.

But when he started working in hospitals, he found those around him didn't seem as interested in incorporating public-health concepts into hospital medicine. "Now, hospitalists are paying more attention to public health," Dr. Vemula said. And a lot of other roles are emerging to expand the skill set and responsibilities of hospitalists beyond their work at the individual patient's bedside.

Dr. Vemula

Hospitalists have been described, since hospital medicine's origins 25 years ago, as the doctors who provide care to patients in the hospital.[1] But in recent years that definition has been stretched in any number of directions.

They now practice in post-acute settings such as inpatient rehabilitation facilities, long-term acute hospitals, and skilled nursing facilities, addressing residents' chronic, high-risk, acute medical needs. The hospital-at-home concept and other outpatient contexts, such as post-discharge clinics for patients who have left the hospital but still need medical followup, are more examples of moving beyond the hospital's four walls.

Conceptually, hospitalists are also finding opportunities to improve quality for their hospitals and health systems, taking on roles as co-managers and consultants, and bridging gaps such as those between pediatric and adult hospitals for young patients who are in the process of aging out of pediatrics. Broader roles also include standards development, patient safety, health promotion, disaster planning, palliative care, and greater involvement in addressing the social determinants of health for discharged patients by connecting them with community resources.

Applications of telemedicine are another example. "We've been talking about virtual medicine for seven to eight years, but we learned through the pandemic that we can expand hospital medicine across distances and collaborate with intensivists while promoting patient safety—especially in rural settings," Dr. Vemula said.

He has worn a variety of hats in his career, such as associate director of a hospitalist service, hospital director of medical affairs, chief medical officer, quality improvement director, and medical educator (with additional responsibilities for utilization management and physician engagement). He has additional training in epidemiology and an MBA. "As a residency-program director, I operated a special hospitalist leadership rotation."

Next steps for hospital medicine

"I'm a practical guy," Dr. Vemula said. "I want hospitalist groups to be more efficient. Balancing my public-health and physician perspectives made me a better hospitalist and a better physician leader. It broadened my view of how hospitalists can affect the overall quality of care and help their health systems become more efficient."

The logical next step is to get involved in population health—with responsibility for the health of covered populations, broadly defined, under new value-based models of organizing and covering health care. This is a direction in which many health systems are now going, with greater attention to health promotion and disease prevention. Additional education may be needed to take a seat on the system's population-health team, he said. If there isn't one, hospitalists can help form one.

"If you look at the larger problems confronting our health care system, reimbursement in the future may force changes that further expand the hospitalist's role beyond the hospital," Dr. Vemula said. The role and definition of the hospital itself will continue to evolve toward caring for proportionally fewer patients, with only the most critically ill remaining in the hospital.

Things hospitalists know

Other hospitalists are looking beyond the practice of primary medical management of hospitalized patients, said Anika Kumar, MD, FAAP, FHM, assistant professor of pediatrics, hospitalist at Cleveland Clinic Children's in Cleveland, and pediatric editor of this magazine. Staffing an acute rehab hospital is one of Dr. Kumar's new roles.

Dr. Kumar

"I provide the medical care where acute medical needs have not completely gone away after discharge from the acute hospital. I round every day for a week at a time on the patients with greatest medical needs," she said. Goals for this service include smooth transitions to post-acute care and meeting higher-complexity patients' unmet needs for post-discharge care.

Another example is the preoperative evaluation of patients who are scheduled for surgery. That is traditionally done in an outpatient clinic setting. "There are things I know as a hospitalist that are very important to surgical care, things that I need to address preoperatively, perhaps working alongside the anesthesiologist. We may be more cognizant of some of these issues than other specialists," Dr. Kumar said.

Tara N. Reddy, MD, a hospitalist with the Northwestern Medical Group in Chicago, is part of an eight-hospitalist service that has evolved to address the perioperative care of hospitalized patients. "We are the medical-consultation service when the patient comes into the hospital. We do risk stratification, we optimize the patient for surgery, we talk to the surgeons and help them understand the comorbidities," she said.

Dr. Reddy

"I think we're valued as members of the surgical team, and we allow the surgeon to focus on other things. We're being asked to do more assessments and consults than before. Knowing how the system works, hospitalists can get

things done quickly and enhance throughput. We get asked about a variety of medical issues. For example: acute kidney injury, troponin elevation—really, any patient complexity is part of our assessment."

SHM understands these evolving roles and has addressed the need for additional support among its members, Dr. Kumar said. This includes opportunities for professional development at the annual conference and in webinars. Converge, scheduled for Nashville April 7-10, includes a track, "Beyond Four Walls", that will explore less traditional, high-impact, emerging roles in which hospitalists have been identified as leaders.

"For those of us who were hospitalists and then went into these other areas—at the core, we're still hospitalists," Dr. Kumar said. "There are all these other places we can diversify outside of the hospital and within the health care system. I speak for the vast majority of my colleagues when I say our goal is still to provide high-quality care that addresses the safety and experience of our patients." The new frontiers are just an extension of that.

Transition to adulthood


Dr. Beck

With medical advances in the pediatric treatment of patients with complex illnesses, more of these patients are growing into adulthood and transitioning from children's to adult hospitals and care teams. Patients diagnosed with a chronic condition during childhood and their families often form healthy therapeutic relationships with the providers who managed their care, and as a result, transitions and transfer of care to a new team of adult-medicine providers can be difficult, said Michael J. Beck, MD, FAAP, a med/peds-trained hospitalist at Hershey's Children's Hospital and Penn State University in Hershey, Pa.

Some specialists are credentialed to provide care within certain age groups, and many sub-specialties are in short supply, Dr. Beck said. "The system is going to need adult providers for these patients." Med/peds hospitalists can help initiate transition-of-care conversations or even initiate the transfer process.

Pediatric patients are being discharged from the hospital sicker and faster, often with pending labs or studies. As pediatric care becomes increasingly regionalized, a patient's primary care provider is often two or three hours away from pediatric subspecialty expertise. Dr. Beck runs a Pediatric Hospital Discharge Clinic designed to bridge some of these gaps.

"Our clinic's mission is to restore health and return patients safely back to their communities and families. I see my role as not just promoting quicker discharges, but also safer discharges, by assuming greater responsibility to work with primary care physicians and families."

There are plenty of ways to be innovative in this area, Dr. Beck said. "As a hospitalist with 10-plus years of experience, it required challenging my mental model of what it meant to be a hospitalist, developing new competencies, and adopting new attitudes and behaviors. I had to learn how to start an outpatient clinic and justify the creation of a spanner position for a nurse case manager to work with inpatient case managers and outpatient providers," he said.

"I'm still a hospitalist. I still round on patients and understand the demands faced by hospitalists. However, since I now work in the outpatient space, I have a better appreciation for the demands faced by outpatient providers."

Nathan Stehouwer, MD, a med/peds hospitalist at University Hospitals in Cleveland also affiliated with Rainbow Babies & Children's Hospital, has tried to bridge some of these same kinds of gaps between peds and adults with a consultation service.[2] "There is a subpopulation of patients, known to hospital staff, which receives a disproportionate amount of inpatient care in pediatric hospitals," he said.


Dr. Stehouwer

A lot comes down to helping families navigate the system, Dr. Stehouwer said. How do consultations work in pediatric versus adult institutions, or inpatient versus outpatient? "Every health system handles these questions differently."

Hospital at home

The hospital at home is a growing concept, although it is still defining its interface and involvement with hospitalists. Patients who meet published criteria qualifying them for acute hospital care but whose clinicians believe they can be managed at home with the provision of hospital-level services are candidates for hospital at home. That care can include access to supplemental oxygen, laboratory services, home intravenous therapies, X-rays, and other diagnostic imagery, said Andrew Dunn, MD, MPH, SFHM, MACP, chief of the division of hospital medicine at the Mount Sinai Health System in New York.


Dr. Dunn

Qualifying patients need to receive two in-person encounters with providers each day. The patient also needs 24-hour (virtual) access to a physician and access to a home visit from a clinician in a crisis, with a higher level of care than traditional home-health care provides. Mount Sinai worked with home-health nurses in the community but has since moved toward hiring its own staff.

"We're also transitioning from mostly in-person medical visits to mostly telemedicine. That's a new challenge for the technology," Dr. Dunn said. "But since it can take 90 minutes or more just to get from Brooklyn to the Bronx, telemedicine is an essential component of our model."

The hospital at home helps free up beds in the hospital for patients who need to be there, and a growing body of research has documented decreased lengths of stay, lower readmission rates,[3,4] and higher patient satisfaction. "The potential is large, and feedback from patients is extraordinarily positive. It's a great opportunity for hospitalists to find their niche, just as some doctors love the observation unit or co-management," Dr. Dunn said.

But there's also a learning curve to develop the expertise—both clinical and logistical—for managing care at home. "In the big picture, clinical management is very similar to what we do every day as hospitalists, but the logistical expertise includes relationships to payers and coverage."

The right kinds of patients

Hospitalists want to know what kinds of patients are best for this approach, Dr. Dunn added. "Ones to avoid are those who need multiple specialty consults or multiple imaging sessions or whose course is uncertain." But those who need basic imaging and are receiving oxygen, intravenous therapy, durable medical equipment, or physical therapy are good candidates.

Financing is a challenge currently, with variable coverage from insurers, although Medicare's diagnosis-related group (DRG) payment and payment bundles (under a current pandemic-related emergency waiver) are the same whether the patient is in the hospital or hospital at home. The Acute Hospital Care at Home program was launched by the Centers for Medicare & Medicaid Services Nov. 2020 for more than 60 listed medical conditions, with a growing list of fully waivered health care organizations and a requirement to conduct screening protocols before admission.

Hospitalist Stephanie Murphy, DO, is the medical director of the hospital at home program for Atrium Health, a hospital system based in Charlotte, N.C. "I've been working beyond traditional hospitalist roles for six years," Dr. Murphy said. "A group of our hospitalists sees this as our future—asking how can we deliver our care in new and innovative ways."


Dr. Murphy

Initially, there was some anxiety among hospitalists about the hospital at home and whether it was a potential competitor to hospitals. "But as we look at our population into the future, when the hospital beds they will need won't be available, hospital at home will be essential. This can be a safe, satisfying, care-delivery model for patients," she said.

"We're staffed with three hospitalists per day who do traditional rounding virtually or act as the quarterback or air traffic controller. Most of our in-home visits are done by certified community paramedics who act as the vessel for our virtual care delivery. Honestly, they have years of experience and a broad scope of practice that doesn't require constant supervision. They're very comfortable going into the home." Every home is different, which is one of the biggest differences from acute hospital care. "When going into the home, you need to quickly analyze its character, to figure out how to facilitate care delivery," Dr. Murphy said.

"We need to make sure hospital at home connects with our acute-care facilities and the needs of those facilities. We need to target the diagnoses we can care for at home, and make sure we're meeting with health system leaders regularly so that hospital at home is part of the conversation." ■

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Larry Beresford is an Oakland, Calif.-based freelance medical journalist.

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Chapter spotlight: New Mexico

By Richard Quinn

Back in 2014, when Eileen Barrett, MD, MPH, MACP, SFHM, was the leader of the New Mexico Chapter of the American College of Physicians, she was asked to help support the launch of the state's first SHM chapter.

It was a no-brainer to say yes.

Why?

"The idea was to make a big thing feel smaller, and to help give people opportunities to feel connected to each other," said Dr. Barrett, a hospitalist in Albuquerque, N.M. "To build a sense of community, and to have an opportunity to engage with a national organization."


Dr. Barrett

And while a chapter in a state as broad as New Mexico might seem of less value than in a denser area, chapter president Sarah Burns, DO, MS, FACP, FHM, a hospitalist at the University of New Mexico, Alguquerque, said, "New Mexico is a much different state than somewhere like New York or California. We're quite rural. There is a large concentration of providers, so physicians, APPs [advanced practice practitioners], residents, and students, here in Albuquerque in the center of the state. But there is also a residency program down south in Las Cruces, and there are hospitals all over the state, some of which made the national news with the pandemic and how impacted they were by COVID."

"Our chapter is very important in being able to connect to all of these different locations. The outreach and visibility the New Mexico chapter have to this state, and our ability to make connections with other groups and to provide content with meetings and opportunities for residents, students is important."


Dr. Burns

It's working.

The chapter debuted with 77 members and ended 2021 with 199 members.

Over the past year, near-monthly virtual meetings have touched on major topics facing hospitalists and health care. In June, it was a document and discussion on "Black Men in White Coats." In August, there was a program on how to succeed after residency and land a job in New Mexico. In December, it was a session on caring for gender minorities.

"These are important topics," Dr. Burns said. "These are things that are very much at the forefront of what we do and what we are encountering. We have the ability, now, to bring this content, virtually, to our chapter members. It's fantastic ... it speaks to how much we believe in bringing such relevant content to our members and affording everyone the opportunity to learn together."

The chapter brings members together via its annual poster competition, started by Dr. Barrett in 2015, and expanded by subsequent chapter leaders.

"I know that doesn't sound like much, but it was something that provided members a chance to show their science, and a way to connect with other people," she said. "And, also, an opportunity for people to have something on their CV that highlights the good work they've done. Again, that provides for career acceleration."

After the poster competition, the chapter added awards for physician hospitalists, advanced-practice-practitioner hospitalists, and residents.

"I started our chapter awards program because I saw there were remarkable people here, and everybody deserves a thank you for doing great work," Dr. Barrett said. "Awards allow us to say with the imprimatur of the chapter, 'We recognize you. We see you. And we value the work you're doing.'"

Subsequent chapter leaders expanded the awards to include students.

Dr. Burns, who was elevated to chapter president in 2020, says that while the COVID-19 pandemic has, of course, made life more difficult for everyone, the national pivot to virtual meetings is a silver lining in a rural state where it can take five hours—one-way—to drive from Santa Fe to Las Cruces.

"Some things became a little bit easier," she said. "With virtual meetings, people can join from anywhere, from any part of the state. And we can be, well, unfortunately not together in person. But we're able to have meetings and have, hopefully, valuable experiences for our members throughout the whole state. They can access us arguably easier than it used to be pre-pandemic."

Access is the keyword.

Whether it's virtual meetings with chapter executives or national SHM voices, or guest appearances by national thought leaders and chapter heads from across the country, being part of the New Mexico chapter offers members entrée to a community of like-minded folk.

"All of us have agency and have a voice, and a small number of really committed people can do really good things," Dr. Burns said. "So, it might be the case that every hospitalist doesn't have time to do something outside of their work, outside of the family duties and obligations. And that's okay, that's understandable.

"But our chapter highlights what happens when a small number of people develop relationships and friendships and say, 'How can we do a little bit of good with each other?'" ■

Richard Quinn is a freelance writer in New Jersey.

It's time for a change

By Rick Hilger, MD, SFHM

Much has been written about the challenges frontline health care workers have faced during the COVID-19 pandemic. Long hours, excessive death, and fear for one's own safety and the welfare of family and colleagues have been a consistent theme over the past 22 months. Physicians and nurses started as heroes, but due to strained politics and social-media misuse, they're now branded by a substantial swath of society as pariahs and purveyors of a medical hoax. The timing of this pandemic could not have been worse: According to the Medscape National Physician Burnout & Suicide Report 2021, 79% of physicians stated their burnout had started before the COVID-19 pandemic.

The pandemic has placed a spotlight on a system strained by burnout and moral distress. Hospitals have always been a safety net for society's sickest and most vulnerable patients, leading to daily stressors that became accepted as part of one's job. In addition, the past decade brought with it new challenges that have led to the gradual erosion of safety, respect, and civility, both within hospitals and also for frontline staff.

At baseline, it's estimated that 75% of workplace violence happens within the health care system. This likely underestimates the actual number, as most frontline workers consider verbal and physical assaults to be part of their job. The American College of Emergency Physicians has stated that 70% of emergency department clinicians have reported acts of violence, while only 3% have pressed charges.

The opioid epidemic brought more risk to frontline staff, as physically addicted patients sought access to pain medications. These interactions often led to verbal and physical threats against both doctors and nurses. Moral and ethical distress was profound as clinicians attempted to navigate the crisis and discern objective pain from opioid-abusing behavior.

Politics began infiltrating the health care system long before the pandemic. Clinicians were accused of advocating for "death panels" by politicians opposed to the Affordable Care Act. Clinicians are now witnessing needless suffering and death due to the politicization of the COVID-19 vaccine and misinformation surrounding appropriate treatments. COVID-19 has brought a new reality: patients and families not only willingly make decisions that place themselves and others at risk of great harm, but also actively deny basic scientific facts and accuse clinicians of lying to them about their illness. Last year in Ohio, a hospital was ordered to give Ivermectin to a COVID-19 patient by a local judge (a decision that was subsequently overturned), despite no current scientific consensus that it provides any benefit. This erosion of basic respect for science, along with the loss of professional autonomy, has only worsened the sense of helplessness sustained by health care workers.

Where do health care workers go from here? What's needed to prevent a continued exodus from the frontlines and to ensure that patients will have continued access to high-quality, evidence-based care?

1. Health care systems need to eliminate all barriers to frontline workers receiving mental health treatment. One model will not work for every system, but some combination of onsite counseling and easy-to-schedule, off-campus treatment is urgently needed. Opt-out (auto-enrollment) programs have been shown to increase the use of mental health resources in resident-physician training programs. State medical boards need to either eliminate mental health questions entirely from applications or ask only about current impairment. Historically, these questions have made clinicians reluctant to seek much-needed mental health care.

2. Increased investment in making hospitals safer. This will require a combination of more security staff, zero tolerance for threatening behavior, and eliminating the culture that physical and verbal assaults are "just part of the job". In our appropriate quest for patient-centered care, we must not allow behaviors in hospitals that are not tolerated (and often prosecuted) in other sectors of society.

3. Health care systems should consider sabbaticals at the end of the pandemic for the most affected frontline workers. Short-term costs would pale in comparison to long-term expenses associated with the loss of experienced staff, and the costs of recruitment and training to replace them. The business world has recognized paid sabbaticals (usually for workers who have at least three years of tenure, with a duration of one to six months) to create more productive, focused, and innovative staff. Although this might be considered radical, it has the potential to reduce overall costs for strained hospital budgets and allow health care workers to come back to work mentally and physically healthy.

Dr. Hilger

Dr. Hilger has been a hospitalist for 20 years with HealthPartners in Minneapolis. He is the system utilization management medical director for HealthPartners, an adjunct associate professor of medicine, University of Minnesota Medical School, and the current chair of SHM's public policy committee.

These steps are just a start. Additional innovative, actionable ideas are required, which should include taking a holistic look at a system that depends on surgical procedures to keep hospitals financially viable. Rolling cancellations of non-urgent surgeries revealed just how much hospital budgets rely on procedures, not medical patients, to remain profitable (and in turn, capable of funding programs and schedules that prevent/treat burnout). Time is of the essence, as the needs of frontline workers to address PTSD, guilt, anger, depression, and anxiety will be there long after society has moved on from the pandemic. ■

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