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For patients hospitalized with COVID-19,¹

HELP REDUCE DISEASE PROGRESSION AND SHORTEN RECOVERY TIME^{1,2}



INDICATION

VEKLURY is indicated for the treatment of COVID-19 in adults and pediatric patients (≥ 28 days old and weighing ≥ 3 kg) with positive results of SARS-CoV-2 viral testing, who are:

- Hospitalized, or
- Not hospitalized, have mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death.

IMPORTANT SAFETY INFORMATION

Contraindication

- VEKLURY is contraindicated in patients with a history of clinically significant hypersensitivity reactions to VEKLURY or any of its components.

Warnings and precautions

- **Hypersensitivity, including infusion-related and anaphylactic reactions:** Hypersensitivity, including infusion-related and anaphylactic reactions, has been observed during and following administration of VEKLURY; most reactions occurred within 1 hour. Monitor patients during infusion and observe for at least 1 hour after infusion is complete for signs and symptoms of hypersensitivity as clinically appropriate. Symptoms may include hypotension, hypertension, tachycardia, bradycardia, hypoxia, fever, dyspnea, wheezing, angioedema, rash, nausea, diaphoresis, and shivering. Slower infusion rates (maximum infusion time of up to 120 minutes) can potentially prevent these reactions. If a severe infusion-related hypersensitivity reaction occurs, immediately discontinue VEKLURY and initiate appropriate treatment (see Contraindications).
- **Increased risk of transaminase elevations:** Transaminase elevations have been observed in healthy volunteers and in patients with COVID-19 who received VEKLURY; these elevations have also been reported as a clinical feature of COVID-19. Perform hepatic laboratory testing in all patients (see Dosage and administration). Consider discontinuing VEKLURY if ALT levels increase to $>10\times$ ULN. Discontinue VEKLURY if ALT elevation is accompanied by signs or symptoms of liver inflammation.
- **Risk of reduced antiviral activity when coadministered with chloroquine or hydroxychloroquine:** Coadministration of VEKLURY with chloroquine phosphate or hydroxychloroquine sulfate is not recommended based on data from cell culture experiments, demonstrating potential antagonism, which may lead to a decrease in the antiviral activity of VEKLURY.

Adverse reactions

- The most common adverse reaction ($\geq 5\%$ all grades) was nausea.
- The most common lab abnormalities ($\geq 5\%$ all grades) were increases in ALT and AST.

Drug interactions

- Drug interaction trials of VEKLURY and other concomitant medications have not been conducted in humans.

Dosage and administration

- **Dosage:**
 - For adults and pediatric patients weighing ≥ 40 kg: 200 mg on Day 1, followed by once-daily maintenance doses of 100 mg from Day 2, administered only via intravenous infusion.
 - For pediatric patients ≥ 28 days old and weighing ≥ 3 kg to <40 kg: 5 mg/kg on Day 1, followed by once-daily maintenance doses of 2.5 mg/kg from Day 2, administered only via intravenous infusion.

ECMO=extracorporeal membrane oxygenation.

In the ACTT-1 overall study population, patients experienced

5 DAYS SHORTER RECOVERY TIME WITH VEKLURY¹

Median 10 days with VEKLURY vs 15 days with placebo; recovery rate ratio: 1.29 (95% CI, 1.12 to 1.49), p<0.001^{1,2}

- Recovery was defined as patients who were no longer hospitalized or hospitalized but no longer required ongoing COVID-19 medical care

Significantly greater likelihood of improvement in clinical status, a key secondary endpoint¹

- Patients were 54% more likely to have improved clinical status on Day 15 vs placebo; odds ratio for improvement: 1.54 (95% CI, 1.25 to 1.91)

Helped reduce progression to more severe disease, an additional secondary endpoint¹⁻³

- 7% absolute reduction in incidence of new noninvasive ventilation or high-flow oxygen with VEKLURY (17%, n=307) vs placebo (24%, n=266) in patients who did not receive either at baseline (95% CI, -14 to -1)
- 10% absolute reduction in incidence of new mechanical ventilation or ECMO with VEKLURY (13%, n=402) vs placebo (23%, n=364) in patients who did not receive either at baseline (95% CI, -15 to -4)

Adverse reaction frequency was comparable between VEKLURY and placebo¹

- All adverse reactions (ARs), Grades ≥ 3 : 41 (8%) with VEKLURY vs 46 (9%) with placebo; serious ARs: 2 (0.4%)* vs 3 (0.6%); ARs leading to treatment discontinuation: 11 (2%)+ vs 15 (3%)

ACTT-1 was a randomized, double-blind, placebo-controlled, phase 3 clinical trial in hospitalized patients with confirmed SARS-CoV-2 infection and mild, moderate, or severe COVID-19. Patients received VEKLURY (n=541) or placebo (n=521) for up to 10 days. The primary endpoint was time to recovery within 29 days after randomization. Secondary endpoints included clinical status of patients on Day 15 as assessed on an 8-point ordinal scale and incidence of new high-flow oxygen requirement or new mechanical ventilation or ECMO.¹

*Seizure (n=1), infusion-related reaction (n=1).

+Seizure (n=1), infusion-related reaction (n=1), transaminases increased (n=3), ALT increased and AST increased (n=1), GFR decreased (n=2), acute kidney injury (n=3).

IMPORTANT SAFETY INFORMATION (cont'd)

Dosage and administration (cont'd)

• Treatment duration:

- For patients who are hospitalized and require invasive mechanical ventilation and/or ECMO, the recommended total treatment duration is 10 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19.
- For patients who are hospitalized and do not require invasive mechanical ventilation and/or ECMO, the recommended treatment duration is 5 days. If a patient does not demonstrate clinical improvement, treatment may be extended up to 5 additional days, for a total treatment duration of up to 10 days.
- For patients who are not hospitalized, diagnosed with mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death, the recommended total treatment duration is 3 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19 and within 7 days of symptom onset.

- **Testing prior to and during treatment:** Perform eGFR, hepatic laboratory, and prothrombin time testing prior to initiating VEKLURY and during use as clinically appropriate.

- **Renal impairment:** VEKLURY is not recommended in individuals with eGFR <30 mL/min.

• Dose preparation and administration:

- There are two different formulations of VEKLURY: VEKLURY for injection (supplied as 100 mg lyophilized powder in vial), the only approved dosage form of VEKLURY for pediatric patients weighing 3 kg to <40 kg; and VEKLURY injection (supplied as 100 mg/20 mL [5 mg/mL] solution in vial). See full Prescribing Information.
- Administration should take place under conditions where management of severe hypersensitivity reactions, such as anaphylaxis, is possible.

Pregnancy and lactation

- **Pregnancy:** A pregnancy registry has been established. There are insufficient human data on the use of VEKLURY during pregnancy. COVID-19 is associated with adverse maternal and fetal outcomes, including preeclampsia, eclampsia, preterm birth, premature rupture of membranes, venous thromboembolic disease, and fetal death.
- **Lactation:** It is not known whether VEKLURY can pass into breast milk. Breastfeeding individuals with COVID-19 should follow practices according to clinical guidelines to avoid exposing the infant to COVID-19.

Please see Brief Summary of full Prescribing Information on the following page.

References: 1. Veklury. Prescribing Information. Gilead Sciences, Inc.; 2022. 2. Beigel JH, Tomashek KM, Dodd LE, et al; ACTT-1 Study Group. Remdesivir for the treatment of COVID-19—final report. *N Engl J Med.* 2020;383(19):1813-1826. doi:10.1056/NEJMoa2007764 3. Beigel JH, Tomashek KM, Dodd LE, et al; ACTT-1 Study Group. Remdesivir for the treatment of COVID-19—final report. Supplementary appendix. *N Engl J Med.* 2020;383(19):1813-1826. Accessed May 24, 2022. https://www.nejm.org/doi/suppl/10.1056/NEJMoa2007764/suppl_file/nejmoa2007764_appendix.pdf



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VEKLURY® (remdesivir)

Brief summary of full Prescribing Information. Please see full Prescribing Information. Rx Only.

INDICATIONS AND USAGE

VEKLURY is indicated for the treatment of COVID-19 in adults and pediatric patients (≥28 days old and weighing ≥3 kg), with positive results of SARS-CoV-2 viral testing, who are:

- Hospitalized, or
- Not hospitalized, with mild-to-moderate COVID-19, and at high risk for progression to severe COVID-19, including hospitalization or death.

DOSAGE AND ADMINISTRATION *[Also see **Warnings and Precautions, Adverse Reactions, and Use in Specific Populations**]:*

Testing Before Initiation and During Treatment: Perform eGFR, hepatic laboratory, and prothrombin time testing prior to initiating VEKLURY and during use as clinically appropriate.

Recommended Dosage in Adults and Pediatric Patients ≥28 Days Old and Weighing ≥3 kg:

- For adults and pediatric patients weighing ≥40 kg: 200 mg on Day 1, followed by once-daily maintenance doses of 100 mg from Day 2, administered only via intravenous infusion.
- For pediatric patients ≥28 days old and weighing ≥3 kg: 5 mg/kg on Day 1, followed by once-daily maintenance doses of 2.5 mg/kg from Day 2, administered only via intravenous infusion.

Treatment Duration:

- For patients who are hospitalized and require invasive mechanical ventilation and/or ECMO, the recommended total treatment duration is 10 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19.
- For patients who are hospitalized and do not require invasive mechanical ventilation and/or ECMO, the recommended treatment duration is 5 days. If a patient does not demonstrate clinical improvement, treatment may be extended up to 5 additional days, for a total treatment duration of up to 10 days.
- For patients who are not hospitalized, diagnosed with mild-to-moderate COVID-19, and at high risk for progression to severe COVID-19, including hospitalization or death, the recommended total treatment duration is 3 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19 and within 7 days of symptom onset.

Renal Impairment: VEKLURY is not recommended in individuals with eGFR <30 mL/min.

Dose Preparation and Administration *[See full **Prescribing Information** for complete instructions on dose preparation, administration, and storage]:*

VEKLURY must be prepared and administered under supervision of a healthcare provider and must be administered via intravenous infusion only, over 30 to 120 minutes. Do not administer the prepared diluted solution simultaneously with any other medication.

- VEKLURY for injection (supplied as 100 mg lyophilized powder in vial) must be reconstituted with Sterile Water for Injection prior to diluting in a 100 mL or 250 mL 0.9% sodium chloride infusion bag.
- Care should be taken during admixture to prevent inadvertent microbial contamination; there is no preservative or bacteriostatic agent present in these products.

Dosage Preparation and Administration in Pediatric Patients ≥28 Days of Age and Weighing 3 kg to <40 kg:

The only approved dosage form of VEKLURY for pediatric patients ≥28 days of age and weighing 3 kg to <40 kg is VEKLURY for injection (supplied as 100 mg lyophilized powder in vial). Carefully follow the product-specific preparation instructions.

CONTRAINDICATIONS *[Also see **Warnings and Precautions**]:*

VEKLURY is contraindicated in patients with a history of clinically significant hypersensitivity reactions to VEKLURY or any of its components.

WARNINGS AND PRECAUTIONS *[Also see **Contraindications, Dosage and Administration, Adverse Reactions, and Drug Interactions**]:*

Hypersensitivity, Including Infusion-related and Anaphylactic Reactions: Hypersensitivity, including infusion-related and anaphylactic reactions, has been observed during and following administration of VEKLURY; most reactions occurred within 1 hour. Monitor patients during infusion and observe for at least 1 hour after infusion is complete for signs and symptoms of hypersensitivity as clinically appropriate. Symptoms may include hypotension, hypertension, tachycardia, bradycardia, hypoxia, fever, dyspnea, wheezing, angioedema, rash, nausea, diaphoresis, and shivering. Slower infusion rates (maximum infusion time ≤120 minutes) can potentially prevent these signs and symptoms. If a severe infusion-related hypersensitivity reaction occurs, immediately discontinue VEKLURY and initiate appropriate treatment.

Increased Risk of Transaminase Elevations: Transaminase elevations have been observed in healthy volunteers and in patients with COVID-19 who received VEKLURY; the transaminase elevations were mild to moderate (Grades 1-2) in severity and resolved upon discontinuation. Because transaminase elevations have been reported as a clinical feature of COVID-19, and the incidence was similar in patients receiving placebo versus VEKLURY in clinical trials, discerning the contribution of VEKLURY to transaminase elevations in patients with COVID-19 can be challenging. Perform hepatic laboratory testing in all patients.

- Consider discontinuing VEKLURY if ALT levels increase to >10x ULN.
- Discontinue VEKLURY if ALT elevation is accompanied by signs or symptoms of liver inflammation.

Risk of Reduced Antiviral Activity When Coadministered With Chloroquine or Hydroxychloroquine: Coadministration of VEKLURY with chloroquine phosphate or hydroxychloroquine sulfate is not recommended based on data from cell culture experiments, demonstrating potential antagonism which may lead to a decrease in the antiviral activity of VEKLURY.

ADVERSE REACTIONS *[Also see **Warnings and Precautions**]:*

Clinical Trials Experience: The safety of VEKLURY is based on data from three Phase 3

studies in 1,313 hospitalized adult subjects with COVID-19, four Phase 1 studies in 131 healthy adults, and from patients with COVID-19 who received VEKLURY under the Emergency Use Authorization or in a compassionate use program. The NIAID ACTT-1 study was conducted in hospitalized subjects with mild, moderate, and severe COVID-19 treated with VEKLURY (n=532) for up to 10 days. Study GS-US-540-5773 (Study 5773) included subjects hospitalized with severe COVID-19 and treated with VEKLURY for 5 (n=200) or 10 days (n=197). Study GS-US-540-5774 (Study 5774) was conducted in hospitalized subjects with moderate COVID-19 and treated with VEKLURY for 5 (n=191) or 10 days (n=193).

Adverse Reactions: The most common adverse reaction (≥5% all grades) was nausea.

Less Common Adverse Reactions: Clinically significant adverse reactions reported in <2% of subjects exposed to VEKLURY in clinical trials include hypersensitivity reactions, generalized seizures, and rash.

Laboratory Abnormalities: In a Phase 1 study in healthy adults, elevations in ALT were observed in 9 of 20 subjects receiving 10 days of VEKLURY (Grade 1, n=8; Grade 2, n=1); the elevations in ALT resolved upon discontinuation. No subjects (0 of 9) who received 5 days of VEKLURY had graded increases in ALT.

Laboratory abnormalities (Grades 3 or 4) occurring in ≥3% of subjects receiving VEKLURY in Trials NIAID ACTT-1, Study 5773, and/or Study 5774, respectively, were ALT increased (3%, ≤8%, ≤3%), AST increased (6%, ≤7%, n/a), creatinine clearance decreased, Cockcroft-Gault formula (18%, ≤19%, ≤5%), creatinine increased (15%, ≤15%, n/a), eGFR decreased (18%, n/a, n/a), glucose increased (12%, ≤11%, ≤4%), hemoglobin decreased (15%, ≤8%, ≤3%), lymphocytes decreased (11%, n/a, n/a), and prothrombin time increased (9%, n/a, n/a).

DRUG INTERACTIONS *[Also see **Warnings and Precautions**]:*

Due to potential antagonism based on data from cell culture experiments, concomitant use of VEKLURY with chloroquine phosphate or hydroxychloroquine sulfate is not recommended.

Drug-drug interaction trials of VEKLURY and other concomitant medications have not been conducted in humans. Remdesivir and its metabolites are in vitro substrates and/or inhibitors of certain drug metabolizing enzymes and transporters. The clinical relevance of these in vitro assessments has not been established.

USE IN SPECIFIC POPULATIONS *[Also see **Dosage and Administration and Warnings and Precautions**]:*

Pregnancy

Risk Summary: There are insufficient human data on the use of VEKLURY during pregnancy to inform a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. COVID-19 is associated with adverse maternal and fetal outcomes, including preeclampsia, eclampsia, preterm birth, premature rupture of membranes, venous thromboembolic disease, and fetal death.

Lactation

Risk Summary: There are no available data on the presence of remdesivir in human milk, the effects on the breastfed infant, or the effects on milk production. In animal studies, remdesivir and metabolites have been detected in the nursing pups of mothers given remdesivir, likely due to the presence of remdesivir in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for VEKLURY and any potential adverse effects on the breastfed child from VEKLURY or from the underlying maternal condition. Breastfeeding individuals with COVID-19 should follow practices according to clinical guidelines to avoid exposing the infant to COVID-19.

Pediatric Use

The safety and effectiveness of VEKLURY for the treatment of COVID-19 have been established in pediatric patients ≥28 days old and weighing ≥3 kg. Use in this age group is supported by the following:

- Trials in adults
- An open-label trial (Study GS-US-540-5823) in 53 hospitalized pediatric subjects

Geriatric Use

Dosage adjustment is not required in patients over the age of 65 years. Appropriate caution should be exercised in the administration of VEKLURY and monitoring of elderly patients, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of potential concomitant disease or other drug therapy.

Renal Impairment

All patients must have an eGFR determined before starting VEKLURY and while receiving VEKLURY as clinically appropriate. VEKLURY is not recommended in patients with eGFR less than 30 mL/min.

Hepatic Impairment

Perform hepatic laboratory testing in all patients before starting VEKLURY and while receiving VEKLURY as clinically appropriate.

OVERDOSAGE

There is no human experience of acute overdosage with VEKLURY. Treatment of overdose with VEKLURY should consist of general supportive measures including monitoring of vital signs and observation of the clinical status of the patient. There is no specific antidote for overdose with VEKLURY.

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SHM'S DIVERSITY AND INCLUSION STATEMENT

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

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Everyone Deserves to Belong

By Daniel Cabrera, MD, MPH, FACP, FHM, Anthony Dao, MD, and Dahlia Rizk, DO, MPH, FHM



Dr. Cabrera



Dr. Dao



Dr. Rizk

This month's magazine focuses on the challenges faced by our colleagues and patients from the lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more (LGBTQIA+) communities and how we can support them as allies in health care.

As health care professionals, we face challenges in how we deliver care to our patients. We recognize that when you can bring your true, authentic self to work, and when your co-workers acknowledge and honor who you are, you are truly supported and successful. Those in the LGBTQIA+ community have been caught in a culture war between morals and righteousness, and it has left many wondering how they might advocate or support those affected by the changes. SHM strives to create a voice for those who feel oppressed or marginalized by creating action steps to build a more equitable and inclusive culture at SHM and in our society. We hope to do so in two ways.

The first aim is to make SHM an organization that creates a sense of belonging for hospital medicine professionals identifying within the LGTBQIA+ community. The second is to provide resources to help SHM members create inclusive and affirming clinical environments for LGBTQIA+ patients.

Research shows that LGBTQIA+ health care workers face similar barriers to other minoritized groups, such as low visibility, discrimination in the workplace, and feelings of isolation. However, sexual orientation and gender identity (SOGI) data are not routinely collected throughout health care institutions for either data tracking or attitudes assessments. Therefore, you may have noticed that SHM member demographic questions now allow for optional self-identification of SOGI data. This data is critical in defining our baseline so we may determine future goals, programmatic innovations, recommendations, and the attitudes of LGBTQIA+ members. We hope to use this information to ensure LGBTQIA+ diversity in our committees, leadership, and educational materials.

LGBTQIA+ patients also encounter obstacles in the pursuit of equitable care. They can have trouble with basic access to health care services along with limited insurance coverage. LGBTQIA+ individuals may face bias and

Dr. Cabrera is a hospitalist at Harborview Medical Center and the University of Washington Medical Center—Montlake, clinical assistant professor, division of general internal medicine at UW School of Medicine, and the assistant program director for diversity and inclusion. Dr. Dao is a hospitalist at Barnes-Jewish Hospital, St. Louis, Mo., and assistant professor of internal medicine at Washington University School of Medicine, St. Louis. Dr. Rizk is the founder and chief of the division of hospital medicine at Mount Sinai Beth Israel Medical Center in New York and a professor at Mount Sinai Icahn School of Medicine. They're members of SHM's Diversity, Equity, and Inclusion Committee.

discrimination from health care professionals resulting in distrust. Finally, LGBTQIA+ patients sometimes find their clinicians are friendly and accepting but do not have the clinical experience or cultural humility to care for them. As part of SHM's ongoing commitment to patient care and building on the work started by the SHM DEI task force, SHM will continue to seek topics centered on LGBTQIA+ health for future conferences, meetings, and CME activities. SHM members are encouraged to participate in the LGBTQ+ Health Series created by the task force in 2021. The course is free to SHM members and contains several timely content areas, which include CME credit.

Increasing diversity leads to increased workplace productivity and innovation as it includes more diverse perspectives from lived experiences improving how workers solve problems. SHM has created a strong framework through its DEI Committee and SIG to ensure there is an ongoing effort to highlight continuous opportunities for the Society to remain focused on LGBTQIA+ inclusion and health. SHM's goal is for local and regional hospitalist groups and their respective organizations to accelerate the progress for DEI work, disrupt biased infrastructures that impede progress, and foster belonging. Now, more than ever, true allyship and effective sponsorship are needed throughout the leadership spectrum to support the LGBTQIA+ community. ■

Richmond Veterans Affairs Medical Center, Medical Research Reviews

By Patrick Fadden, MD, Samuel Sullivan, MD, Kieu Hoang, MD, Kevin Houston, MD, Hanh Le, MD, Derek Leiner, MD, Christopher Achilli, MD, and Bahnsen Miller, MD

Richmond Veterans Affairs Medical Center, Virginia

IN THIS ISSUE

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By Patrick Fadden, MD

1 For some patients with CLTI, surgery may be better than endovascular intervention

CLINICAL QUESTION: Which is a better approach for patients with chronic limb-threatening ischemia (CLTI): surgery or endovascular therapy?

BACKGROUND: CLTI is a complication of advanced peripheral vascular disease (PVD). CLTI occurs in patients with PVD who have ischemic foot pain at rest, ischemic ulcerations, or gangrene. In addition to guideline-directed medical therapy, revascularization practices utilizing vascular surgery and endovascular therapy have both been practiced. This trial compared the clinical outcomes of these interventions.

STUDY DESIGN: Superiority trial that used two parallel cohort trials: Cohort 1 included patients with the ability to use a single autogenous conduit graft (using the greater saphenous vein), and Cohort 2, patients who needed an alternative bypass graft. Both cohorts were randomized into receiving surgical bypass or endovascular intervention in a 1:1 ratio.

SETTING: 150 sites in five different countries. Enrollment occurred from August 2014 through October 2019 with follow-up through October 2021 (Cohort 1) and December 2019 (Cohort 2).

SYNOPSIS: For Cohort 1, the primary composite outcome of major adverse limb event and/or death from any cause was 42.6% with surgery and 57.4% with endovascular treatment ($P < 0.001$), with 32% reduction in major medical events related to CLTI with surgery, a 65% reduction in re-interventions and a 27% reduction in amputations. No difference was found between the two groups in death rates alone.



Dr. Fadden

For Cohort 2, the primary composite outcome was 42.8% in the surgical group and 47.7% in the endovascular group ($P = 0.12$). There was no difference in the incidence of new or recurrent CLTI events or time until amputation or death from any cause.

BOTTOM LINE: Patients who could and did have saphenous vein grafting did better than those that received only endovascular intervention. But in patients without a saphenous vein graft option, both surgery and endovascular treatment had similar outcomes and efficacy. The major limitation is the exclusion of patients too high-risk for open vascular surgery.

CITATION: Farber A, et al. Surgery or endovascular therapy for chronic limb-threatening ischemia. *N Engl J Med*. 2022;387(25):2305-16.

Dr. Fadden is an academic hospitalist at Richmond Veterans Affairs Medical Center and an assistant professor of medicine at Virginia Commonwealth University in Richmond, Va.

By Samuel Sullivan, MD

2 Recurrence of VTE associated with COVID-19 is unlikely after stopping anticoagulation

CLINICAL QUESTION: How long should anticoagulation be continued after COVID-19-associated venous thromboembolism (VTE)?

BACKGROUND: COVID-19 infection is associated with an increased risk of VTE; however, it is unclear if the risk is transient or ongoing. Understanding the risk of recurrence would help guide decisions on the duration of anticoagulation.

STUDY DESIGN: Prospective cohort study

SETTING: Data from the Registro Informatizado de la Enfermedad, a multinational database reg-



Dr. Sullivan

istry of patients with VTE and other thrombotic conditions

SYNOPSIS: 431 patients in the registry with COVID-19-associated VTE who had undergone at least 3 months of anticoagulation therapy were followed up at a median of 5.8 months for symptomatic recurrent VTE after discontinuing anticoagulation. There was a 4.8 per 100 patient-years rate of recurrent VTE in these patients, which is similar to previously reported rates of recurrent VTE following the discontinuation of anticoagulation after a single, non-surgical, provoked VTE.

This suggests that the hypercoagulable state associated with COVID-19 is limited and providing a short course of anticoagulation to patients with COVID-19-associated VTE as opposed to an extended course is optimal.

BOTTOM LINE: Patients with a single COVID-19-associated VTE are at low risk for recurrence following a short course of anticoagulation.

CITATION: Jara-Palomares L, et al. Rate of recurrence after discontinuing anticoagulation therapy in patients with COVID-19-associated venous thromboembolism. *JAMA Intern Med*. 2022;182(12):1326-28.

Dr. Sullivan is an academic hospitalist at Richmond Veterans Affairs Medical Center and an assistant professor of medicine at Virginia Commonwealth University in Richmond, Va.

By Kieu Hoang, MD

3 Naltrexone for AUD is safe to use in patients with and without liver disease

CLINICAL QUESTION: Is naltrexone hepatically safe for the treatment of alcohol use disorder (AUD) in patients with and without liver disease?

BACKGROUND: Treatment of underlying AUD can prevent and potentially reverse alcohol-associated liver disease. Given naltrexone's warning of hepatotoxicity, there is an ongoing underutilization of pharmacologic treatments for AUD. Despite small previous studies showing no rise of transaminases with naltrexone use, the data is limited, especially for patients with underlying liver disease.

STUDY DESIGN: Retrospective cohort study

SETTING: Large safety-net hospital, May 2015 to November 2019

SYNOPSIS: The study followed 160 patients who were prescribed naltrexone for AUD. They were



Dr. Hoang

separated into two primary groups, those with liver disease (n=100) and those without (n=60). For those with liver disease, almost half had evidence of cirrhosis (n=47) (defined by ICD-10 code or by a composite of fibrosis score, imaging, portal hypertension, international normalized ratio, and thrombocytopenia). Of those 47 patients with cirrhosis, 22 were considered decompensated. Differences in aspartate transaminase (AST), alanine aminotransaminase (ALT), alkaline phosphatase, and total bilirubin were measured before, during, and after naltrexone treatment.

Among patients with liver disease, AST, ALT, and total bilirubin improved while on naltrexone. For patients without liver disease, no significant differences in mean ALT or AST were observed. Of 160 treated patients, three cases of liver enzyme elevations occurred (1.2 events [95% CI] per 1,000 persons per year).

Limitations to this include the timing of lab draws. Only patients with labs obtained during the three interval assessments were included. In addition, patients with liver disease not on naltrexone were not included for comparison. Generalizability is limited as this study's cohort was composed mostly of Hispanic men living in an underserved area.

BOTTOM LINE: Naltrexone for AUD is safe to use in patients with and without liver disease as demonstrated by an overall reduction in liver enzymes.

REFERENCE: Ayyala, D, et al. Naltrexone for alcohol use disorder: hepatic safety in patients with and without liver disease. *Hepatol Commun.* 2022;6(12):3433-42.

Dr. Hoang is an academic hospitalist at Richmond Veterans Affairs Medical Center, and an assistant professor of medicine at Virginia Commonwealth University in Richmond, Va.

By Kevin Houston, MD

4 Moderate fluid resuscitation preferred over aggressive resuscitation in acute pancreatitis

CLINICAL QUESTION: Does early, aggressive, fluid resuscitation improve clinical outcomes in acute pancreatitis when compared to moderate fluid resuscitation?

BACKGROUND: Studies comparing different volumes of intravenous fluid resuscitation in acute pancreatitis have provided conflicting results.



Dr. Houston

STUDY DESIGN: Multicenter, open-label, randomized, controlled trial, including patients with mild-moderate acute pancreatitis based on the Revised Atlanta Classification

SETTING: 18 centers across four countries (India, Italy, Mexico, and Spain)

SYNOPSIS: Of 249 total patients with mild to moderate acute pancreatitis, 122 received aggressive resuscitation (20 mL/kg bolus of lactated Ringer's over two hours followed by 3mL/kg/hr) while 127 received moderate resuscitation (1.5 mL/kg/hr lactated Ringer's, with 10 mL/kg bolus over first two hours if hypovolemic).

No significant difference in the development of moderately severe or severe acute pancreatitis during hospitalization (22.1% in the aggressive group versus 17.3% in the moderate group, adjusted relative risk, 1.30; 95% CI, 0.78 to 2.18;

$P=0.32$). Fluid overload occurred more often with aggressive resuscitation (20.5% versus 6.3%, adjusted relative risk, 2.85; 95% CI, 1.36 to 5.94; $P=0.004$). The aggressive-resuscitation group received a median of 7.98 L during the first 48 hours, compared to 5.5 L.

Of note, the majority of the patients were diagnosed with biliary pancreatitis and had less than two of four SIRS criteria. Patients were also re-evaluated at 12, 24, 48, and 72 hours and fluids were adjusted as needed. Some of the many exclusion criteria included hyponatremia, hypercalcemia, chronic renal failure, decompensated cirrhosis, and heart failure (NYHA class II or greater).

BOTTOM LINE: Early aggressive fluid resuscitation in mild-moderate acute pancreatitis resulted in a higher incidence of fluid overload without improvement in clinical outcomes when compared to moderate resuscitation.

CITATION: de-Madaria E, et al. Aggressive or moderate fluid resuscitation in acute pancreatitis. *N Engl J Med.* 2022;387(11):989-1000.

Dr. Houston is an internal medicine resident at Virginia Commonwealth University in Richmond, Va.

By Hanh Le, MD

5 Daily low-dose aspirin is associated with increased serious fall risk in healthy older adults

CLINICAL QUESTION: Does daily low-dose aspirin for primary prevention decrease fractures and fall-related hospital presentations in healthy older adults?

BACKGROUND: Falls and resulting fractures contribute significantly to the burden of disease in the elderly. Aspirin may reduce bone fragility and falls by delaying bone loss, but no randomized controlled trials have previously investigated this.

STUDY DESIGN: Double-blind, randomized, placebo-controlled, primary-prevention trial; outcome analyses on an intention-to-treat basis.

SETTING: Elderly adults living in the community recruited by general practice clinics in Australia as part of the Aspirin in Reducing Events in the Elderly (ASPREE) clinical trial.

SYNOPSIS: The ASPREE-FRACTURE sub-study included 16,703 healthy, community-dwelling adults older than 69 years without significant cognitive impairment, who were randomized 1:1 to receive 100 mg enteric-coated aspirin or placebo daily, seen in person annually, and followed by telephone every 3 to 6 months for a median of 4.6 years. No difference was seen in first (HR, 0.97; 95% CI, 0.87-1.06; $P=0.50$) or recurrent (HR, 0.96; 95% CI, 0.87-1.06; $P=0.40$) fracture events. However, aspirin was associated with a higher risk of serious falls (884 versus 804, incidence rate ratio 1.17; 95% CI, 1.03-1.33; $P=0.01$). Results were unchanged when adjusted for covariates that influence fracture and fall risk.

Limitations include a lack of generalizability with an older, relatively healthy cohort. The intervention duration and aspirin dose may not be enough to allow for changes that affect fracture risk. Bone quality markers and comorbidities, like inflammatory arthritis and osteoporosis, that affect study risks were not measured.

This sub-study supports the findings of the



Dr. Le

ASPREE principal trial that the use of low-dose aspirin did not prolong disability-free survival.

BOTTOM LINE: Daily low-dose aspirin use in healthy older adults increases serious fall risk but does not affect fracture risk.

CITATION: Barker AL, et al. Daily low-dose aspirin and risk of serious falls and fractures in healthy older people. A substudy of the ASPREE randomized clinical trial. *JAMA Intern Med.* 2022;182(12):1289-97.

Dr. Le is an academic hospitalist at Richmond Veterans Affairs Medical Center, and an assistant professor of medicine at Virginia Commonwealth University in Richmond, Va.

By Derek Leiner, MD

6 Apixaban has a lower risk of bleeding than warfarin in ESKD

CLINICAL QUESTION: In patients with end-stage kidney disease (ESKD) and venous thromboembolism (VTE), does apixaban have a lower bleeding risk and VTE recurrence than warfarin?



Dr. Leiner

BACKGROUND: A safe and effective therapy for VTE is needed for patients with ESKD due to their increased risk of both thrombosis and bleeding. High-quality data evaluating direct oral anticoagulants in ESKD is limited, especially in VTE. The authors sought to evaluate the safety and effectiveness of apixaban compared to warfarin in treating VTE in ESKD.

STUDY DESIGN: Retrospective cohort study

SETTING: The United States Renal Data System (USRDS) includes all available Medicare Parts A, B, and D claims data for patients with chronic kidney disease and ESKD in the U.S.

SYNOPSIS: Using the USRDS, authors identified 11,565 patients aged 18 and older who were newly initiated on either apixaban or warfarin between January 2014 and June 2018. Apixaban was associated with lower total major bleeding (HR, 0.81; CI, 0.7-0.94) and total clinically-relevant nonmajor bleeding (HR, 0.84; CI, 0.74-0.94) compared to warfarin. Recurrent VTE was not significantly different between the medications but trended toward lower rates in the apixaban group (HR, 0.83; CI, 0.69-1.002). Apixaban also has previously established benefits of no required bridging therapy and no need for therapeutic monitoring. These findings suggest apixaban offers several advantages in treating VTE in ESKD.

Limitations included the inability to control for initial anticoagulation during the index hospitalization, uncertainty whether patients received a full apixaban loading dose, and inability to capture recurrent VTE in a prolonged hospitalization using Medicare claims data.

BOTTOM LINE: In ESKD, apixaban has a lower bleeding risk than warfarin with similar VTE recurrence.

CITATION: Ellenbogen MI, et al. Safety and effectiveness of apixaban versus warfarin for acute venous thromboembolism in patients with end-stage kidney disease: a national cohort study. *J Hosp Med.* 2022;17(10):809-18.

Dr. Leiner is an academic hospitalist at Richmond Veterans Affairs Medical Center and an assistant professor of medicine at Virginia Commonwealth University in Richmond, Va.

By Christopher Achilli, MD

7 Lidocaine may be more beneficial than amiodarone for the management of in-hospital cardiac arrest

CLINICAL QUESTION: Are amiodarone and lidocaine associated with different outcomes for the treatment of in-hospital cardiac arrests?

BACKGROUND: Both amiodarone and lidocaine are recommended in the American Heart Association's advanced cardiac life support guidelines for the management of ventricular tachycardia/ventricular fibrillation (VT/VF) resulting in cardiac arrest, based on studies looking at out-of-hospital cardiac arrests. However, there have been no studies looking at their use in in-hospital cardiac arrests.

STUDY DESIGN: Retrospective cohort study

SETTING: Hospitals participating in American Heart Association Get With the Guidelines-Resuscitation

SYNOPSIS: The retrospective cohort study looked at 14,630 adult patients who experienced CPR and defibrillation refractory cardiac arrest due to VT/VF from January 1, 2000 to December 31, 2014, and received lidocaine or amiodarone. 68.7% were treated with amiodarone and 31.3% were treated with lidocaine. In each of the four primary outcomes following extensive risk adjustment for potential confounders, lidocaine showed a significant benefit over amiodarone. The primary outcomes, with associated adjusted odds ratio (aOR) and confidence interval (CI), were: return of spontaneous circulation (aOR,

By Bahnsen Miller, MD

Iron sucrose has a lower rate of anaphylaxis compared to iron dextran and ferumoxytol

Retrospective cohort study; 167,925 Medicare patients. Adjusted incidence rates for anaphylaxis per 10,000 first administrations: iron dextran (9.8), ferumoxytol (4.0), ferric gluconate (1.5), iron sucrose (1.2), ferric carboxymaltose (0.8).



Dr. Miller

CITATION: Dave CV, et al. Risks for anaphylaxis with intravenous iron formulations: a retrospective cohort study. *Ann Intern Med.* 2022;175(5):656-664.

Administration of a beta-lactam prior to vancomycin as the first dose of empiric

1.15; CI, .5-4.2), 24-hour survival (aOR, 1.16; CI, 0.9-5.1), survival to discharge (aOR, 1.19; CI, 1.5-5.2), and favorable neurologic outcome at hospital discharge (aOR, 1.18; CI, 1.3-4.9). Limitations of the study include it being an observational study as well as including a small selection of hospitals that may not be generalizable.

BOTTOM LINE: Patients who experience in-hospital cardiac arrest due to VT/VF that is refractory to defibrillation and CPR may benefit from

SHORT TAKES

antibiotic therapy may improve survival in patients with bloodstream infection

Multicenter, retrospective observational study. The mortality within seven days was 6.9% in the beta-lactam group, and 10.7% in the vancomycin group ($P=.001$). Similar results were observed with 48-hour mortality. Administration of vancomycin prior to a beta-lactam was not associated with improved survival in the subgroup with methicillin-resistant *Staphylococcus aureus* bloodstream infection. Fluid management and source control are potential confounders.

CITATION: Amoah J, et al. Administration of a beta-lactam prior to vancomycin as the first dose of antibiotic therapy improves survival in patients with bloodstream infections. *Clin Infect Dis.* 2022;75(1):98-104.

Dr. Miller is an academic hospitalist at Richmond Veterans Affairs Medical Center and an assistant professor of medicine at Virginia Commonwealth University in Richmond, Va.

the use of lidocaine versus amiodarone.

CITATION: Wagner D, et al. Comparative effectiveness of amiodarone and lidocaine for the treatment of: in-hospital cardiac arrest. *CHEST.* 2022;S0012-3692(22)-4-39-9. doi:10.1016/j.chest.2022.10.024

Dr. Achilli is an academic hospitalist at Richmond Veterans Affairs Medical Center and an assistant professor of medicine at Virginia Commonwealth University in Richmond, Va. ■





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Society of Hospital Medicine

2023 Masters in Hospital Medicine

SHM's outgoing president Rachel Thompson, MD, MPH, SFHM, kicked off SHM Converge 2023 in Austin, Texas in March by honoring the newest members to become Masters in Hospital Medicine. "They join 39 other Masters in Hospital Medicine," Dr. Thompson said. "For a total of 43 from a universe of tens of thousands worldwide."

Pictured at right SHM CEO, Dr. Eric Howell with the new MHM members Danielle B. Scheurer, MD, MSCR, MHM, Daniel Payson Hunt, MD, MHM, Margaret C. Fang, MD, MPH, MHM, Alpesh N. Amin, MD, MBA, MACP, MHM, and Dr. Thompson.

Alpesh N. Amin, MD, MBA, MACP, MHM,

was elected to the program in honor of his dedication to the specialty and SHM, along with his research and transformative models of care that have helped advance the field.



Dr. Amin

"Dr. Amin has been a champion for hospital research in many high-impact publications," Dr. Thompson said. "He has more than 280 peer-reviewed publications and numerous books relevant to the hospitalist practice."

Dr. Amin served on the SHM Board of Directors from 2005 to 2009 and helped create and co-author the core competencies curriculum that has defined the skillset for hospitalists. He was also an inaugural member of the National Association of Inpatient Physicians, which is known today as SHM.

Dr. Amin has played an important role in multiple SHM committees and served as the annual conference course director in 2006. He was a key contributor to numerous quality improvement tools generated by SHM, including glycemic control and venous thromboembolism prevention.

"His leadership has benefited SHM, our profession, and our patients' care," Dr. Thompson said. "The innovations he has created and partnered with others to develop will have lasting impacts for years to come."

Dr. Amin completed his internal medicine residency at the University of California, Irvine, where he also served as chief resident in internal medicine. Following residency, he earned his Healthcare MBA from UC Irvine.

He then joined the faculty at UC Irvine and rose through the ranks quickly. He is currently a professor of medicine at the UC Irvine



School of Medicine and founder and executive director of its hospital medicine program. Dr. Amin was the first hospitalist to be chair of medicine.

Margaret C. Fang, MD, MPH, MHM,

completed her internal medicine training at Beth Israel Deaconess Medical Center and Massachusetts General Hospital in Boston. She obtained her Master's in Public Health from Harvard and began her career at the University of California, San Francisco, where she remains today as a professor of medicine and division chief of hospital medicine. Dr. Fang was elected to the program in recognition of her leadership, service, and innovations to advance the field of hospital medicine.



Dr. Fang

"Dr. Fang is among hospital medicine's most impactful hospitalist researchers," Dr. Thompson said. "She has published more than 140 peer-reviewed papers and leads an independent research program that has been continuously funded for the past 15 years."

Dr. Thompson singled out Dr. Fang's work in mentoring others in her profession.

"Dr. Fang also has an extraordinary track record of mentorship and has directly mentored more than 60 people through her work as a research mentor and director of the USCF Academic Hospital Medicine Fellowship," she said.

Additionally, she is one of a few hospitalists to have been awarded a K24 Mid-Career Mentoring Grant from the National Institute of Health, an award that recognizes and supports individuals with a history of successfully mentoring others.

She has a legacy of service to SHM and helped grow its academic footprint, including three years as chair of the Research, Innovation, and Vignette program and as a se-

nior deputy editor for the *Journal of Hospital Medicine*.

During her time on SHM's annual conference committee, she worked to expand content for early-career hospitalists and to increase the diversity of invited speakers. Her strong leadership, curious mind, and trailblazing research make Dr. Fang a model for clinician-investigators and hospitalist leaders across the country.

Daniel Payson Hunt, MD, MHM,

is the director of the division of hospital medicine at Emory University in Atlanta, where he has nurtured a culture of kindness and respect while



Dr. Hunt

developing and augmenting the research and scholarship infrastructure within the division. His election as a Master in Hospital Medicine is in honor of his consistent, longstanding citizenship and service to patients, colleagues, and the field of hospital medicine.

"Some of Dr. Hunt's most innovative changes in the [Emory Division of Hospital Medicine] have been in faculty development," Dr. Thompson said. "He supported the infrastructure for an associate division director for faculty development role and encouraged a mentoring framework with significant positive impacts on recruitment and retention."

Dr. Hunt helped lead the Emory Division of hospital medicine's expansion into Grady Memorial Hospital in Atlanta—one of the largest public hospitals in the nation—and supported division leadership for the addition of a large two-hospital medical system in addition to a long-term acute care hospital.

He has been an active member of SHM since 2005. During that time, he demonstrated an impressive commitment to scholarship. He has previously served as associate editor and deputy editor of the

Journal of Hospital Medicine.

Dr. Thompson also specifically cited Dr. Hunt's work within SHM at the annual conferences.

"Dr. Hunt has given numerous presentations and workshops at SHM annual conferences since 2011," she said. "That includes the popular 'Stump the Professor' session. He has also served as faculty at the Academic Hospitalist Academy."

Dr. Hunt operates as a catalyst to help others grow and succeed and has been an advocate for the hospitalist movement since its inception.

Danielle B. Scheurer, MD, MSCR, MHM,

serves as the chief quality officer at the Medical University of South Carolina in Charleston, S.C., where she continues to



Dr. Scheurer

practice as a hospitalist. Dr. Thompson said she is recognized for her leadership and commitment to both SHM and the field of hospital medicine.

"Dr. Scheurer's commitment to SHM has been unwavering, including during her time on the Board of Directors from 2014 to 2022," Dr. Thompson said. "Her leadership as president during the peak of the COVID-19 pandemic was instrumental in guiding SHM's response to canceling in-person events and pivoting SHM toward the new virtual formats necessary to reach our membership."

As SHM president, Dr. Scheurer also appointed the SHM Diversity, Equity, and Inclusion Task Force, which ultimately led to SHM forming a full-fledged DEI Committee. She also led the *Journal of Hospital Medicine* editor-in-chief search committee in 2018 and the SHM chief executive officer search committee in 2020.

Outside of her presidency, Dr. Scheurer served as the physician editor of *The Hospitalist* for nine years and presented at multiple SHM annual conferences. She was also chair of the communications strategy committee and an active member of the education and research committees.

Dr. Danielle Scheurer has been elected a Master in Hospital Medicine in recognition of her leadership and commitment to SHM and the field of hospital medicine.

Dr. Scheurer completed her joint internal medicine-pediatrics residency at Duke University in Durham, N.C., and her Master of Science in Clinical Research from the Medical University of South Carolina in Charleston, S.C. ■

NHD Contest Winners

Showcasing hospitalists' creativity

To celebrate National Hospitalist Day in March, SHM ran the HM Voices contest for creative writing and art. Participants were asked to submit works based on the Future of Hospital Medicine theme.

Congratulations to our winners—Andrea Lauffer, MD, FAAP, Lucas Gortz, MD, and Niki Shahrrava! Scan the QR code then click on the HM Voices tab to view all contest submissions.



Females and the Future of Hospital Medicine

Andrea Lauffer, MD, FAAP

I was unknowingly the future of hospital medicine, but it was a future that almost didn't come true. The first time I stepped onto the hospital wards was with a physician who called himself a "hospitalist." I was 18 years old and fulfilling my career shadowing requirement that would allow me to graduate high school. Little did I know that 12 years later, I would be pursuing hospital medicine as a full-time career.

During residency, there was no doubt my clinical interests were centered in hospital medicine. It was important for me to find a med-peds hospitalist position that would allow me to care for both adults and children. Upon graduating residency, acclimating to attending life was my primary goal. However, I didn't realize how much I needed a trusted mentor to help me navigate progressing through and advancing my career as a hospitalist. I was new at my first institution as an attending, and there was no emphasis on the importance of having a mentor. I had no new goals set for myself because I had just finished the most challenging career obstacles of my life: graduating residency and successfully passing two board exams.

Early in my hospitalist career, I discovered I was pregnant with my first child. At this point, I was truly lost in my career path. I absolutely loved being a hospitalist, but I had convinced myself that I could not be both a hospitalist and a mother successfully. I made the decision to step away from hospital medicine and join an outpatient clinic.

During my time at the clinic, it became evident to me that I was not professionally fulfilled. After having my daughter, I started devising ways how I could return to my previous hospitalist group and just occasionally help with admissions or rounding on a few patients. But putting myself in two realms of medicine would stretch me too thin. It would also frustrate me to only be able to tip-toe back into hospital medicine and not be able to work more in the clinical setting I loved the most.

After having my second child, I knew I needed a career adjustment. The opportunity to return to hospital medicine fell into my lap, and I could not turn away my second chance. My previous group was extremely short-staffed, and they were in need of hiring new hospitalists.

Creating the terms of my return allowed me to comfortably express myself as a physician who loved hospital medicine as well as a mother of young children. I returned with a work schedule that allowed me to practice the medicine I love while still being the mother I wanted to be for my children.

Today, I am in academia where I work as a med-peds hospitalist at the Marshall University School of Medicine. I have achieved certification in focus practice in hospital medicine through the ABIM. I am also board certified in pediatric hospital medicine. I have a mentor with knowledge of who I am holistically. Through



Dr. Lauffer

Dr. Lauffer is an assistant professor of internal medicine-pediatrics, associate program director, Marshall PHM fellowship program at the Joan C. Edwards School of Medicine, Marshall University, Huntington, WVa.

mentorship, I have short and long-term goals outlined for my career. I have also added two more children to my family. I am the associate program director of our pediatric hospital medicine fellowship program. I chair the Women in Medicine in Science committee at my institution.

Being a hospitalist and having a family have fulfilled me in ways I could not imagine. I work for a program that recognizes and honors female physicians in clinical and leadership roles. Having this support has increased my confidence as a physician and allowed me to pursue unique opportunities in the field of hospital medicine to facilitate my professional growth.

But my current reality almost did not happen for me. All along, I was the future, but I almost never found my way back. The movement of positively recognizing females as both mothers and physicians working in the field of medicine helped re-direct my course. The presence of this support and encouragement from the medical community as a whole was not as showcased as it is today. Now, it is strongly felt by many. Women were once made to choose personal or professional happiness. This new force in medicine recognizes that when we support women in both pursuits of happiness, it only allows the field to grow so that current and future patients can have the best care available to them. To those behind this new force and bringing it to the forefront, I thank you.

How do we keep the momentum going to keep the future of hospital medicine bright? We must encourage women to pursue their interests in medicine while honoring their personal goals as well. We must celebrate and recognize those around us that help the advancement of women in medicine. In the Women in Medicine and Science committee I chair at my institution, we designed an award given yearly to recognize any individual who helps the advancement of women in medicine or science. We need to ensure structured mentorship programs exist and are promoted and accessible to women as they are developing and planning their careers.

I was and am the future of hospital medicine, but it was a future that almost didn't happen. In a field I passionately love, I feel a sense of duty to now extend the lessons I have learned in my journey to those women currently navigating their journeys. A bright future in the field of hospital medicine awaits many females. Let's all be a light to help guide their paths. ■

▲ Passing the Baton

By Niki Shahrrava



Ms. Shahrrava

Ms. Shahrrava is a 4th-year medical student at St. George's University School of Medicine



The Future of Hospital Medicine

By Lucas Gortz, MD

In the future, the hospital's heart will beat
With a rhythm that is new and sweet.
Technology, including AI's might,
Will aid patient care innovation, day and night.

The hospitalist will be the captain
Of this ship, navigating us to action.
Collaborating with AI's precision,
And using machine learning's predictive vision.

With algorithms analyzing data and trends,
Hospitalists can make better decisions in the end.
Machine learning's insights provide a guide,
As hospitalists navigate the tide.

The future of hospital medicine is bright,
As human-machine collaboration takes flight.
Hospitalists, still the quarterbacks in the game,
Will have a big data brain to gain better aim.



Dr. Gortz

Dr. Gortz is an academic internist/hospitalist at Hospital de Clínicas da Universidade Federal do Paraná (HC-UFPR), Curitiba, Parana, Brazil, practicing and teaching with a focus on hospital medicine. He is the program director of the internal medicine residency program at HC-UFPR, where he sees complex patients as preceptor and attending physician of the inpatient internal medicine ward and does research in this field.

Finding Your Comfort Zone

Hospitalist members of the LGBTQIA+ community talk challenges, offer insight, and advocate for peers

By Vanessa Caceres

Hospitalists who are part of the lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other (LGBTQIA+) community have had an array of experiences, both in medical school and professionally, related to their personal identity. While many see real progress and describe their workplace as welcoming, these same hospitalists have had previous struggles with fitting in. Some find themselves still fielding unusual comments from colleagues, which they dodge with humor or sincere curiosity.

The Hospitalist recently spoke with five hospitalists who shared more about their challenges and opportunities as members of the LGBTQIA+ community.

Ian Chua, MD, (he/him) is a

pediatric hospitalist, assistant professor of pediatrics at Stanford Children's Health in Palo Alto, Calif. and Children's



Dr. Chua

National Medical Center in Washington, D.C., and co-chair of the American Academy of Pediatrics section on hospital medicine, LGBTQIA subcommittee.

Dr. Chua sees himself in an interesting role, being gay and an Asian immigrant (originally from the Philippines). "Because of the collective challenges that you carry from being an immigrant and in the gay community, it makes you more receptive and sensitive to others in terms of how to get them to open up more," said Dr. Chua, who spends his time about 50/50 between his two hospitals on the west and east coasts.

With patients, being gay sometimes provides a safe area where they can share themselves more, whether it's a teenager who's struggling with their sexuality or someone who just feels they are more fluid.

He feels that he needs to be mindful of how open he is about himself among colleagues or patients. "That's more pronounced in the current political climate. You can tell if someone is giving you a look because you're wearing a rainbow pin," he said.

Although Dr. Chua practices in two more liberal-leaning areas, he still sees a spectrum of acceptance toward being gay. "Some are more heteronormative, even if they are accepting, meaning they are more accepting if you want to be married and have children like they



do," he said.

Dr. Chua also has at times noticed some differences in interactions with nurses or other hospital workers from his native country. They may want to set him up with a niece or other family member; when they find out he's gay, their attitudes toward him change. "The Philippines is a very Catholic country, so there's religion at play," he said.

Dr. Chua didn't come out until residency and aimed to find a place or places where he could feel truly comfortable. "It took me a while, but I got to the point of, why would I go somewhere that didn't want to welcome me for me?" he said.

Damian Crawford, MD, (he/him) is chief hospitalist with Frederick Memorial Hospital, and with Sound Physicians, both in Frederick, Md.



Dr. Crawford

Dr. Crawford feels that being a gay man in his current part of the country—the Northeast, which tends to be more liberal—has not created challenges at work. He felt more trouble "finding my tribe" at medical school, also in Maryland, and then in residency in Boston. He

says he didn't know any other gay people for years and befriended a female friend during residency. The friend went on to finish school and get married. She invited Dr. Crawford to her wedding but said he couldn't bring the man who was his partner at the time. "She said, 'You people want all these special privileges,'" Dr. Crawford said.

What concerns Dr. Crawford about that incident is how physicians who may have biases can provide safety for someone with special health concerns, such as a person who is positive for human immunodeficiency virus (HIV) or who is transitioning genders.

The biggest challenge that Dr. Crawford faces is meeting someone at work and not knowing where they'll fall in terms of acceptance toward the gay community. "There's the additional navigation of knowing if this is a safe person or not. You become skilled at not talking about your personal life."

Dr. Crawford recently had a coworker who didn't know that he was gay. When Dr. Crawford casually mentioned being gay, the female coworker acted surprised and said she would have been open to dating him if he were straight. It was an awkward experience, he said.

Still, Dr. Crawford believes that people should be careful about always trying to find a struggle when discussing the LGBTQIA+

community. "We've come so far, and I think there's a lot to celebrate now," he said.

Ian Jenkins, MD, SFHM (he/him), is a hospitalist and chair of the patient safety committee at UCSD Hospital Medicine in San Diego and chair of the SHM Hospital Quality and Patient Safety Committee.



Dr. Jenkins

Dr. Jenkins says that he's fortunate to be a hospitalist in California. "Generally speaking, our patients are treated with respect. We have great programs to recognize gender identity in the EMR [electronic medical records] and make our patients feel welcome," he said. He also sometimes senses a subtle surprise or appreciation from LGBTQIA+ patients for how comfortable they feel talking to him.

Dr. Jenkins, who lives with two same-sex partners, has turned his story into a book, "Three Dads and a Baby: Adventures in Modern Parenting," which has been well publicized and has been discussed by hospital leadership at their tier-five huddle. He also wrote about being gay and marriage equality in a short article that was published in the *Annals of Internal Medicine*.¹

Key Takeaways



7 Tips for LGBTQIA+ Hospitalists

Finding your comfort zone on the job isn't always easy. Here are seven tips for newer hospitalists who are gay, lesbian, or in the queer community.

1. Know the local environment both culturally and politically. Dr. Jenkins recommends. This is something to keep in mind when you're searching for places to work. If the environment is favorable, you can likely feel comfortable being out. Otherwise, you'll need to ask yourself if you're ready to fight for change.

2. Go where you feel comfortable. "Don't stay somewhere you don't feel welcome," Dr. Crawford said. "In 2023, there are other places where you can exist as yourself. Don't be a martyr. Life is short."

Dr. Jenkins shares the story of an interviewer in medical school who said he could use his student activism to keep him out of medical school after seeing that Dr. Jenkins was his school's LGB Union president. "I said I'd much rather go to a better school where I was wanted and terminated the interview," he said.

3. Be who you are, Dr. Wright advises. "We spend so much of our time at work that I feel it's important to be in a work environment that appreciates me as I am," Dr. Wright said. It will be easier to get through the task of helping sick people every day if you can be who you are versus leaving a big chunk of your heart at home, Dr. Wright explains. In their case, Dr. Wright has tattoos, a nose ring, and platinum hair. They have wondered if that would cause any controversy at work, especially at the local veterans' hospital. If anything, they have received compliments for their style.

4. Take your time coming out. "For few people, coming out may be a snapshot in time. For many, it's a slow process," Dr. Singh said. Don't feel pressured to come out before you're ready. "Take your time and be

comfortable before you feel you're ready to be out," he said. Take time to understand the outlook of life after coming out. Plan!

5. Think about how you want to respond to personal-life inquiries or biased comments. Dr. Singh points to situations at work where someone has assumed he has a wife and has asked about his "wife." He'll reflect on where the person is coming from and if he doesn't perceive any malintent, he'll respond with some humor. "These conversations come up," he said.

You also may want to consider how to respond to inappropriate comments made about others, Dr. Jenkins says. One response he's found helpful is, "That isn't kind." This helps, as most people don't want to be perceived as mean. Another response he's used when someone says something biased is, "Oh, I don't get that one. Can you explain it?" That forces the person to backtrack or detail their bias, Dr. Jenkins says.

6. Seek out allies. Check in with your hospital's human resource department or diversity, equity, and inclusion office to see what resources are available for those who are LGBTQIA+. If you don't find an organization that would meet your needs, then check at your city or state level. "It doesn't have to be in the hospitalist community. It could be at the physician level," Dr. Singh said. "The whole idea of seeking out allies is to feel more empowered, safe, and comfortable."

7. Remember that you're not alone. By seeking out others within the LGBTQIA+ community and allies, you'll feel the collective power and be able to help each other. "If you connect with the community—the stronger the community becomes—whether that's joining your nearest LGBTQIA+ sub-committee or local gay sports league, then the more impact you'll have on other hospitalists and beyond," Dr. Chua said. ■

"Visibility turns queer from some shameful reveal to being left-handed, which has been a goal of mine since my undergrad days," he said.

One challenge has been fighting a parental-leave policy that granted much more time to biological parents than to adoptive or surrogacy parents. He was able to apply some pressure to help change that policy.

Having more faculty members who are out can help bring positive attention to being gay, including in places around the U.S. that are undermining the worth of people who are LGBTQIA+, Dr. Jenkins says.

"Doctors are respected leaders, and we can help by consistently advocating for equity and inclusion for everyone," he said.

Amteshwar Singh, MD, MEd, FACP (he/him)

is associate program director for the hospital medicine fellowship with the division of hospital



Dr. Singh

medicine at Johns Hopkins Bayview Medical Center in Baltimore.

Dr. Singh characterizes the work environment at Johns Hopkins and Sinai Hospital in Baltimore, where he worked previously, as rich in resources for those who are part of any marginalized community.

Among hospitalist peers, he says their work is very much supported and that people feel comfortable expressing their identity. He points to an affinity group that meets regularly to discuss initiatives, keep allies engaged, and celebrate events like Pride Month. There are even social clubs at Hopkins geared toward the LGBTQIA+ community.

Hopkins also offers Safe Zone training, which focuses on LGBTQIA+ awareness and ally training. The Safe Zone Project promotes "an environment where the lesbian, gay, bisexual, transgender, and queer community and their allies flourish intellectually, socially, and emotionally."

Although Dr. Singh sees the overall atmosphere where he works as favorable for him as a gay man, he believes it would be useful for more hospitalists to do the Safe Zone training. This would help "so they know our history, where we came from, who we are, and how they can be strong allies." This is important in light of other parts of the country where the climate and news headlines have been less favorable to those in the queer community.

Dr. Singh also would like to see traditional medical education ex-

pand to include current best practices in the care of the LGBTQIA+ community. He shares the example of learning about HIV post-exposure prophylaxis during medical school. "Now, we have come a long way in HIV prevention; we are, in fact, moving from oral to long-acting injectable pre-exposure prophylaxis, or PrEP," he said. Transition options for transgender folks have remarkably progressed over the years, but learners' exposure to

such care is quite limited.

"These types of evidence-based clinical care specific to our community and perhaps the general community haven't been as deeply engrained in the current medical education system," Dr. Singh said. He has seen patients mislabeled as HIV-positive due to their use of PrEP. "If providers aren't aware of current progress in LGBTQIA+ care, they could get mislabeled or

mistreated, which can have negative outcomes," he said.

Dr. Singh believes that with their heavy presence in undergraduate medical education and graduate medical education, hospitalists are perfectly situated to become more aware of these care advances and educate learners.

Masina Wright, DO (they/them) is a locum tenens hospitalist in New Mexico.



Dr. Wright

Dr. Wright, who is embarking on a second career as a hospitalist, says they advocate frequently for queer health at work and while in medical school. This has included advocating for expanded pronoun use in the EMR. This advocacy led Dr. Wright, who uses the pronouns they/them, to receive a diversity award from their residency class.

Dr. Wright describes themselves as a nonbinary femme-presenting lesbian, which offers "straight passing privilege" in medicine culture. Dr. Wright will go out of the way to connect with patients who appear queer and come out at the bedside to establish a sense of possible community or trust. "By me being queer, there's an extra layer of trust that can happen," they said, pointing to the discomfort patients may feel from being sick and surrounded by strangers in a hospital environment where it feels unsafe to disclose their gender or sexuality.

With their location in New Mexico, acceptance of being queer is usually not an issue, Dr. Wright says. However, they have struggled with not feeling like themselves at work. "It's difficult to feel like it's safe or okay with who I am outside of my private community," Dr. Wright said. Over the past year, they have worked toward being at peace with their identity while practicing medicine. "If I'm taking care of a 97-year-old patient who can see me as his doctor and care provider, then the hospital administrator can see me for that as well," Dr. Wright said.

Dr. Wright would like to see more pipelines for members of the queer community to get into medicine by advocating for increased diversity in medical school. "There are other minorities that need to be lifted up in medicine as well," they said. "For people in academic medicine, bringing up more (members of the queer community) will help everyone." ■

Vanessa Caceres is a medical writer in Bradenton, Fla.

Reference

1. Jenkins IH. Reflections on marriage equality. *Ann Intern Med.* 2016;164(2):129-30.

SHM 2023 Awards of Excellence and Junior Investigator Award

SHM's Awards of Excellence Program honors members who've made exceptional contributions to hospital medicine in a variety of categories. Please join *The Hospitalist* and SHM in congratulating the 2023 award winners.

Clinical Leadership for Physicians

Benji K. Mathews, MD, MBA, SFHM

Dr. Mathews is the department chair of hospital medicine and division head at Regions Hospital with HealthPartners in Minnesota and an associate professor of medicine with a passion for education, innovation, care delivery, and quality.



Dr. Mathews

He's known as a master clinician with extensive expertise in diagnostic reasoning and point of care ultrasound (POCUS). He's led clinical innovations with novel care models, peer support programs, ultrasound, and telemedicine, and supporting the growing arena of hospital-at-home, and he devotes considerable time to mentorship and faculty development.

When COVID-19 hit, Dr. Mathews was tapped as the lead physician on all operations related to the pandemic in the hospital medicine department. At the same time, he made another pandemic pivot while serving as course director for Hospital Medicine 2020 and leading preparations for SHM's national conference by turning the convention into a virtual gathering.

Dr. Mathews is a past president of SHM's Minnesota chapter and is active locally, nationally, and internationally with SHM. He serves on the Practice Management and POCUS steering committees, the executive council of the Diversity, Equity, and Inclusion Special Interest Group (SIG), and as the chair for the Research, Innovations, and Clinical Vignettes program.

He earned his medical degree and completed his residency and chief residency at the University of Minnesota Medical School, and he has completed a Diagnostic and Patient Safety Fellowship and a Master's degree in Business Administration.

Clinical Leadership for NPs and PAs

Bridget A. McGrath, MPAS, PA-C, FHM

Ms. McGrath is the director of advanced practice provider hospital medicine services, co-lead for the interprofessional education section, and chair of the hospital-level advanced practice provider executive council at the University of Chicago in Ill. She also holds affiliate faculty status for Butler University's physician assistant program in Indianapolis and adjunct clinical educator status in Midwestern University's physician assistant program in Downers Grove, Ill.



Ms. McGrath

Within her administrative role, Ms. McGrath oversees the clinical performance, staffing, and career mentorship of the nurse practitioner (NP) and physician assistant (PA) hospitalist

team. She aligns care delivery with section and hospital priorities by identifying and implementing clinical operations, quality improvement, and medical education initiatives.

Ms. McGrath's academic focus is on the assessment and expansion of professional-development opportunities that promote bidirectional mentorship among NPs, PAs, and physicians. Through this work, she co-developed the framework LEAD: Leadership roles and responsibilities, embedding ideas into pre-existing realms, and academic development.

Ms. McGrath graduated from Butler University's physician assistant program and started her career as a meds/peds hospitalist PA at Schneck Medical Center in Seymour, Ind. She's held leadership positions in the SHM Academic Committee and NP/PA SIG. Through her service, she co-developed a national multi-site onboarding survey leading to the published SHM NP/PA Onboarding Case Studies. Additionally, she co-led the pilot year of NP/PA inclusion in academic speed mentoring.

Diversity, Equity & Inclusion Leadership Award

Archna Eniasivam, MD

Dr. Eniasivam is an associate professor in the departments of internal medicine and pediatrics at the University of California, San Francisco (UCSF) where she also serves as director of social medicine for the division of hospital medicine and as a diversity, equity, inclusion, and belonging (DEIB) physician lead for UCSF Health. She co-leads her division's anti-racism task force and DEI summer internship for first-year medical students. She co-led the Hospital Medicine Reengineering Network (HOMERuN) Anti-Racism and Health Equity work group (2020-2022), benchmarking health-equity initiatives across academic hospital medicine programs.



Dr. Eniasivam

Dr. Eniasivam is committed to transforming systems and structures along with the people that uphold them. As a DEIB physician lead, she works on cultural change in the clinical space, including developing processes for policies to be created and reviewed through an anti-racism and healing-centered lens. As director of social medicine, she works to embed health equity into the pillars of quality improvement, faculty and staff development, research, and patient experience.

Her current focus is on building relationships with community organizations to better incorporate patients and the community in identifying and addressing inequities within the hospital. In addition to mentoring faculty and learners, she also developed the curriculum as a co-director (2017-2022) focused on health systems science and social justice for six weeks of her first year of medical school. She also co-led a social-justice discussion club for graduate medical education (2020-2022).

Excellence in Humanitarian Services

Ilan Alhadeff, MD, MBA, CLHM, SFHM

Dr. Alhadeff is a board-certified physician executive who has served in numerous health care leadership roles over the last 18 years. Currently the assistant vice president of medical services and care management at Boca Raton Regional Hospital in Florida, he has various administrative and operational department responsibilities. He also works as a physician assistant, serves as affiliate faculty for Florida Atlantic University in Boca Raton, Fla., and practices as a hospitalist. Previously, he worked for the national company TeamHealth in various leadership roles, including hospital-medicine vice president and business-development and startup advisor.



Dr. Alhadeff

Dr. Alhadeff received his medical degree from Ross University in Miramar, Fla., completed an internal medicine residency at Mount Sinai School of Medicine in Elmhurst, N.Y., and received his Lean Six Sigma Green Belt and MBA from Florida Atlantic University in Boca Raton, Fla. He has served as an SHM Leadership Academy facilitator since 2013.

Dr. Alhadeff is the co-founder and board chairman of Make Our Schools Safe, a non-profit foundation formed by Dr. Alhadeff and Lori Alhadeff after their daughter's tragic death in the 2018 Parkland school shooting. Successes include passing Alyssa's Law in three states, the mobile panic alert law named after his daughter, disbursing more than \$200,000 for various school safety projects, and forming 20 high-school safety clubs across five states. Dr. Alhadeff also lectures on leading through tragedy and post-traumatic growth.

Lori Alhadeff

Mrs. Alhadeff is a former health and physical education teacher for grades K-12. She graduated from The College of New Jersey in Ewing, N.J. with a Bachelor of Science in health and physical education, and holds a Master of Arts in Education from Gratz College in Melrose Park, Pa.



Mrs. Alhadeff

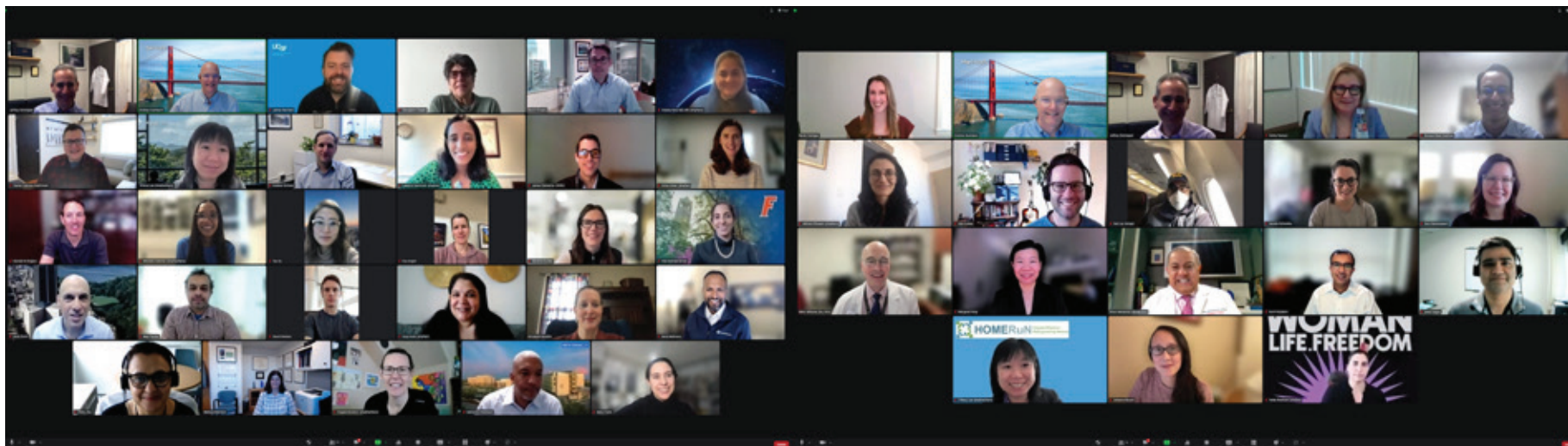
She spent four years at Union Township School in Hampton, N.J., where she coached volleyball, cheerleading, and softball. She worked one year at Windward School in New York City as a health and physical-education teacher for children with dyslexia and language-based learning disabilities. She also coached cheerleading.

Mrs. Alhadeff was elected to Florida's Broward County school board in 2018 to serve as a District 4 board member. She is deeply involved in her community, including as a fundraising volunteer for the Parkland Soccer Club. She is also co-founder and president of Make Our Schools Safe and is dedicated to protecting students and teachers at school.

Excellence in Research

Valerie G. Press, MD, MPH, SFHM

Dr. Press is an associate professor of medicine and pediatrics, executive medical director of



The HOMERuN COVID-19 Collaborative Group, winner of the Excellence in Teamwork award, included more than 150 members across 80 institutions.

specialty value-based care, and medical director of the Care Transitions Clinic at the University of Chicago.

Her research is focused on developing, testing, and implementing patient and system-level interventions to improve the quality and value of care for patients with chronic lung disease across care-transition settings. She currently serves as principal investigator for two R01 research project grants (from the National Institutes of Health and Agency for Healthcare Research and Quality). SHM is a collaborator on both R01 projects that are focused on improving care by using tailored patient and system-centered interventions to reduce revisits to the emergency department and/or hospital post-hospitalization for chronic obstructive pulmonary disease.



Dr. Press

Dr. Press has been an active member of SHM since 2009 and has served as chair of the Research Committee, of which she is currently a member. She was also the chair for the Research, Innovations, and Clinical Vignettes program. She is a dedicated award-winning mentor and has mentored through the SHM student scholar summer program. She was a recipient of SHM's Junior Investigator Award in 2017.

Dr. Press received her medical degree and Master of Public Health in health management and policy at the University of Michigan in Ann Arbor. She completed her internal medicine and pediatrics residencies and the hospitalist scholars fellowship training program at the University of Chicago.

Excellence in Teaching

Somnath Mookherjee, MD

Dr. Mookherjee is an associate professor of medicine at the University of Washington in Seattle. His clinical practice is in perioperative medicine and internal medicine consultation. His scholarly work focuses on optimizing clinical teaching.



Dr. Mookherjee

In recent years, he has published research on peer feedback on teaching, physical examination education, and education in quality improvement and patient safety. He is co-editor of the "Handbook of Clinical Teaching," co-editor of "Chalk Talks in Internal Medicine: Scripts for Clinical Teaching," and co-author of a manual on "Writing Case Reports—A Practical Guide from Conception through Publication."

Dr. Mookherjee is a faculty member at the

University of Washington (UW) School of Medicine in Seattle, a role in which he mentors students and teaches fundamental physician skills. As associate director for faculty development in clinical teaching for the UW Center for Learning and Innovation in Medicine Education, Dr. Mookherjee directs the UW clinical teaching certificate program. He also directs the faculty development program and the academic hospitalist fellowship for the UW division of general internal medicine.

Dr. Mookherjee has been active in SHM since completing the UCSF Fellowship in Academic Hospital Medicine in 2008. He is currently the deputy editor of the Clinical Care Conundrum series for the *Journal of Hospital Medicine*. Dr. Mookherjee completed his training in internal medicine at UW in 2007. After his time at UCSF, he returned to the UW division of general internal medicine in 2012.

Leadership for Practice Managers

Trevor J. Coons, MHA, FACHE

Mr. Coons is an assistant professor of health care administration at Mayo Clinic's College of Medicine and Science in Rochester, Minn. He has more than 10 years of practice leadership experience with the Mayo Clinic. For the last five years he has served as operations manager for its division of hospital internal medicine as well as supporting Mayo Clinic's mid-west community division with its 17 hospital internal-medicine practices.



Mr. Coons

Mr. Coons serves as chair for SHM's Hospital Medicine Administrators SIG. He is a contributing member of numerous national and international professional committees and workgroups, including the Healthcare Information and Management Systems Society, the Association of American Medical Colleges, and the Cochrane Policy Research Institute. He is a fellow in the American College of Health Care Executives (ACHE) in Chicago and has served on the board of his state chapter. He presently is a member of ACHE's national examination committee.

In addition to his professional roles, Mr. Coons has volunteered in numerous civic roles including serving on a rural ambulance commission and also on a chamber of commerce board. He is a member of the Minnesota Governor's rural health advisory committee and also chairs the Olmsted County Public Health Services advisory board. Mr. Coons has a Bachelor of Arts in management from Brigham Young University in Provo, Utah, and holds a Master of Healthcare Administration degree from the University of Minnesota in Minneapolis.

Excellence in Teamwork

HOMERuN COVID-19 Collaborative Group

The Hospital Medicine Reengineering Network (HOMERuN) COVID-19 collaborative group produced wide-ranging and impactful support for hospitalists, hospitals, and patients, as well as their family caregivers, during the pandemic's darkest days. HOMERuN exemplifies a nimble, scalable, near-real-time structure to share best practices and lessons for many challenges facing hospitalists and hospitals beyond COVID-19.

HOMERuN connected hospitalists across the United States, rapidly sharing best practices and lessons learned to improve patient care. Video calls with breakout sessions facilitated more than 150 members providing real-time data collection and dissemination to and from as many as 80 medical centers. Email summaries, surveys, newsletters, and an accompanying website provided a broader hospital-medicine audience insight into numerous institutions' approaches to evaluating and managing patients with COVID-19.

The team comprehensively addressed topics ranging from clinical pathways and workforce planning to discharge criteria. HOMERuN also generated multiple peer-reviewed publications and presentations. The number of HOMERuN institutions and participants grew throughout the pandemic, a testament to its perceived value to participants.

Perhaps HOMERuN's greatest impact occurred early in the pandemic when hospitalists were overwhelmed by a deluge of new information—all while caring for a torrent of patients. HOMERuN provided a safe harbor in that storm, a reliable venue to find reassurance that others were similarly struggling, and a source of fortifying knowledge. The HOMERuN team epitomized dedicated collaboration among hospitalists, working to address the biggest challenge of our careers, together.

Outstanding Service in Hospital Medicine

Anand Kartha, MBBS, MS, SFHM

Dr. Kartha is head of hospital medicine at Hamad Medical Corporation in Qatar and associate professor of clinical medicine at Weill Cornell Medicine in New York. He completed his residency at University of Pittsburgh Mercy, and his Postgraduate Internal Medicine Fellowship and a Master's



Dr. Kartha

in Health Services Research at Boston University. He is a hospitalist whose work and leadership have significantly impacted the field of hospital medicine, with particular emphasis on veterans' healthcare and international hospital medicine.

As associate chief for quality at the VA Boston Healthcare System, Dr. Kartha helped establish the Veterans' Administration's hospitalist field advisory committee, the SHM VA Hospitalist SIG, and the Boston Association of Academic Hospital Medicine Chapter of SHM. He established Hospital Medicine at Hamad Medical Corporation, a world-class academic system providing 90% of Qatar's acute care. He implemented multiple programs that significantly improved the entire patient journey.

Dr. Kartha's work was instrumental to the success of the COVID-19 response and the 2022 FIFA World Cup in Qatar. He founded the SHM Middle East Chapter, strengthened the SHM International Chapter, and promoted international membership to grow

SHM's international footprint.

Dr. Kartha is also an inpatient education leader, developing curricula recognized by the Joint Commission and Office of Inspector General as best practice. He has actively published internationally and serves on the editorial boards of several peer-reviewed journals. He has received multiple awards including the David Littman Award and the Qatar Stars of Excellence Award.

Jr. Investigator Award

Sagar B. Dugani, MD, PhD, MPH, FHM

Dr. Dugani is an assistant professor of medicine at Mayo Clinic in Rochester, Minn., where he also serves as research chair in the division of hospital internal medicine. He completed his resi-

dency in internal medicine at Brigham and Women's Hospital in Boston, and a fellowship at the University of Toronto, Ontario.

Dr. Dugani served as a consultant to the World Bank in Washington, D.C. to develop metrics for health systems in low- and middle-income countries. He directs the Hospital Experiences to Advance Goals and Outcomes Network (HEXAGON), a research network for hospital internal medicine across Mayo Clinic sites in Minnesota, Arizona, Wisconsin, and Florida. Through HEXAGON, he leads the longitudinal COVID-19



Dr. Dugani

well-being survey for hospitalists.

Dr. Dugani led the Post-discharge Early Assessment with Remote Video Link randomized clinical trial to improve post-discharge outcomes and serves as principal investigator of the Hospital Internal Medicine Patient Reported Outcomes Versus Experiences study to improve the experience of hospitalized patients.

Through a career development award from the National Institute on Minority Health and Health Disparities, he leads the Rural Patient Risks and Exposures for Diabetes Control study to characterize rural-urban disparities in diabetes care and improve risk prediction for diabetes in the U.S. Midwest. Dr. Dugani is a member of the SHM Research Committee and both the Patient Experience and the Rural Hospitalists SIGs. ■

Diversity

LGBTQIA+ Allyship

How to show support for colleagues and patients in this community

By Karen Appold

Hospitalists are in a unique position to be allies for the lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other (LGBTQIA+) community because they're on the frontlines of new-patient encounters, said Jennifer K. O'Toole (@busymomjen), MD, MEd, SFHM, program director of the internal medicine-pediatrics residency program and professor of pediatrics and internal medicine at Cincinnati Children's Hospital Medical Center and the University of Cincinnati Medical Center, two large, urban, safety-net hospitals in Ohio. She believes that many individuals who identify as LGBTQIA+ may not seek regular health care because they may fear how they will be treated and labeled by the health care system. Therefore, when they are seen, these individuals may have advanced conditions due to delaying care.



Dr. O'Toole

Along these lines, Catherine Washburn, MD, assistant professor of medicine in the division of hospital medicine at Johns Hopkins Bayview Medical Center in Baltimore, an urban hospital with 420 beds, said that hospitalists are the primary care providers for hospital inpatients. In this role, they are the leaders of advocacy for their



patients, which should include not only making a correct diagnosis, but also treating patients with dignity and respect.

Keshav Khanijow, MD, assistant professor of internal medicine at Johns Hopkins Bayview Medical Center, pointed out that LGBTQIA+ people, who comprise less than 10% of the U.S. population, have a history of being discriminated against. "Allies can help amplify this community's voice, so the battle against discrimination can be heard, whether it's at work advocating for equal insurance benefits, or



Dr. Khanijow

by supporting positive resolutions through organizations," he said.

Promoting allyship for patients

Hospitalists can support the LGBTQIA+ community in many ways, beginning with the initial patient encounter. "It's important to make patients who identify as LGBTQIA+ feel safe because they're in crisis mode and can feel especially vulnerable when at a hospital," Dr. O'Toole said.

At Cincinnati Children's Hospital, Dr. O'Toole wears a pride flag sticker on her name badge showing her support for the LGBTQIA+ community, as well as a list of her pronouns. "When patients look at my badge, they can see a physical sign that I support them," she said. "Some have

even thanked me for wearing it."

"Another way to help put LGBTQIA+ patients at ease is to ask them about their pronoun preference so that this information can be correctly used in encounters and documented in their electronic health record," Dr. O'Toole said. "This helps patients to feel accepted and safe within our health care system."

Focused educational training efforts for issues that the LGBTQIA+ community face are part of Dr. O'Toole's residency training program at Cincinnati Children's Hospital Medical Center and the University of Cincinnati Medical Center. "It's important to make sure that all providers are up to date with the latest information on conditions that are more prevalent in this population and how to provide the safest and most equitable level of care," Dr. O'Toole said.

To show community support, Dr. O'Toole—along with residents and faculty from the University of Cincinnati Medical Center—has manned a booth at a local Pride Day parade, where they handed out information about the health care they recommend for individuals who identify as LGBTQIA+ and contact information for providers who welcome LGBTQIA+ patients.

"Hospitalists can serve as connectors, pointing patients to primary care and specialty providers who have expertise in caring for the LGBTQIA+ population," Dr. O'Toole said. "In showing our support and providing these connections, the LGBTQIA+ community will feel safer about seeking health care," she said.

Showing support for colleagues

Regarding colleagues, team leaders need to affirm and support LGBTQIA+ team members, both within the team, and beyond it with patients and their families. “Learning the appropriate language to use in these situations and practicing it is critical for team leaders,” Dr. Washburn said.

“When a patient or their family member insults or questions an LGBTQIA+ trainee, a team’s leader needs to be ready with language to handle the situation gracefully while clearly affirming the value of all team members,” Dr. Washburn said. “Normalizing inclusive pronoun use will relieve a transgender team member of the burden of having to ask the team to use a particular pronoun for themselves.”

As a health care system, Johns Hopkins has events and awards that celebrate and recognize the contributions of LGBTQIA+ community members, such as an achiever’s award that is publicized to the entire Hopkins community. Dr. Washburn’s hospital medicine division supports an affinity LGBTQIA+ group and has supported career paths of members that focus on disparities for LGBTQIA+ patients and correcting those disparities.

Another way to show support for the LGBTQIA+ population is to make sure that employee benefits are applied equally to everyone, regardless of whether they are a same-sex or heterosexual couple, by working with human resources personnel and stakeholders in employee benefits, Dr. Khanijow said. “Advocating for zero tolerance of anti-LGBTQIA+ hate speech through mission statements, admission notices to patients regarding expected code of conduct, and workplace rules also sends a signal that an organization values all of its employees,” he said.

Advice for trainees

Regarding future employment opportunities, Dr. O’Toole advises trainees to choose positions wisely. “Seek out institutions that support the LGBTQIA+ community,” Dr. O’Toole said. “The presence of LGBTQIA+ affinity organizations and leave policies, mission statements, and patient support initiatives that are inclusive and supportive to the LGBTQIA+ community are just a few ways to identify such environments without having to ask directly.”

Another piece of advice is to seek out allies when becoming acclimated to a new position. “Find individuals who will provide support and be a champion for the LGBTQIA+ community both inside and outside of the work environment,” Dr. O’Toole said. Lastly, “If

someone identifies as LGBTQIA+, they should be proud of who they are and not settle. Imposter syndrome may creep in at times, but when that happens, seek out your friends and allies so they can reflect on the amazing qualities that they see in you.”

Getting started

When looking to promote allyship with the LGBTQIA+ community among your colleagues and co-workers, Dr. O’Toole recommends starting small and building from there. “Begin with visible ways that show your support, such as wearing supportive stickers on your hospital badge or displaying your preferred pronouns in email signatures,” she said. “From there, begin to build on your efforts. Join LGBTQIA+ affinity groups within your organization or consider starting one.”

Begin conversations with colleagues who identify as LGBTQIA+ to learn about their experiences and develop an understanding of how you can become a better ally. “From there, think about how you can get involved in system-wide initiatives and/or advocacy to provide more support to LGBTQIA+ colleagues,” Dr. O’Toole said. “Advocate for fair and equitable workplace policies and procedures that support these colleagues and ensure that they are allowed to thrive and succeed at work and in their personal lives.”

For example, ensure that leave policies for birthing, adopting, or fostering a child apply to all employees equitably, regardless of their gender identity, Dr. O’Toole said. Actively sponsor LGBTQIA+ colleagues for opportunities or awards and find innovative ways to highlight their work and achievements.”

Dr. Khanijow recommended finding out if an organization recognizes Pride Month in June. “If not, treating colleagues to rainbow cupcakes or sending out an email about LGBTQIA+ medical figures in history could be a good start to bringing awareness to this population,” he said. A next step would be education. For example, encourage people to watch SHM’s LGBTQIA+ Health Series for continuing education credit or invite a guest lecturer to discuss the topic at your organization. The series includes courses on LGBTQ+ Affirming Language and Documentation, Inpatient Care of Transgender Individuals: Gender Affirming Hormone Therapy, LGBTQ+ as Social Determinant of Health, Advocacy for/with LGBTQ+ Persons: Population and Policy, and PrEP 101: A Hospitalist’s Guide to HIV Pre-Exposure Prophylaxis.

Overcoming challenges

The COVID-19 pandemic and the

current political climate have left many health care workers exhausted and overwhelmed, both physically and emotionally. “Many of us have little left to give after the challenges of the past few years,” Dr. O’Toole said. “But now would be a good time to revisit our own mental health and that of our colleagues, especially those in the LGBTQIA+ community.”

Another major obstacle for many hospitalists is new or proposed state laws that discriminate against the LGBTQIA+ community, such as those that restrict health care for transgender youth. “As hospitalists, it’s important to be registered to vote and partake in local, state, and national elections,” Dr. O’Toole said. “Getting involved in advocacy work both within your institution and community is a critical action that everyone can take. Physicians hold a powerful voice in our institutions and communities.”

When looking to start an initiative, Dr. Khanijow recommended being sure that it is something that your LGBTQIA+ co-workers want and need. “When stepping in as an ally, ask what the community wants and how you can best help them,” he said. Be sure to balance new initiatives with a workplace’s culture. In some parts of the country, where anti-LGBTQIA+ laws are

being implemented, there may be more implicit or even explicit bias toward the LGBTQIA+ community among providers, patients, or both.

Performing a knowledge-and-attitudes survey on LGBTQIA+ health could be a good starting point to gauge clinicians’ self-perceived comfort and clinical competence regarding LGBTQIA+ health. “It’s important to distinguish between comfort and clinical competence,” Dr. Khanijow said. “Someone may want to be an ally and be comfortable working with LGBTQIA+ peers, but not feel competent about LGBTQIA+ health.”

Conducting a survey can show where a hospital community stands. “Then, determine which misconceptions or biases employees may have, and address them through education,” Dr. Khanijow said. “As an ally, it’s important to remember that some LGBTQIA+ people may keep this information confidential, so when planning events or activities specifically geared toward this community, be sure to invite everyone.” ■

Karen Appold is an award-winning journalist based in Lehigh Valley, Pa. She has more than 25 years of editorial experience, including as a newspaper reporter and newspaper and magazine editor.



“My SFHM designation allowed me to connect with other hospitalists and gave me national recognition among my peers. Ultimately, this led to growing leadership roles both at SHM and at my home hospital.”

- Kierstin Kennedy, MD, MSHA, SFHM



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Our SHM Village

By Khaalisha Ajala, MD, MBA, FHM

I've wanted to be a doctor for as long as I can remember. I wasn't sure how to get there, and as an inquisitive child I had a lot of questions. "Is it hard to be a doctor?" "How much is medical school?" "How can I find a mentor?"

Black physicians represent 5% of all U.S. physicians.¹ This number has not increased since 1978. The number of Black male physicians has declined despite increased enrollment in colleges and universities. To increase these numbers, as well as those of Indigenous, Latino, and LGBTQIA+ physicians, we must be intentional. We must be creative and make this work a priority.

SHM asked itself a few important questions. "What are our priorities in diversity, equity, and inclusion?" "How can we create sustainable solutions?" In response, a diversity, equity, and inclusion (DEI) task force was formed which included members of the SHM DEI special interest group as well as other motivated SHM leaders. Our task force evolved into a committee that crafted a longitudinal plan to do this work and help us find our answers.

One of the DEI committee's priorities is to help medicine reflect the communities we serve. We sought to do this by being the



Dr. Ajala

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mentors we wished we had when we were younger. We all recall the village that helped us become the physicians we are today. We all need to be a part of that village for someone else. To that end, I'm proud to say we hosted our second annual SHM Village Day at SHM Converge in March.

Many times, it has been said that it takes a village to accomplish many things. It still rings true. Indeed, it takes a village to become a doctor, whether it comes as the support of an advisor or professor, or as help from a faculty physician who taught you how to improve your presentation for rounds. It might have been the nurse who helped you as a new intern or the environmental services staff member who encouraged you to keep going on a rough day. Members of our village are present at various points of our path.

It has been my intention, along with those of my fellow SHM DEI committee members, to help create this sense of extended community in the lives of URiM (underrepresented in medicine) medical students and residents. They may have an interest in other medical fields, but they will always have a village among SHM members.

One of the joys of hospital medicine is how we engage so many subspecialties. Our annual SHM Village Day at Converge is a day where URiM learners at various stages of their path to medicine spend half a day with members of SHM in each city where we hold our annual conference. We engage and partner locally with organizations and medical schools to invite residents and medical students and provide a meaningful day at Converge. Erasing barriers to medical education includes addressing financial barriers, and that's why SHM offers an annual DEI scholarship (made possible by keystone sponsor, Vituity) to a URiM U.S. medical student who's interested in hospital medicine. Now that is moving with intention!

Society memberships and conferences are expensive for learners. The cost alone can be a deterrent, so we decided to make SHM Converge registration free for these learners. Hospital medicine is still young. The challenge a hospitalist may face when participating in national efforts to create and strengthen the URiM pipeline is helping learners understand who we are and what we do. This allows us to share the possibilities of hospital medicine and how one can craft a very specific career in global health, health policy, medical education, quality improvement, pediatric hospital medicine, DEI, and so much more. We also delight in helping learners connect with our vast network of colleagues in other fields.

Often, we are excited to engage the next generation of physicians but feel stifled by the time constraints of busy clinic days, hospital rounds, and family responsibilities. Converge offers a great opportunity to bring together physicians and learners for direct interaction and allows us to build a mentorship network in every city where we host our annual national



meeting. Everyone wins!

We hosted the first SHM Village at Converge 2022 in Nashville, Tenn. Nashville is home to several historically Black colleges and universities including Meharry Medical College, Fisk University, and Tennessee State University. The conference was less than seven minutes away from Meharry, where there were medical students with an interest in internal medicine, pediatrics, surgery, and internal medicine-psychiatry.

I contacted the chapter president of the Student National Medical Association at Meharry. She helped me place an all-call to medical students who might be interested in attending Converge for a half-day. We offered spaces on a first-come, first-served basis and were able to connect with seven interested second-, third-, and fourth-year medical students.

To my surprise, the students responded within 48 hours of the all-call. Students who were not very familiar with hospital medicine went to the SHM page link embedded in the invitation. They learned more about SHM and the opportunity of free membership for medical students. Their itinerary consisted of five hours of meaningful activity so as not to interrupt their entire day.

SHM chief of staff Jenna Goldberg and I created a sense of connection with the learners through the consistent communication leading up to Converge. We were excited to meet one another amid the vibrant energy of the Nashville conference. One can't go wrong with SHM swag bags and lunch in the large dining area. Amid the buzz, we aimed to break bread with one another and discuss our individual paths to medicine. We were able to get to know one another and had an in-depth conversation about health equity and the need for more Black physicians with various lived experiences.

I expressed my gratitude for Meharry's legacy as a Tennessee State University graduate and the thousands of Black physicians

that it had produced since 1872. It also produced one of my amazing mentors, Dr. Kimberly Manning, a professor of medicine and associate vice chair of diversity, equity, and inclusion in the department of medicine at Emory University School of Medicine in Atlanta, and the recipient of the inaugural Excellence in Diversity Leadership award in 2020.

We attended the session "Protecting Our Patients and Trainees From Physician Unconscious Bias." They enjoyed the session because it helped them further build a lexicon around this topic and empowered them to further verbalize their lived experiences or be an upstander for patients and colleagues.

We ended the day with me moderating a roundtable with leaders in hospital medicine including Dr. Eric Howell, SHM's CEO; Jenna Goldberg; Dr. Dan Dressler, professor of medicine and director of internal medicine teaching services at Emory University School of Medicine; Dr. Emily Malin, assistant professor of medicine at the University of Arizona College of Medicine, Phoenix, Ariz., and the director of the academic hospitalist service at Banner-University Medical Center Phoenix; and Dr. Amira del Pino-Jones, associate professor, division of hospital medicine, and associate dean for diversity, equity, and inclusion at the University of Colorado School of Medicine in Aurora, Colo. We asked the students to share stories about their "why," which is what keeps them going on their path to medicine even when things get tough. Each of us gave direct support and feedback and even shared our journey. We had some laughs as well as a heartfelt conversation. We may have walked into the room as strangers, but we left as a village.

The students commented that they felt that our intentions were authentic and that meant the world to us because they were. We didn't stop there! I hosted several one-on-one follow-up meetings via Zoom to further discuss their goals and questions about medicine. We

were able to share the opportunity for students to apply for a hospital-medicine away sub internship at many programs, including a rotation at Johns Hopkins School of Medicine in Baltimore. Guess what? One of our fourth-year medical students, Idris Kosoko, applied for and was accepted to the external rotation! It was a success. He learned a lot and made a few long-lasting connections. During this most recent match cycle, he matched to the internal medicine residency at Johns Hopkins!

We continued with three optional group check-ins where we asked the students how we could best serve their needs. This was important to us as we wanted to create a mentorship partnership with their direct input. The first two check-ins were with our chief of staff, the chair of our DEI committee, and me. The third check-in was a session of mini-mock interviews with SHM members who are national leaders in medical education. The students were matched with their subspecialty of interest. The mock interview included feedback. We found it important to continue to have a presence during their matriculation so that when the opportunity for mentorship presented itself at various stages, we could be an additional resource. I continue to mentor a few of the students, and it has been an amazing experience. They help me pay it forward as we group-mentor URiM students in undergraduate programs at institutions such as the Xavier University of Louisiana in New Orleans. A true pipeline. A true village.

This year, at SHM Converge 2023 in Austin, Texas, we expanded our village and joined forces with Dr. Ryan Sutton, assistant dean of diversity, equity, and inclusion at Dell Seton Medical School at the University of Texas- Austin. The students and residents were from diverse backgrounds such as Latino, Black, Indigenous, and LGBTQIA+.

We were excited and grateful for this opportunity, and we won't stop there. We will continue to build bonds and offer optional sessions throughout the year that can help these learners move forward on their paths to medicine. It's a wonderful time to be a part of an organization that believes in true partnership and innovation. We will continue the work to diversify not only hospital medicine but medicine at large. I am excited about the future of SHM Village, and I am grateful to our DEI committee for the continued excitement and support for this effort.

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SIG Spotlight: Family Medicine

By Richard Quinn

Hospital medicine is often synonymous with internal medicine, but as Bob Dylan famously said, the times they are a-changin'.

Family-medicine-trained hospital medicine practitioners may only represent 10 to 15% of practicing hospitalists, but they are a growing subgroup in the specialty, and the leaders of SHM's Family Medicine Special Interest Group (SIG) aim to make that known as often and as loudly as they can.

"Family medicine historically has been looked at as traditional outpatient practice," said the SIG's immediate past president Shyam Odeti, MD, MS, FAAFP, MBA, SFHM, section chief of Carilion Clinic in Roanoke, Va.



Dr. Odeti

In the early days of hospital medicine, "there were not many organizations that were too familiar with family medicine physicians taking care of hospitalists' roles," he said. This perception has improved, but isn't completely gone. "So, one of the biggest advocacy initiatives is, 'How do we make sure all the organizations across the nation know that family-medicine-trained physicians' training during their residency programs adequately prepares them for the inpatient medicine practice?'"

Advocacy began with statements of support from SHM and the American Academy of Family Physicians. But to keep the progress rolling, the SIG acts as a real-time advocacy platform for its 1,129 members.

For SIG chair Usman Chaudhry, MD, FHM, advocacy often starts with recruiters and medical directors hiring physicians in the first place. "They should



Dr. Chaudhry

be comfortable hiring them in their programs," said Dr. Chaudhry, a family-medicine hospitalist medical director with Texas Health Physicians Group in Flower Mound, Texas.

SIG vice-chair Krishna Syamala, MD, FAAFP, says a basic step for health care is for many institutions to change hospital bylaws, some created 25 or 50 years ago, long before hospital medicine became a specialty. Protocols that don't account for family-medicine-trained hospitalists may not seem important, but some of the SIG leaders' experiences suggest otherwise. They've secured positions in hospital leadership roles that were advertised for internal-medicine trained hospitalists exclusively.



Dr. Syamala

"They ended up in their roles because of their exemplary track records, experience, and their ability to make a case for their roles," said Dr. Syamala, who practices with SSM Health in suburban St. Louis. "So, likewise, I think educating more hospital medicine department chiefs, and engaging with them and advocating for taking family-medicine-trained hospitalists into their programs, I think that's where SHM is really important for us."

Another area of education is, well, education.

"When people are training in family medicine, they may not be aware of all the opportunities they would have in hospital medicine," Dr. Odeti said. "So, we want to educate the group on what opportunities we have after the training."

The SIG "reaches out to the residency programs and is also looking into reaching out to the medical students and having them be a part of the special interest group," Dr. Chaudhry said. "That will help future residents, and it will help their careers improve."

As is often the case in health care, continuing education is just as important. So family-medicine-minded hospital medicine leaders worked with the American Board of Family Medicine

(ABFM) and the American Board of Internal Medicine (ABIM) to create a pathway for practitioners with different training backgrounds to work better together.

"We had to work with ABFM and ABIM to come up with the specialized certification called designated focus in hospital medicine," Dr. Odeti said. "Once the hospitalists trained in family medicine were able to get certified after taking a test, per the Accreditation Council for Graduate Medical Education, they could be faculty in the internal-medicine training programs.

"What would that do? That would help family-medicine-trained hospitalists progress farther in their careers and be able to seek opportunities where there are internal-medicine residents in a program, and that would not become an exclusion factor for them for being hired."

The SIG's leadership board is focusing on advocacy not just with SHM and hospitalist leaders nationwide, but with stakeholders from the American Academy of Family Physicians, ABFM, ABIM, and other physician associations that have a role in spreading the word. Steps as seemingly simple as creating training modules within each specialty that recognize the roles played by family-medicine-trained hospitalists would be a step in the right direction.

"This is a cross-organization collaboration," Dr. Odeti said, "so that we are not doing the work in silos."

One initiative gaining steam is a critical-care fellowship that the SIG is pursuing via the ABIM.

"If family-medicine-trained hospitalists are accepted by ABIM, and they are allowed to participate in academic programs as full faculty members, it will be a big change in practice," Dr. Syamala said. "The critical care pathway is one option that will be open. Also, other fellowship options will be open for us, like endocrinology, rheumatology, and so on and so forth." ■

Richard Quinn is a freelance writer in New Jersey.



Chapter Spotlight: St. Louis

By Richard Quinn

To many, engagement is a buzzword used to make employees feel like they have a say.

To Farzana Hoque, MD, MRCP (UK), FACP, FRCP, it's the path to value. So as president of the St. Louis chapter of SHM, she knows she has to keep hospitalists in her region engaged if she wants them to join and be active in the chapter.

"I know we have to deliver value if we want to keep and grow our membership," said Dr. Hoque, assistant professor of medicine and acting internship co-director at Saint Louis University School of Medicine in St. Louis. "They need to feel that they are winning. That's why we all focus to have important, relevant topics that our hospitalists will benefit from."

Never was that sense of engagement tested like it was during the COVID-19 pandemic.

"We faced challenges like every other chapter in America—but our chapter leadership did not stop," Dr. Hoque said. "We focused on virtual meetings. We published newsletters, and those highlighted chapter leaders, their achievements, their contributions—and that was inspiring to the other members."



Dr. Hoque

Dr. Hoque is working on plans to institutionalize the newsletter idea, to keep members tethered to each other on a more formal basis.

"That newsletter will highlight some of the successful hospitalist journeys," she said. Hospitalists "will share their challenges. I think that will not only inspire the early-career hospitalist but the mid-career hospitalists, as well."

One of the other lessons learned from the pandemic adjustments is the value of virtual connectivity.

"I believe that the virtual world has opened doors for us," said Dr. Hoque, who took over as president of the St. Louis chapter in April 2022. "For example, we had a great collaboration with our Kansas chapter. We did two programs. One program was an in-person point-of-care ultrasound workshop where we brought standardized patients so our participants could gain hands-on experiences, and the other was about advocacy in health care."

Another lesson of the pandemic is the value of hearing from other colleagues in the specialty. To Dr. Hoque, that means casting "wider nets."

"I believe SHM is an inclusive platform," she said. "The hospitalists should be represented from all aspects of the specialty. For example, we focused on having membership from academic hospitals and community hospitals, and I'm very happy to share that right now we have almost 50% more engagement from providers than the last year. We have some very

new hospitalists, as well as seasoned hospitalists who have been practicing for almost 40 years and are maybe department chairs. We have a wide variety of hospitalists in our chapter, which we are very proud of."

Not that Dr. Hoque is satisfied.

"We are still facing challenges in bringing in more women hospitalists," she said. "I understand they have a lot of family commitments that may be challenging for them to come regularly. I'm working on having a pipeline for our chapter to have more engagement from women hospitalists."

Dr. Hoque is also working on creating an early-career hospitalist mentorship program, "where a seasoned hospitalist can have at least quarterly communication with our early-career hospitalists." She'd additionally like to see more pediatric hospitalists involved as well as making sure that the chapter adheres to diversity, equity, and inclusion principles that help ensure its board reflects its membership.

"Those are some solutions we are working on to overcome the challenges of engagement," she said.

Professional growth doesn't just happen within hospitals, Dr. Hoque says, so the chapter is giving hospital medicine professionals a chance to fill more roles within the chapter. Dr. Hoque created a new role, director of membership development—again, think engagement and value—that would be a leadership role within the chapter. In addition, there is a new advisory board role and a plan to create

another board-level seat for an advanced practice professional.

Another avenue of additional engagement was the chapter's Hospitalist Day back in September 2022, which was co-branded with the Missouri chapter of the American College of Physicians (ACP) for the first time.

"I believe this was a huge success and shows the collaboration between ACP and SHM at this regional level. We are optimistic and planning further ACP/SHM celebrations to celebrate Hospitalist Day," she said.

And—this being a chapter, of course—let's not forget the poster competition.

"One of our huge successes is our poster competition," she said. "And not just the medical students and residents. A couple of fellows also joined our poster competition. We were surprised to know that we received three times more submissions than we were expecting."

Why the success?

Well, engagement.

"As a leader, I truly get the opportunity to engage with other physicians," Dr. Hoque said. "Maybe they are seasoned hospitalists. Maybe they are residents. I get to know them and learn from their experiences. I can share what challenges I'm facing, and what challenges they're facing. I think it's a win-win situation for all the chapter leaders and participants: learning and networking opportunities." ■

Richard Quinn is a freelance writer in New Jersey.

Multiverse of Medicine



By Adam Gray, MD, Paula Skarda, MD, and Ethan Molitch-Hou, MD, MPH

A captivating feature of hospital medicine is its variety and flexibility. This manifests daily in our clinical duties caring for a wide spectrum of patients and diseases. While our hours are long, we also generally have some control over our average day's workflow. This variety and flexibility extend to our longer-term career aspirations. Given our broad medical knowledge and experience with the intricacies of the hospital system, we hospitalists often find ourselves involved in additional leadership roles. Here, we outline several hospital medicine career pathways including early tips for involvement in hospital leadership, quality improvement and research, education, and primary clinical care.

Leadership

Hospital medicine is often the largest division, section, or practice group within the hospital and is integral to clinical service, interacting with all care teams and medical specialties. Thus, it's not surprising that numerous leadership roles may be available within the internal medicine department and across the hospital system. Hospitalists are well suited for a

variety of hospital leadership roles such as division chief, department chair, information technology director, utilization management director, vice president of medical affairs, and chief of staff or chief medical officer. Hospital leadership roles can be extremely rewarding and have the ability to positively impact global change affecting thousands of patients and practitioners. In these roles, hospitalists can reason through day-to-day hospital functions and develop strategies and ideas to position the hospital for the future.

Early-career hospitalists can get a sense of what hospital leadership looks like by joining hospital committees such as patient care committees, credentialing committees, or a variety of interdepartmental work groups. These are great ways to grow professionally and understand and troubleshoot systems issues. For those passionate about hospital leadership, it's often worth pursuing additional local leadership training (e.g., the SHM Leadership Academy), and/or post-secondary education such as a Master in Business Administration.

Quality improvement and research

Being on the front line for inpatient care can lead directly to research and quality improvement to improve best practices. The pan-



Dr. Gray



Dr. Skarda



Dr. Molitch-Hou

Dr. Gray is a hospitalist and clerkship director at the University of Kentucky, Lexington. Dr. Skarda is a hospitalist and primary internist at HealthPartners and Regions Hospital in Saint Paul, Minn. She is also an associate program director for the University of Minnesota Internal Residency Program and chair of credentialing at Regions Hospital. Dr. Molitch-Hou is a hospitalist and assistant professor of medicine at the University of Chicago, Ill. This content is provided by the SHM Physicians in Training committee, which submits quarterly content to The Hospitalist on topics relevant to trainees and early-career hospitalists.

demographic exemplified our critical role in clinical research as hospitalists joined in recruiting and organizing randomized controlled trials for COVID-19 treatments. As experts in the hospital system, we are also exposed to challenges in the direct implementation of care. Quality improvement is critical in making systems work and providing evidence-based care. Hospitalists are exposed to system-based errors that impact clinical care and can help navigate barriers in order-set creation, protocol development, and care-change implementation, assuring direct-care practitioners

have input into the process. Experience in quality improvement and research can lead to funded positions and potential opportunities as task-force and committee leaders, quality directors, chief quality officers, and funded researchers. Satisfaction in a quality-improvement and research career can be considerable; knowledge to improve patient care can be disseminated and impactful on numerous health systems and millions of patients.

Building this as part of your career can be accelerated by connection with appropriate mentors

who can connect you to studies and committees. Additional training in quality improvement such as Plan-Do-Study-Act or courses on hospital quality improvement (e.g., SHM Quality Improvement Academy) or research can help you better understand how an effective intervention can impact the hospital and, most importantly, patients.

Education

Whether at an academic center, a residency-affiliated hospital, or a community hospital, there are many opportunities to become a skilled physician-educator. Opportunities exist at academic centers within the medical school to serve on educational committees, as small group leaders, as pre-clinical or clinical course directors, or in the dean's office. Within residency programs, there are opportunities to become rotation directors, core faculty, and associate program directors. In these roles, there is time set aside to develop specialized rotations and curriculum or to manage educational sites, rotations, and workload aimed at improving the skillset of our future colleagues. In a community hospital setting, you can seek out opportunities to teach colleagues integral to hospital medicine, such

as junior physicians, advanced practice clinicians, or pharmacy students. There may be opportunities for medical-student teaching as well. The benefits of an educational career are the development of long-lasting relationships with your learners and the positive impact on the development of numerous future providers.

Get involved early in your career by taking on a learner in the clinical setting. If you enjoy teaching, join an educational committee, volunteer for residency interviews, or develop an educational session for the learners at your site. Opportunities typically evolve from there, so follow the path you find most fulfilling. Seeking faculty development conferences (e.g., Academic Hospitalist Academy) and mentorship can open up further opportunities and stimulate growth.

Clinical

Lastly, it should be emphasized how important a primary clinical career caring for patients can be. Hospitalists are the backbone of direct inpatient care throughout the U.S. We continue to grow in our clinical roles at every type of institution, whether at a rural community hospital or an academic hospital in the city. We went into

medicine to care for patients. Our enjoyment of the acute care of hospitalized patients, seeing them through admission to discharge, is what drove us to hospital medicine. Our roles vary vastly from working in intensive care units, through telemedicine, on direct care subspecialty services, and as consultants and co-managers of surgical patients. Some work with outpatients in consultative medicine or post-discharge clinics. In the community, we may be the primary service for all inpatients, with other services serving in a consultative role. At academic institutions, expectations may extend beyond just clinical care. In the current environment, residency programs are limited in positions available, and residents are limited by work hours with hospitalists shouldering more of the clinical workload. This has led to an increase in purely clinical jobs at academic hospitals.

Building a clinical career takes knowing what environment you want to work in and knowing what patient population you want to serve. However, flexibility remains throughout your career for transforming your role. Payment structures vary when you are primarily clinical. There may be a higher relative value units burden

when focused solely on clinical care, which can lead to a higher, but possibly less regular, salary. In the community, you may work for a larger organization rather than the hospital itself. Expectations beyond clinical care are minimal, aside from standard annual training and certification maintenance. You may be asked to work as a contractor rather than a full employee with benefits, especially if seeking part-time work.

Gratification from a primary clinical career comes with the fulfillment of helping care for patients in a time of need, factors that drove many of us to a career in medicine in the first place. You can also develop a niche in clinical care, including targeted work with subspecialized populations such as hospital management of oncologic or transplant patients, or in specific treatments such as anticoagulation.

Summary

Hospital medicine provides a plethora of diverse opportunities for career fulfillment. Early-career hospitalists should consider initial opportunities and faculty development in different domains to see what sparks their passion and brings them the most joy. ■



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