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The Hospitalist

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Dr. Ian Jenkins talks about healthcare for LGBTQIA+ individuals

Leslie Boehl Photography

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IN THE NEXT ISSUE...
SHM Converge 2025 coverage

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The Hospitalist

From *JHM*

The *Journal of Hospital Medicine* Editor's Pick this month is Optimizing Learners on Direct Care Teaching Services: A Qualitative Study of Hospitalist Clinicians at 26 Sites, written by Catherine Callister, MD, Gopi Astik, MD, MS, R. Matthew Atkin, MD, Angela Alday, MD, Khooshbu Dayton, MD, Angela Keniston, PhD, MSPH, Anne Linker, MD, Lauren McBeth, BA, John Merriman, MD, MPH, Sara Westergaard, MD, MPH, Amy Yu, MD, Andrew Auerbach, MD, MPH, and Marisha Burden, MD, MBA.

Academic medical centers are experiencing rapid clinical growth, which has outpaced traditional teaching services. Learners such as medical students, advanced practice provider fellows, and residents may be placed onto inpatient services where attendings provide both direct care to patients and supervise learners, creating potential challenges for attending physicians due to clinical demands. The study aims to characterize the hospitalist experience with direct care teaching services. Scan the QR code to read the full study. ■

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The Hospitalist is looking for SHM members to interview for these upcoming articles:

Unions: Members who've been in a union and ones who've chosen not to join

Celebrating Women: Women in hospital medicine working to improve healthcare for women

Non-VA: Members who work in Army/Navy hospitals (non-VA)

HIV/AIDs Medicine: Members with experience in the evolution of the treatment for HIV/AIDs and how they've influenced treatment for other diseases

If you'd like to be considered a source for any of these articles, email lcasinger@wiley.com. ■

THE Hospitalist®

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

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In the Literature

MaineHealth Maine Medical Center

By Christina Tsui, DO, Kenleigh Hebel, DO, Raymond Klein, MD, Matthew Clark, DO, Nellie Wood, MD, Meagan Clark, MD, Michael Tozier, MD, and Lesley B. Gordon, MD, MS

MaineHealth Maine Medical Center, Portland, Maine

IN THIS ISSUE

By Christina Tsui, DO

1 Antibiotic Treatment for 7 days is Noninferior to 14 days in Patients with Uncomplicated Bacteremia

CLINICAL QUESTION: Is seven days of antibiotic treatment for bloodstream infections noninferior to 14 days of treatment?

Dr. Tsui

BACKGROUND: Bloodstream infections are very common, can originate from a variety of infectious foci, and are highly lethal. Randomized controlled trials have shown that shorter courses of antibiotics for infections such as pneumonia, pyelonephritis, and cellulitis are noninferior compared to longer durations of treatment. However, these results cannot be extrapolated to treatment of bacteremia due to prior exclusion criteria or limited size of the studies. Therefore, the treatment duration of bacteremia remains highly variable.

STUDY DESIGN: Multicenter, randomized, controlled, noninferiority study

SETTING: 74 hospitals across Australia, Canada, Israel, Saudi Arabia, New Zealand, Switzerland, and the U.S.

SYNOPSIS: The study enrolled 3,608 hospitalized patients with a positive blood culture during admission and randomized them to seven or 14 days of antibiotic treatment. Exclusion criteria included severely immunocompromised status, presence of prosthetic heart valves or endovascular grafts, infections requiring prolonged treatment (e.g., endocarditis, osteomyelitis), *Staphylococcus aureus* and *Staphylococcus lugdunensis* bacteremia, and fungemia. Clinicians determined the antibiotic selection, dose, and method of delivery. The primary outcome was all-cause mortality 90 days after bacteremia diagnosis, with a non-inferiority margin of 4%. Intention-to-treat analysis found that seven days of treatment was non-inferior to 14 days (difference, –1.6%; confidence interval [CI], -4.0 to 0.8). There were no significant differences in the secondary outcomes regarding death in intensive care (-0.6%; CI, –3.2 to 1.9), death in the hospital (-1.0%; CI, -2.9 to 0.9), or relapsed bacteremia (0.4%; CI, –0.6 to 1.4).

Limitations of this work include the inability of noninferiority trials to prove identical outcomes between groups. Additionally, this study was underpowered to assess whether the longer course of antibiotics would confer a potential benefit to subgroups.

BOTTOM LINE: In hospitalized patients with uncomplicated bloodstream infections with important exclusions (e.g., *S. aureus, S. lugdunensis*, and fungemia), a clinician-driven strategy of seven days of antibiotic treatment is non-inferior to 14 days of treatment.

CITATION: Daneman N, et al; Antibiotic treatment for 7 versus 14 days in patients with bloodstream infections. *N Engl J Med*. 2025;392(11):1065-1078. doi: 10.1056/NEJMoa2404991.

Dr. Tsui is a fourth-year resident in internal medicine and pediatrics at Maine Medical Center-Tufts University School of Medicine in Portland, Maine.

By Kenleigh Hebel, DO

2 Restrictive Transfusion in MI May Lead to an Increase in 6-Month Mortality

CLINICAL QUESTION: How does a restrictive transfusion strategy (transfusion threshold of 7 to 8 g/dL) compare to a liberal transfusion strategy (transfusion threshold of 10 g/dL) in patients with acute myocardial infarction (MI) and anemia?

Dr. Hebel

BACKGROUND: Management of anemia in patients with acute MI is an important topic with considerable variability in practice. Generally, there has been a push towards restrictive transfusion to conserve resources and prevent adverse effects, but these patients may be especially vulnerable to physiological strain from anemia. Current clinical guidelines indicate there is insufficient data to support a strong recommendation for hemoglobin thresholds in this patient population.

STUDY DESIGN: Meta-analysis; patient-level data pooled from multiple randomized controlled trials

SETTING: Four randomized controlled trials in various clinical settings

SYNOPSIS: Investigators pooled data from four recent randomized controlled trials that evaluated lower versus higher hemoglobin transfusion thresholds for anemia in patients with MI: MINT, CRIT, REALITY, and MINT Pilot. This included 4,311 patients (mean age 72 years, 55% men). The primary outcome of death or recurrent MI within 30 days was not significantly different between groups (15% in the restrictive transfusion group versus 14% in the liberal transfusion group). For secondary outcomes, there was an increase in cardiac mortality at 30 days and all-cause mortality at six months in the restrictive transfusion group compared with the liberal transfusion group (relative risk [RR], 1.47; 95% CI, 1.11 to 1.94; hazard ratio [HR], 1.08; 95% CI, 1.05 to 1.11, respectively). Limitations included that over 80% of the participants were from MINT, and that design differences in the trials limited analysis (e.g., not all trials characterized the type of MI as type 1 versus type 2).

BOTTOM LINE: For patients with acute MI and anemia, there was no demonstrable harm of a restrictive transfusion threshold for the major outcome of death or recurrent MI at 30 days. However, it was associated with an increased risk of 30-day cardiac mortality and six-month all-cause mortality. This suggests that restrictive strategies may not be the best option universally for patients with acute MI.

CITATION: Carson JL, et al. Restrictive versus liberal transfusion in myocardial infarction—a patient-level meta-analysis. *NEJM Evid*. 2025;4(2): doi:10.1056/EVIDoa2400223.

Dr. Hebel is an internal medicine resident, PGY-2, at MaineHealth Maine Medical Center in Portland, Maine.

By Raymond M. Klein, MD

3 Efficacy of Adjuvant Corticosteroid Therapy for CAP Varied Significantly Based on C-Reactive Protein Concentrations

CLINICAL QUESTION: Can baseline C-reactive protein concentrations help identify which patients with community-acquired pneumonia (CAP) are most likely to benefit from adjuvant treatment with corticosteroids?


Dr. Klein

BACKGROUND: CAP is a heterogeneous disease and a leading cause of morbidity and mortality. The use of corticosteroids to treat patients hospitalized with CAP is evolving, and factors such as the causative pathogen may impact treatment effects. There is a widespread hypothesis that corticosteroids may provide the most benefit for patients with severe CAP. However, severe CAP does not have a universal definition, and the population that would most benefit has not been precisely identified.

STUDY DESIGN: Individual patient meta-analysis using heterogeneity of treatment effect (HTE) analysis

SETTING: Hospitals in Italy, the Netherlands, Switzerland, Spain, the U.S., and France

SYNOPSIS: The authors included eight randomized controlled trials (RCTs) comparing adjuvant therapy with corticosteroids versus placebo in patients hospitalized with CAP. The RCTs were published between 2005 and 2023 and represented 3,224 patients. Across all trials, the corticosteroid therapy group had significantly reduced 30-day mortality (6.6% versus 8.7%, P=0.017). An HTE analysis was performed on the first six studies, and C-reactive protein (CRP) was identified as an important treatment modifier with a concentration of 204 mg/L as a cutoff for predicted benefit. The resulting HTE model was then validated on data from the two most recent RCTs. Among patients with a CRP over 204 mg/L, adjuvant corticosteroid therapy was associated with significantly reduced mortality (13.0% versus 6.1%; number needed to treat, 14; $P_{interaction}$=0.026). No significant difference was observed in patients with a CRP up to 204 mg/L. There was a significant increase in hospital re-admissions and hyperglycemia associated with corticosteroid treatment. Point estimates also showed harmful effects of corticosteroids in patients with influenza, consistent with other studies. Limitations include pooling studies with significant methodological differences spanning nearly 20 years.

BOTTOM LINE: A markedly elevated CRP concentration (over 200 mg/L) may help identify patients with CAP who are most likely to benefit from adjuvant corticosteroid treatment, however, causative pathogens and risk of side effects should be considered.

CITATION: Smit JM, et al. Predicting benefit from adjuvant therapy with corticosteroids in community-acquired pneumonia: a data-driven analysis of randomised trials. *Lancet Respir Med*. 2025;13(3):221-233. doi:10.1016/S2213-2600(24)00405-3.

Dr. Klein is an attending physician and associate medical director for quality in the division of hospital medicine at Maine Medical Center in Portland, Maine, and an assistant professor of medicine at Tufts University School of Medicine in Boston.

By Matthew Clark, DO

4 Evidence for Reduced-Dose DOAC in Those at High Risk for VTE Recurrence in Extended-Phase Anticoagulation: The RENOVE Trial

CLINICAL QUESTION: Is extended-phase anticoagulation with dose-reduced direct oral anticoagulants (DOACs) as effective and safe as full-dose DOACs in those with venous thromboembolism (VTE) at high risk for VTE recurrence?


Dr. Clark

BACKGROUND: The American College of Chest Physicians published guidelines on the treatment of VTE in 2021. These guidelines recommend an extended course of reduced-dose anticoagulation (apixaban or rivaroxaban) for those at high risk of VTE recurrence in those without transient risk factors beyond the initial three months of therapy. However, there is a paucity of high-quality investigations to support the recommendation for dose reduction. The RENOVE trial, published in the *Lancet* in March 2025, aimed to assess the efficacy and safety of this strategy.

STUDY DESIGN: Non-inferiority, randomized, open-label trial

SETTING: 47 hospitals in France

SYNOPSIS: 2,768 adult ambulatory patients with symptomatic VTE (either pulmonary embolus or proximal deep vein thrombosis) who received six to 24 months of uninterrupted full-dose anticoagulation and who were felt to be high risk for recurrence (defined as unprovoked first episode of VTE or expectation of persistent risk factors) were included. Patients were randomized to receive oral treatment with a reduced-dose DOAC (apixaban 2.5 mg twice daily or rivaroxaban 10 mg daily) or a full-dose DOAC (apixaban 5 mg twice daily or rivaroxaban 20 mg daily). Over five years, recurrent VTE occurred at a rate of 2.2% in the reduced-dose group and 1.8% in the full-dose group. Clinically relevant bleeding occurred less in the reduced-dose group (9.9%) compared to the full-dose group (15.2%) over five years. Though the dose reduction did not meet the prespecified criteria for non-inferiority in preventing recurrent VTE in extended-phase anticoagulation, the real-life difference between both groups was small (19 versus 15 patients). Dose reduction, however, resulted in a statistically significant reduction in clinically relevant bleeding (HR, 0.61).

BOTTOM LINE: Given relative effectiveness and significant safety benefits, physicians should offer a reduced-dose DOAC for extended-phase treatment of VTE. This is congruent with existing CHEST guidelines on the treatment of VTE.

CITATION: Couturaud F, et al. Extended treatment of venous thromboembolism with reduced-dose versus full-dose direct oral anticoagulants in patients at high risk of recurrence: a non-inferiority, multicentre, randomised, open-label, blinded endpoint trial. *Lancet*. 2025;405(10480):725-735. doi: 10.1016/S0140-6736(24)02842-3.

Dr. Clark is a hospitalist and associate program director of the internal medicine residency at Maine Medical Center in Portland, Maine, and an assistant professor at Tufts University School of Medicine in Boston.

By Nellie Wood, MD

5 Potential Post-Discharge Benefits of Continuing Metformin During Acute Hospitalization

CLINICAL QUESTION: Does the continuation of metformin during hospitalization result in fewer post-hospitalization complications, such as hypoglycemia or death?


Dr. Wood

BACKGROUND: Despite metformin's first-line role in the management of type 2 diabetes, it is common clinical practice, supported by professional guidelines, to hold metformin in the inpatient setting due to concern for lactic acidosis. However, this association has been disputed in several studies and is based primarily on data from the older related drug phenformin. The benefits of the continuation of metformin have not been robustly studied.

STUDY DESIGN: Observational cohort study with target trial emulation

SETTING: 114 Veterans Health Administration (VHA) hospitals in the U.S.

SYNOPSIS: Using the VHA Corporate Data Warehouse, patients with type 2 diabetes prescribed metformin and admitted to a VHA hospital from 2016 to 2022 were identified (96.9% male). Exclusion criteria were glomerular filtration rate less than 30 mL/min/1.73 m² or death during hospitalization. After propensity score matching, 33,581 patients who received metformin at any point during their hospitalization were compared with an equal number for whom metformin was held. Interestingly,

SHORT TAKE

Incidence of Invasive Group A Streptococcal Infections on the Rise

By Raymond M. Klein, MD

Population-based surveillance across 10 U.S. states demonstrated that the incidence of invasive group A *Streptococcus* infections (necrotizing fasciitis or streptococcal toxic shock syndrome) increased substantially between 2013 and 2022 (from 3.6 to 8.2 per 100,000 persons, P<0.001 for trend). Incidence was highest among males, individuals aged 65 years or older, American Indian or Alaska Native persons, residents of long-term care facilities, people experiencing homelessness, and people who inject drugs. All isolates were susceptible to beta-lactam antibiotics, but there was increasing resistance to tetracyclines, macrolides, and clindamycin.

CITATION: Gregory CJ, et al. Invasive group A streptococcal infections in 10 US states. *JAMA*. 2025:e250910. doi: 10.1001/jama.2025.0910.

practice patterns varied considerably, with the proportion of patients continued on metformin ranging from 6.3 to 76.6% across hospitals. Those who received metformin had significantly fewer post-discharge hypoglycemic events, the primary outcome (1.5% versus 1.8%; OR, 0.83; 95% CI, 0.73-0.93; *P*=0.003). They also had significantly lower 90-day mortality (6.4% versus 7.4%), risk of readmission (29.4% versus 30.6%), and fewer new insulin prescriptions. Limitations include residual confounding, single health-system data, and lack of information on when metformin was initiated during the hospital stay in the metformin continuation arm of the study.

BOTTOM LINE: Though absolute risk reduction was modest, this large study shows an association with improved post-discharge outcomes when metformin is continued during hospitalization. Given no evidence of significant adverse events in prior studies, continuation of metformin should be considered during hospital stay, with the caveat that optimal time of introduction (at admission versus mid or late hospitalization) is not addressed in this study and needs to be further evaluated.

CITATION: Gallo RJ, et al. Inpatient metformin utilization and post-hospitalization clinical outcomes: an observational cohort study. *J Gen Intern Med*. 2025. doi: 10.1007/s11606-025-09384-y.

Dr. Wood is a hospital medicine attending physician at Maine Medicine Center in Portland, Maine, and an assistant professor at Tufts University School of Medicine in Boston.

By Meagan Clark, MD

6 Should Hospitalists Throw Caution to the Wind? Overly Cautious Correction of Severe Hyponatremia May Lead to Greater Harm Than Good

CLINICAL QUESTION: Does the correction rate for hospitalized adults with severe hyponatremia correlate with mortality or length of stay?

Dr. Clark

BACKGROUND: Hyponatremia is a commonly encountered problem among medically hospitalized patients, with increased prevalence among patients with comorbidities or older age. European and U.S. clinical practice guidelines recommend limits to correction rates in the first 24 to 48 hours to avoid the development of osmotic demyelination syndrome (ODS). However, more recent publications have suggested that rapid (defined here as at least eight to 10 mEq/L per 24 hours) correction rates are associated with lower mortality and no increase in occurrence of ODS compared to slower rates (slow defined here as less than eight, or as six to 10, mEq/L; and very slow as less than four to six mEq/L per 24 hours).

STUDY DESIGN: Systematic review and meta-analysis that included 16 cohort studies (14 retrospective, two prospective)

SETTING: 11 countries, 249 sites

SYNOPSIS: 11,811 patients with severe hyponatremia (sodium below 120 mEq/L) were included. Rapid correction was associated with 32 (OR, 0.67; 95% CI, 0.55 to 0.82) and 221 (OR, 0.29; 95% CI, 0.11 to 0.79) fewer in-hospital deaths per 1,000 treated patients compared with slow and very slow correction, respectively (moderate-certainty evidence). Rapid correction was also associated with 61 (RR, 0.55; 95% CI, 0.45 to 0.67) and 134 (RR, 0.35; 95% CI, 0.28 to 0.44) fewer deaths per 1,000 treated patients at 30 days, as well as a reduction in length of stay of 1.20 (95% CI, 0.51 to 1.89) and 3.09 (95%CI, 1.21 to 4.94) days, compared with slow and very slow correction, respectively (low-certainty evidence). There was no statistically significant increase in ODS events.

There are important limitations to this study, including the heterogeneity of the studies and the non-insignificant presence of confounders. Notably, primary and secondary outcomes were not available in all the studies. Additionally, the authors were not able to assess for chronicity of hyponatremia or patients' symptoms and could not perform sub-group analysis to account for the impact of co-morbidities or co-occurring acute medical conditions.

BOTTOM LINE: Very slow correction in patients with hyponatremia in the range of 115 to 120 mEq/L may be associated with a higher mortality and length of stay without an increased rate of ODS when compared to more rapid correction, but potential confounders make causality uncertain.

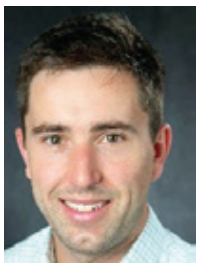
CITATION: Ayus JC, et al. Correction rates and clinical outcomes in hospitalized adults with severe hyponatremia: a systematic review and meta-analysis. *JAMA Intern Med*. 2025;185(1):38-51. doi: 10.1001/jamainternmed.2024.5981.

Dr. Clark is a hospital medicine attending physician at Maine Medicine Center in Portland, Maine.

By Michael Tozier, MD

7 Addiction Consultation and Medications for Substance Use Disorders Associated with Reduced 30-Day Readmission Rates

CLINICAL QUESTION: In patients with opioid use disorder (OUD) and alcohol use disorder (AUD), do addiction consultations or medications for opioid use disorder (MOUD) and alcohol use disorder (MAUD) impact 30-day readmission rates?



Dr. Tozier

BACKGROUND: Patients with substance use disorders (SUD), including AUD and OUD, are often admitted to the hospital and have higher rates of readmission once discharged. Prior studies have shown a variety of benefits of addiction consultation, MOUD, and MAUD, though few have examined readmission rates specifically.

STUDY DESIGN: Single-center, retrospective cohort analysis

SETTING: Massachusetts General Hospital in Boston

SYNOPSIS: Investigators examined admissions from 2019 through 2023 and identified 19,697 admissions in 10,453 patients with SUD. The examined exposures were addiction consultation and prescription of MOUD (buprenorphine, methadone, or extended-release naltrexone) or MAUD (naltrexone, acamprosate, disulfiram, topiramate, or gabapentin). The primary outcome was 30-day readmission rates at the same hospital. Overall readmission rates were 16.7% with addiction consultation and 20.4% without consultation (RR, 0.82; CI, 0.75 to 0.89).

Among patients with OUD, addiction consultation was associated with a reduction in readmissions (RR, 0.77; CI, 0.68 to 0.87), as was prescription of discharge MOUD (RR, 0.83; CI, 0.73 to 0.94). For AUD, prescription of discharge MAUD was associated with a reduction in readmissions (RR, 0.77; CI, 0.66 to 0.89), though the association with addiction consultation was not statistically significant (RR, 0.91; CI, 0.83 to 1.01).

Limitations include the inability to capture methadone administered at outpatient clinics and generalizability beyond this single center and its addiction consult team. In addition, there may be uncaptured confounders, including the patients' baseline motivation.

Despite the limitations, this study demonstrates a significant association between two low-risk interventions and a reduction in readmission rates.

BOTTOM LINE: In this single-center retrospective analysis, addiction medicine consultation and prescription of MOUD or MAUD were associated with lower readmission rates in patients with OUD and AUD.

CITATION: Lambert E, et al. The impact of addiction consultation and medication for opioid or alcohol use disorder on hospital readmission. *J Gen Intern Med*. 2025. doi: 10.1007/s11606-024-09301-9.

Dr. Tozier is a hospital medicine attending physician at Maine Medical Center in Portland, Maine, and an assistant professor at Tufts University School of Medicine in Boston.

By Lesley B. Gordon, MD, MS

8 Health Systems and Prescribers Can Favor a Single Triple-Therapy Inhaler in COPD that Both Improves Patient Outcomes and Reduces the Climate Impacts of Healthcare

CLINICAL QUESTION: How do the two available (U.S. market) single triple-therapy inhalers compare in terms of safety and efficacy for patients with chronic obstructive pulmonary disease (COPD), with the background knowledge that one of these inhalers has much lower global warming potential?

Dr. Gordon

SHORT TAKE

Midline Catheters Did Not Meet Noninferiority Criteria When Compared to PICC

By Lesley B. Gordon, MD

This randomized clinical trial at a single center compared patients with peripherally inserted central catheters (PICC, n=148) to peripheral midline venous catheters (MVC, n=146) and found that MVCs had a 33% rate of adverse events or dysfunction compared to 7% in the PICC group, driven by partial occlusion events. Rates of complete occlusions and bacteremia were similar between groups.

CITATION: Bentridi A, et al. Midline venous catheter vs peripherally inserted central catheter for intravenous therapy: a randomized clinical trial. *JAMA Netw Open*. 2025;8(3):e251258. doi: 10.1001/jamanetworkopen.2025.1258.

BACKGROUND: Single triple-therapy inhalers containg inhaled corticosteroids, long-acting beta 2-agonists, and long-acting muscarinic antagonists (ICS-LAMA-LABA) confer benefit to certain patient populations with COPD, including patients who experience exacerbations despite dual therapy (LAMA-LABA). In the U.S., there are two such inhalers available: fluticasone-umeclidinium vilanterol as a once daily dry powder inhaler (DPI), and budesonide-glycopyrrolate-formoterol as a twice daily metered dose inhaler (MDI), which have never been compared head-to-head. Notably, MDIs confer an approximately 20 times higher greenhouse-gas footprint as compared to DPIs, related to the potent greenhouse-gas propellants currently used in MDIs, hydrofluoroalkanes. Health systems around the world have been targeting MDIs for replacement with DPI due to the positive impact on climate change.

STUDY DESIGN: One to one, propensity score matched, new user, cohort study

SETTING: Optum's database of administrative health claims

SYNOPSIS: Participants had COPD, were at least 40 years old, and were new users of single-inhaler triple therapy. The main outcomes were first moderate or severe COPD exacerbation (effectiveness) and first admission to hospital with pneumonia (safety). There were 20,388 propensity-score-matched pairs of new users. Those who received budesonide-glycopyrrolate-formoterol MDI had a 9% higher incidence of first moderate or severe COPD exacerbation (HR, 1.09; 95% CI, 1.04 to 1.14) and an equivalent incidence of first admission to hospital with pneumonia compared with patients receiving fluticasone-umeclidinium-vilanterol DPIs. The authors pose several possible reasons why the patients receiving fluticasone-umeclidinium-vilanterol DPIs had lower incidence of COPD exacerbations: 1) it was once daily versus twice daily, thus possibly enjoying better adherence; 2) MDIs necessitate timing of breaths with action, but DPIs just need deep breaths; and 3) perhaps it is the medications themselves.

BOTTOM LINE: Health systems can "breathe easy" by moving their single-inhaler triple therapy to fluticasone-umeclidinium-vilanterol DPIs; this study demonstrates effectiveness and safety, while reaping the known benefits of a DPI's lower global warming potential as compared to an MDI that utilizes hydrofluoroalkanes.

CITATION: Feldman WB, et al. Comparative effectiveness and safety of single inhaler triple therapies for chronic obstructive pulmonary disease: new user cohort study. *BMJ*. 2024;387:e080409. doi:10.1136/bmj-2024-080409.

9 Naturalized Citizen and Noncitizen Immigrant Healthcare Workers are Important Members of the Workforce

CLINICAL QUESTION: How do the Trump administration's plans for deporting undocumented immigrants and some individuals with temporary protected status impact the already strained healthcare workforce?

BACKGROUND: Hospitalists are well aware of the ongoing shortage of nurses and other healthcare workers and have witnessed firsthand the impact of staffing challenges on patient care. Two-thirds of hospitals were noted to operate below full capacity in 2023, largely due to staffing shortages. Additionally, a lack of skilled nursing facility and home healthcare workers may delay discharges from hospitals, further bottlenecking care.

STUDY DESIGN: Descriptive study using Current Population Survey (CPS) and Census Bureau person-level weights

SETTING: CPS, a nationally representative sample of the noninstitutionalized U.S. population

SYNOPSIS: The authors estimated the number of naturalized citizen immigrants and noncitizen immigrants and then identified the proportion that lack official immigration papers (undocumented) who are employed in a wide range of healthcare settings (e.g., hospitals, outpatient clinics, nursing homes, home care, and private households). They estimated that 2,319,224 naturalized citizen immigrants and 1,064,147 noncitizen immigrants (698,000 documented, 367,000 undocumented) work in the U.S. healthcare system. Noncitizen immigrants accounted for at least 10% of workers for home care agencies and non-formal home settings, 7% of nursing home workers, and 4% of hospital and outpatient clinic workers. Notably, more than three-quarters of the 55,802 noncitizen physicians worked in hospitals, accounting for 8.8% of all physicians in this setting.

BOTTOM LINE: Immigrant healthcare workers have played and continue to play an important role in providing clinical care in the U.S.; policies that negatively impact the ability of this group to begin or continue to work in this arena will negatively impact healthcare.

CITATION: Azaroff LS, et al. Deporting immigrants may further shrink the health care workforce. *JAMA*. 2025:e253544. doi: 10.1001/jama.2025.3544.

Dr. Gordon is associate program director of Maine Medical Center's internal medicine residency program, a hospital medicine attending at Maine Medical Center in Portland, Maine, and an assistant professor at Tufts University School of Medicine in Boston.

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The National Hospital Medicine Writing Challenge

Registration opens June 7

By Mary Ann Kirkconnell Hall, MPH, and Angela Keniston, PhD, MSPH

It is highly unlikely that any hospitalist, academic or otherwise, has ever complained that they have too much time for writing or that writing is too easy. Even professional writers often struggle to find and maintain a consistent writing discipline. Alex Arges, MD, a hospitalist at Emory University in Atlanta and past participant in the challenge, said, "Allocating time to write is often a barrier for busy clinicians," and hospitalists are some of the busiest, especially during service blocks.

In 2021, Marisha Burden, MD, MBA, and Angela Keniston, PhD, MSPH, both of the University of Colorado at Anschutz in Aurora, Colo., co-founded the National Hospital Medicine Writing Challenge to inspire and encourage hospitalists and other hospital medicine staff to establish a daily writing practice through a light-hearted, friendly competition. They sought to build a community of hospitalists who wanted to write but were hesitant or who had trouble finding time to write, from seasoned hospital medicine scholars to people who have never written outside of school or work assignments in their life.

The idea for the challenge emerged from the experiences of Drs. Burden and Keniston as part of the SHM Research Committee's Innovations Subcommittee. They realized there was a significant need to foster scholarly writing and academic productivity for hospitalists—especially for those without previous experience or who were not comfortable with writing. They also recognized that even those with lots of writing experience often needed assistance holding space in their day for writing.

The first year of the challenge was co-sponsored by SHM and the University of Colorado but later moved to UC's website. Since the Challenge's founding and first round in June 2021, more than 250 individuals have participated; many participate multiple times, with an average of 53 participants per round. Each year, in two rounds (one each in January and July), participants commit to write at least 400 words on at least four days a week for four weeks. Over the years, participants have written editorials, grants, research manuscripts, promotion dossiers, poems, and even chapters of a fantasy novel.

So what actually happens in the Challenge? There are two primary components: an online daily log to track words written and projects, and weekly virtual check-ins with current Challenge co-directors Angela Keniston, PhD, and Mary Ann Kirkconnell Hall, MPH, of the Emory University Division of Hospital Medicine in Atlanta.

Participants can log in daily to record their number of words, but also the number of separate projects they are working on. A leaderboard for both individuals and teams on the Challenge website is updated each week for the greatest number of writing sessions, number of words written, and number of different writing projects, and for the group or team with the greatest number of participants.

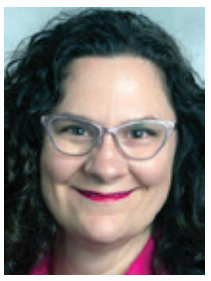
The invitations for the virtual check-ins are an hour long, with the first 20 minutes dedicated to the co-directors and participants sharing what they are working on and any challenges or successes they have experienced, and the remaining 40 minutes for dedicated, individual writing time.

The Challenge works to increase writing productivity both during and after the four official weeks of the challenge. Dr. Keniston and colleagues found that 68% of participants increased their writing during the 2021 challenge, and half planned to publish their work in the future.[1] Participants also find that the Challenge can be both an opportunity to set goals and to collaborate. Dr. Arges said, "Participating in the writing challenge incited my competitive side and forced me to write regularly. I appreciated the camaraderie of working within a team at my institution."

The Florida International University-Baptist Health (FIU-BH) PiñaMed team is a Challenge participation powerhouse. "The [National Hospital Medicine] Writing Challenge was a wonderful way to bond with scholars across the country with a common goal of dedicating some time every day to writing and scholarship. Just like going to the gym with a friend makes the workout more fun, being in a team motivated me to keep writing!" said Seema Chandra, MD. Tina Sanjar, MD, MBA, echoed the sentiment, commenting that "A writing challenge not only drives me to seek new writing opportunities for the sake of the competition but also transforms routine, mandatory, and otherwise mundane projects into fun, competitive pursuits. It turns a task into a game and drives you to want to write more to win!"

Others have found that the challenge has inspired them beyond just academic productivity and into creative writing, like FIU's JoVonnda Chresfield, MBA. "As someone who almost lost her love for writing, this challenge was my push toward sustaining a daily habit," she said. "I really enjoyed bonding with my teammates and testing new waters, like writing a perspective piece on the unique dual reality of being a patient and a healthcare professional. Just like tapping into new writing endeavors, I hope to eventually get back to previous loves like poetry."

The Summer 2025 round of the National Hospital Medicine Writing Challenge will begin Monday, July 7, and registration will open one month earlier, on June 7. The Challenge will be a key initiative of the brand-new Research Special Interest Group at SHM Converge and beyond. ■



Ms. Hall

Dr. Keniston

Ms. Hall is the senior medical writer at Emory University's Division of Hospital Medicine in Atlanta. Dr. Keniston is an assistant professor of hospital medicine and director of data and analytics at the University of Colorado Anschutz Medical Campus in Aurora, Colo.

References

1. Keniston A, et al. Utilization of a national writing challenge to promote scholarly work: a pilot study. *Cureus*. 2022;14(2):e21935. doi: 10.7759/cureus.21935.

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Setbacks, Disparities, and Long-Term Progress in Healthcare for LGBTQIA+ Individuals

By Ruth Jessen Hickman, MD

During his adolescence in conservative Virginia, Ian Jenkins felt isolated and alone as he began getting in touch with his gay identity. He didn't know any gay people, and they weren't portrayed on television. The surrounding culture was quite homophobic, and slurs, epithets, and unfair biases and judgements were commonplace.[1]

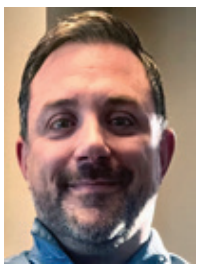
But he had a dream that one day he might be able to bring a gay partner to a holiday celebration with family members and friends without it being a big deal. He dreamt that being gay would be perceived as something akin to being left-handed—a normal variation experienced by a significant minority of the population.

Today, Ian Jenkins, MD, SFHM, is a hospitalist at the University of California, San Diego. He pointed out that since his adolescence, the broader culture has progressed significantly in terms of broader acceptance of individuals' lesbian, gay, bisexual, transgender, queer or questioning, intersex, and additional related (LGBTQIA+) identities. Some real legal gains have been made, as in the case of the Marriage Equality Act and general expansions in anti-discriminatory laws regarding sexual orientation and gender identity.

Dr. Jenkins

But recent changes in the political climate, including efforts to target diversity, equity, and inclusion (DEI) at the national level, are creating stress and anxiety for many in the LGBTQIA+ community.

"More than likely, it's forcing some younger people back in the closet," said Andrew J. Stefani, DO, a hospitalist at UnityPoint Clinic Central Iowa Hospitalists in Des Moines, Iowa. Dr. Stefani shared that some longer-term pediatric transgender patients previously seen at a local LGBTQIA+ clinic are now having to drive hundreds of miles for care they previously received in-state, due to recent state legislative restrictions on such care.



Dr. Stefani

Dr. Stefani, who is out as gay, added, "It can be really disheartening, as a provider, to not be able to directly connect them to the care they need."

The Hospitalist talked with Dr. Jenkins, Dr. Stefani, and other hospitalists about ongoing health barriers and challenges facing LGBTQIA+ individuals. They also gave insights on other important related topics, such as how hospitalists can deliver better care to these individuals, hospitalists' role as educators and advocates, and the need to stay determined and hopeful while continuing to fight for these individuals' well-being.

Progress in the LGBTQIA+ movement and current setbacks

The first major movements toward awareness of LGBTQIA+ health issues and disparities grew out of activism following the Stonewall riots in 1969, underscored by the formation of the Lesbian and Gay Health Foundation in 1977. As part of this movement, activists began lobbying the American Psychiatric Association to stop classifying homosexuality as a mental disorder in the "Diagnostic and Statistical Manual of Mental Disorders," a designation that was only fully removed in 1987.[2]

With the devastating outbreak of Human Immunodeficiency Virus (HIV) in that same decade, the LGBTQIA+ community had to channel much of its energy into advocating for the urgent needs of the gay, bisexual, and transgender people most directly affected. Damian Crawford, MD, an out gay hospitalist with Frederick Memorial Hospital and Sound Physicians, both in Frederick, Md., shared, "These days there is much less stigma about HIV, although I don't think it is completely gone."

The early 80s also saw some of the first research efforts to obtain information about these populations, e.g., through the first National Lesbian Health Care Survey.[2] These research gains especially accelerated in the 2010s, after a 2011 report from the Institute of Medicine underscored the need to address care inequalities.[3] These research gains eventually contributed to the creation of formal clinical guidelines on topics such as perioperative hormone management. However, recent federal restraints on DEI-related research funding may stall future progress.

Nicole Damari, MD, MS, a hospitalist in Cincinnati who is out as bisexual and nonbinary, said, "We've also made progress in terms of folks of diverse gender and sexual orientation being more in

Dr. Damari

the mainstream conversation. Even just the fact that I'm able to be out professionally is a huge deal compared to where we've been."

With the modern trans-rights movement, the broader culture has also become more aware of this population and their health concerns. However, this is also a subgroup that has been targeted with some of the most pushback and weaponization in the political sphere over the past decade, with legislation targeting various aspects of trans-specific healthcare issues, bathroom access, education, sports, and other topics, accelerating especially in the past few years.

Health outcome disparities

Although some metrics have improved over the past several decades, many members of the LGBTQIA+ community still face significant healthcare disparities and challenges.

On the most basic level, societal discrimination takes a personal toll. "You can't be fully happy and healthy if your mere existence drives people to discriminate against you and hold you in poor regard," Dr. Jenkins said. "It causes a kind of chronic stress. Our trans community members especially feel like they are at risk in terms of their relationships, their privacy, and their healthcare, and all of that is a huge strain on them."

On average, higher rates of mental health problems have been documented in the LGBTQIA+ community, with higher rates of depression, anxiety, and substance abuse (including tobacco, alcohol, and other drugs). Higher rates of suicide have also been found, especially in transgender and nonconforming individuals.[4,5]

Dr. Damari also noted that research has demonstrated that rates of suicidality increase after the passage of anti-LGBTQIA+ legislation.[6] She added, "The way that society stigmatizes or does not stigmatize the community has a massive impact on mental health."

Relatedly, a well-established body of research has shown that, on the whole, LGBTQIA+ individuals tend to demonstrate poorer medical outcomes, although this is heavily influenced by other factors like the specific subgroup and other intersecting factors, like race, education, socioeconomic status, housing insecurity, level of family acceptance, and geography.[5]

On average, LGBTQIA+ individuals more often engage in risky sexual behaviors, and they report higher rates of forced sexual contact, especially transgender, nonbinary, or gender-questioning individuals.[7]

Lesbians and bisexual women have a higher prevalence of several cancer types, and rates of multiple kinds of cancer are also higher in gay and bisexual men. These individuals also have higher rates of transmission of sexually transmitted infections such as HIV and viral hepatitis, as well as higher rates of body image and eating disorders.[5]

Transgender people also face specific needs related to their body modification process, such as hormones, hormone blockers, binders, and surgeries. Transgender women, especially, may experience particularly high rates of discrimination, violence, and poor health outcomes.[5]

Importantly, maladaptive coping mechanisms such as substance abuse, risky sexual behaviors, and self-harm may relate to previous negative experiences of personal rejection, victimization, and discrimination.[5]

Lack of access to informed care

Although the reasons for poorer health outcomes are likely multifactorial, the lack of access to LGBTQIA+ informed health centers is likely one contributing cause. Many people in the community report feeling uncomfortable in the healthcare system due to perceived discriminatory and biased attitudes and culturally inappropriate care.[5]

"I've met patients who didn't seek any HIV care because they did not trust doctors and felt rejected by the medical system," Dr. Jenkins said. "I've seen trans patients who stopped seeking care because they felt like they wouldn't be accepted by their doctors, or at a minimum, didn't think their doctors would know what to do about their special needs."

Unfortunately, Dr. Stefani noted this distrust may be heightened in the current climate. He explained, "To comply with federal funding mandates, organizations may have to draw back some of their inclusive language. But that also sends a devastating message to patients, who might not feel as comfortable going there."

Dr. Stefani noted that in addition to providing informed and compassionate care oneself, it can be helpful to maintain a list of practitioners who excel with LGBTQIA+ patients for referral post-hospital stay, especially if one is practicing in a more conservative region of the country. These do not necessarily need to be clinics with specific LGBTQIA+ designations, he added.

Although relative rates of coverage have improved with the Affordable Care Act and marriage equality, LGBTQIA+ patients may also be more likely to lack adequate health insurance, as plans may not cover non-traditional families or certain health services.[8] This is especially true for transgender individuals, which can cause them to delay or forego needed care due to cost.

Creating inclusive environments and building rapport

LGBTQIA+ youth who live in supportive homes have much better mental health outcomes than those who do not; moreover, individuals without family support who do have other forms of support also fare better.[9] "I think that it really provides evidence that simply by affirming somebody's identity and creating a psychologically safe space, you can have a positive impact on their mental well-being," Dr. Damari said.

Thus, although practitioners can't change the external challenges faced by these groups, they can forge positive physician-patient relationships to positively influence their mental and physical health.

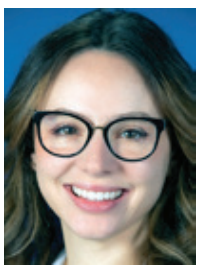
"If you don't take the time to show that you care about someone, they may not be forthcoming about their medical issues," Dr. Jenkins said. "That could cause misdiagnoses and add hospital days. It could cause poor treatment adherence [at discharge] if people don't think you care about them."

Dr. Crawford stressed the value of simple human-to-human connections in building rapport, whether that's connecting with someone from a different culture, regional identity, religious background, or someone with a different sexual or gender identity. "Even if your experience hasn't been identical, there is always something human you can connect on," he said.

Dr. Jenkins agreed, "Healthcare providers can find it difficult to connect. They may not feel sufficiently familiar with [LGBTQIA+] issues, and I think that that's okay. Every trans person I've ever met has been understanding that others won't know everything that they need or experience."

Building on rapport for better sexual history taking

Sarah L. Herrman, MD, a hospitalist at the University of California Davis Medical Center, noted that building rapport is step one in obtaining a comprehensive sexual history. Dr. Herrman is also a course director for teaching clinical skills to first- and second-year medical students, including topics such as gender-affirming care and taking inclusive sexual histories.


Dr. Herrman

A full sexual history is not necessary for all LGBTQIA+ patients being seen by hospitalists, but it's key in certain clinical contexts. Dr. Herrman noted that many trainees and even some older clinicians may be uncomfortable taking this part of the medical history, which might feel overly intrusive, but becoming competent at performing it is important for all clinicians.

A good sexual history employs open-ended questions without making assumptions, and uses specific, matter-of-fact, nonjudgmental, gender-affirming language, Dr. Herrman explained. It's also important to be especially clear to the patient about the confidentiality of the interview. She recommends the use of the "6Ps" framework, asking questions about sexual partners, sexual practices, protection for sexually transmitted infections, past history (including sexually transmitted infections and injected drugs), pregnancy desires, and sexual pleasure or

Additional Tips for Creating Safe Environments

- Don't make assumptions about anyone's sexual orientation or gender identity or make assumptions about their practices or lifestyle based on these.
- Ask to be introduced to everyone in the room, without making assumptions about people's connections or family life.
- Ask people how they would like to be addressed as a basic courtesy. If you're unsure of what pronouns to use, just ask. Apologize if you make a mistake, but don't make it a big deal.
- Use a relaxed and open body posture and empathetic tone of voice to help connect.
- Ask open-ended questions.
- If you are out, feel free to share a detail of your personal life that signals you are in the LGBTQIA+ community.
- Use visual signals to indicate a LGBTQIA+ friendly environment.
- Be sensitive and respectful when asking about potentially delicate topics.
- If people share experiences of past unpleasant healthcare encounters or other sources of bias or trauma, express empathy without downplaying their concerns.
- Maintain confidentiality and do not inadvertently out a patient who is not out, except if medically necessary.

problems.[10]

Dr. Herrman also recommended only examining body parts relevant to the specific clinical encounter. Additionally, she noted that, if needed, pelvic or urologic exams should be performed with extra sensitivity and especially clear communication, given the increased rates of past sexual trauma in these groups.

Education

All the hospitalists discussed the importance of ongoing education on these topics. Although training for medical students and residents has increased over the past decade, many current practitioners received little to no education on health topics related to LGBTQIA+ care during medical school or residency.

Added Dr. Damari, "People in the [LGBTQIA+] community have unique elements of their culture, practices, and risk factors that impact their health. We need to be knowledgeable about those and provide specific care, but we don't always get good education about those topics."

Education gaps can include both direct management techniques (e.g., hormone management perioperatively) or more subtle aspects, such as using more welcoming gender-inclusive language. To remedy these, clinicians may need to take the initiative to seek out educational resources, such as those of the National LGBTQIA Health Education Center (https://www.lgbtqiahealtheducation.org/).

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Dr. Crawford acknowledges that this gap may feel intimidating to some physicians who feel less knowledgeable and comfortable on these topics. But he urged, "Just have the same curiosity you would have about another topic you don't understand in medicine—like an unusual leukemia. That way, you can learn and provide good medical care."

Dr. Jenkins added, "I encourage providers to stay out of judgment, be open and curious, and relax. I face clinical uncertainty or unfamiliar problems all the time. You're not supposed to know everything."

Dr. Herrman noted that others in the environment may need additional education as well. "You could be a provider who is providing excellent, inclusive care and creating a safe environment. But if your ancillary staff is not educated—for example by using the wrong name or pronouns—that's still a negative healthcare interaction." When needed, it's important to give feedback to others about creating safe and inclusive environments, gently drawing it to their attention if something misses that mark.

Holding on and moving forward

Dr. Damari urges hospitalists to take seriously their role as advocates for all their patients, including members of the LGBTQIA+ community. "I think both individually and through institutions and advocacy groups, we can help translate studies so that patients and the public and legislators can be informed about what the data really mean for the health of [LGBTQIA+] people."

To LGBTQIA+ practitioners working or considering working in more conservative areas of the country, Dr. Stefani encouraged, "That visibility is important. Your presence there matters just as much now, if not more so, and there are pockets of support wherever you go."

"We can't give up all hope and all efforts to improve," he added. "But we may need to temporarily recalibrate to goals that are attainable, even if they're smaller or different in scope."

Dr. Damari agreed, "It's important that we hold on to the progress [on LGBTQIA+ issues] that we have made and not take steps backwards, because I think there is still a long way to go." ■

Ruth Jessen Hickman, MD, is a graduate of the Indiana University School of Medicine in Bloomington, Ind., and a freelance medical writer.

References

1. Jenkins IH. Reflections on marriage equality. *Ann Intern Med.* 2016;164(2):129-30. doi:10.7326/M15-1687.

2. Landers S, Kapadia F. 50 years after Stonewall, the LGBTQ health movement embodies empowerment, expertise, and energy. *Am J Public Health.* 2019;109(6):849-850. doi:10.2105/AJPH.2019.305087.

3. IOM (Institute of Medicine). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.* Washington, DC: The National Academies Press; 2011. Available at: https://nap.nationalacademies.org/resource/13128/LGBT-Health-2011-Report-Brief.pdf. Accessed April 23, 2025.

4. Narang P, et al. Suicide among transgender and gender-nonconforming people. *Prim Care Companion CNS Disord.* 2018;20(3):18nr02273. doi:10.4088/PCC.18nr02273.

5. Medina-Martínez J, et al. Health inequities in LGBT people and nursing interventions to reduce them: A systematic Review. *Int J Environ Res Public Health.* 2021;18(22):11801. doi:10.3390/ijerph182211801.

6. Lee WY, et al. State-level anti-transgender laws increase past-year suicide attempts among transgender and non-binary young people in the USA. *Nat Hum Behav.* 2024;8(11):2096-2106. doi:10.1038/s41562-024-01979-5.

7. The Trevor Project. Sexual violence and suicide risk among LGBTQ+ young people. The Trevor Project website. https://www.thetrevorproject.org/research-briefs/sexual-violence-and-suicide-risk-among-lgbtq-young-people. Published March 27, 2024. Accessed April 23, 2025.

8. Bolibol A, et al. Health insurance coverage and access to care among LGBT adults, 2013-19. *Health Aff (Millwood).* 2023;42(6):858-865. doi:10.1377/hlthaff.2022.01493.

9. McConnell EA, et al. Families matter: Social support and mental health trajectories among lesbian, gay, bisexual, and transgender youth. *J Adolesc Health.* 2016;59(6):674-680. doi:10.1016/j.jadohealth.2016.07.026.

10. National Coalition for Sexual Health. Sexual health questions to ask all patients. NCSH website. https://www.nationalcoalitionforsexualhealth.org/tools/for-health-care-providers/sexual-health-questions-to-ask-all-patients/. Updated November 22, 2023. Accessed April 23, 2025.

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Don't Throw Away Your Shot

Negotiation for hospitalists

By Joanna Bonsall, MD, PhD, FACP, SFHM, Alyssa M. Stephany, MD, MS, FAAP, PCC (ICF), SFHM, and Carrie Herzke, MD, MBA, SFHM

Many of us did not go into medicine to negotiate and so feel uncomfortable with negotiations. However, we negotiate more often in our day-to-day lives than we realize (those with children *definitely* negotiate, but we also negotiate with patients and colleagues). There are a few principles that are important to understand to be a successful negotiator.

Principle #1: Focus on interests, not positions1

Positions are specific requests or asks; interests are the desires and concerns behind each ask. To understand your interests, ask yourself *why* you are asking for what you are asking for. We often get stuck on our position ("I will not work nights") instead of our interests ("I need a predictable schedule so I can arrange childcare"). Taking the time to think about *why* you are negotiating helps you and the person you are negotiating with consider other options. It can be easy to fall back into your position, so this one takes some practice.

Principle #2: BATNA, or "best alternative to a negotiated agreement"[1]

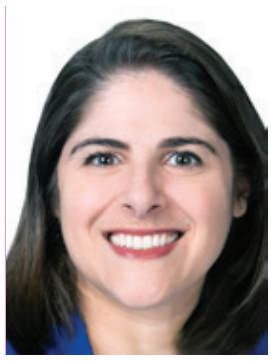
A BATNA is a list of options available to you if your negotiation is not successful. Get creative—list all the potential options that could meet your interests, then choose the best. You may even find you like one of your other options better! You may have lots of options and have a strong position in the negotiation. Sometimes, you have limited options, and that is important to consider also. Your goal is to have a BATNA that you feel good about and that is as much in your control as possible—you shouldn't rely on another negotiation if you don't succeed in the first one. As an example, if your BATNA is to resign or leave, you should make certain that you can resign in a way that doesn't derail your career and/or that there is another position or job you are certain you can take. If your plan is to switch institutions, do your research on the job market and even do some interviews.

Principle #3: Remember the relationship goals

It is important to remember that in medicine, we often work together and negotiate with the same people around many things over time. For this reason, it is important to think about how to negotiate effectively while also considering the importance of maintaining good relationships with colleagues and leaders. Effective negotiations can even improve relationships by finding mutually beneficial solutions. It is important to balance your goals for the negotiation so you achieve your outcomes but don't get so focused on maximizing your gain that you ruin the relationship. Taking time to consider the perspectives of those you are negotiating with can help you achieve your goals.

With these principles in mind, the following steps will help you prepare and navigate your next negotiation. The most important steps require some homework. Preparing is the most critical piece of any negotiation and will likely take far longer than the negotiation itself. However, putting the time into preparation will reduce your stress and increase the chance of success (and, in many cases, may lead to a solution without tough negotiation). As we walk you through the steps, we will use negotiating for protected time for an administrative role as an example.

Dr. Bonsall



Dr. Stephany

Dr. Herzke

Dr. Bonsall is an associate professor in the department of medicine at Emory University School of Medicine and the chief of Emory Medicine services at Grady Memorial Hospital, both in Atlanta. Dr Stephany is a med-peds hospitalist and the founder and president of A.I.M. Coaching & Consulting, where she works with teams and individuals in the healthcare space. Dr. Herzke is vice president of medical affairs and chief medical officer of the Johns Hopkins Hospital in Baltimore.

STEP ONE: **Identify your interests.**

Understanding your interests will allow a wider range of possibilities for negotiation and allow you to determine your BATNA. In our example, the desire for protected time is a position. Do you want administrative time because you want to feel more valued, and this would be a recognition of your work? Are you feeling burned out from clinical work and want to reduce your clinical time? Is your role taking far more administrative time than you anticipated? Each of these interests presents different alternative negotiations and different BATNAs. Keep asking *why* until you get to the core of what you want. The same applies if you are negotiating *not* to do something. Why, exactly, do you not want to do it?

STEP TWO: **Establish your BATNA.**

Once you have clarified your interests, you should develop your BATNA. What are all the possible alternatives that will still address your interests? In our example, if the reason that you are asking for more administrative time is that you don't have time to do the work, can you spread the work among other people? If you are feeling burned out from clinical work, can you reasonably afford to take a temporary salary reduction and cut back on your clinical FTE? List all the potential alternatives and then pick the best one(s).

At the end of these two steps, you should have a clear understanding of *why* you want what you want and have a BATNA that you are comfortable with. Achieving this will allow you to negotiate from a position of strength and allow you to feel more relaxed when entering the negotiation—you are clear about your needs, and you have a backup plan.

Table 1: Key Takeaways for Successful Negotiation

- Do your homework: what do you want (or not want) and why?
- Spend time thinking about your BATNA and strengthening it.
- Spend time thinking about the other party's point of view, interests, and BATNA.
- During the negotiation, listen for understanding.
- Remember the relationship goals.

STEP THREE: **Identify the interests and potential BATNAs of the people you are negotiating with.**

Understanding the interests and potential BATNAs of the people you are negotiating with will allow you to reach solutions that may be mutually beneficial and will prevent the negotiation from being a "yes" or "no" conversation. You also may be able to reframe your negotiation in a way that highlights the value of what you're asking for.[2] Consider a different example of proposing the creation of a procedure team. Your group may want a procedure team because they enjoy doing procedures and want to spend focused time on this type of work. This argument may not be meaningful to the institution but decreasing lengths of stay and increasing patient safety outcomes might be. In this case, you could frame your proposal as an improvement to patient safety rather than focusing on the desires of your group. In many situations, the "BATNA" is the status quo—how is what you're proposing better for the institution than the status quo?

STEP FOUR: **What do you ask for? Is there a mutually beneficial solution?**

Whatever you ask for should be fair to yourself and to the people you are negotiating with, as well as support your success. Rely on industry standards as much as possible—this can help provide some support to your requests. If you can't find industry standards, use your professional organizations to identify other people or groups who are working in similar environments. Consider what else you may need to support what you are asking for. In our example, how much administrative time do other people get in similar roles? In addition to more time, do you need different office space? Other administrative support?

After considering what you might request, explore additional solutions that might be mutually beneficial. Applying creativity to come up with solutions that were not originally presented can add value to both parties. Working together, can you create something more than either party would have had alone? Can you get your protected time *and* bring even more value to the institution?

STEP FIVE: **The negotiation.**

While you may be anxious to make your pitch, your first focus in the negotiation should *not* be to get your point across. Rather, your focus should be on truly understanding the other party's point of view and interests.[1-3] Specifically, you are listening for any areas of agreement and areas where you can create value for the other party.[2] You're also listening to understand why they may say no. Finding areas of agreement can help provide an anchor for the conversation, and finding areas of value can help you find easy wins. To accomplish these goals, make sure you're not making assumptions about what the other party's interests are, and during the conversation, avoid focusing on what you are going to say next.[3] Instead, use active listening techniques like asking open-ended questions and reflecting back what the other party is saying.[3] Any tools that help you understand the other party's interests will improve your chances of success—everyone is more open to ideas if they feel they are being listened to and understood.

During the discussion, continue to refocus yourself on your interests (rather than on your position) and continue internally to compare what is being offered with your BATNA. It may be helpful to avoid coming to an agreement at the time of the first conversation and allow everyone involved to think through the issues. If you intentionally set up the first meeting as an exploratory meeting rather than as a conclusive meeting, you may remove some pressure on both sides and make it easier for you to explore the other party's interests.

While negotiating can seem overwhelming, developing skills to negotiate effectively can be important for career (and personal) satisfaction. With some preparation and practice, you too can become an expert negotiator! ■

References

1. Fisher R, Ury W. *Getting to Yes: Negotiating agreement without giving in*. 3rd ed. New York: Penguin Group; 2011.
2. Bazerman MH. *Negotiation: The Game Has Changed*. Princeton: Princeton University Press; 2025.
3. Walker S. Negotiate like a pro. Harvard Business Review website. https://hbr.org/2024/03/negotiate-like-a-pro. Published March-April 2024. Accessed April 24, 2025.

What Hospitalists Should Know About ICE Visits

Hospitals need to prepare

By Thomas R. Collins and Mihir Patel, MD, MPH, FACP, CLHM, SFHM

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In the course of a hectic day with a huge patient load, the last thing a hospitalist might expect to handle is a visit from immigration officials demanding access to a patient the federal government says is in the country illegally.

But that possibility, legal experts say, has risen considerably in the second Trump administration, and hospitalists and other hospital staff should have a plan in place and be prepared to put it into action if officials from Immigration and Customs Enforcement (ICE) show up at a hospital wanting access to protected areas.

President Trump has promised to oversee the "largest deportation operation in American history." On the first day of his new term, he rescinded a Biden administration policy that protected certain areas—called "sensitive locations"—from immigration enforcement. These areas include hospitals, churches, and schools.

These policy shifts present challenges for hospitalists, who must balance patient care, legal compliance, and ethical considerations. Given their frontline role in inpatient care, hospitalists are often the first to encounter patients affected by ICE enforcement activities. Understanding how to respond in such situations is critical to preserving patient trust, maintaining hospital operations, and ensuring adherence to healthcare laws.

Tiffany Baldwin, senior counsel at the Husch Blackwell law firm in St. Louis, where she specializes in immigration law, said physicians need to know what to do before seeing ICE walk through the door.

"When it happens, it's scary, but if you know what to do, then it is much less scary and much less anxiety-producing," she said.

In Texas recently, ICE agents arrived requesting access to a patient who was recovering from surgery. The hospital's established protocol required ICE agents to present a judicial warrant before entering patient areas. Hospital leadership intervened, ensuring that the patient's medical needs were addressed before any law enforcement action occurred, highlighting the importance of preparedness and adherence to hospital policies in managing ICE interactions effectively.

In a recently published overview on how hospitals and hospitalists should prepare, Ms. Baldwin and Kelli Meilink, a partner at Husch Blackwell in Kansas City, said most hospitals should already have a policy on handling law enforcement visits, including those from ICE, and it's largely a matter of re-familiarizing the staff with that policy and practicing putting it to use.[1]

A key aspect is an "internal communication plan to control the flow of information and lessen any disruption to patient care in these situations," she said. This includes, ideally, a designated liaison knowledgeable about rights and responsibilities who can be the point of contact with ICE until legal counsel can be reached. During off hours or overnight hours, a kind of "backup" liaison should be designated as the point of contact—and that person will reach the primary liaison should they not be on site at the time, Ms. Baldwin said.

"Staff should say that they do not have the authority to answer any of the agent's questions and refer them to [an] authorized representative," Ms. Baldwin wrote in the overview. "This will avoid any action on the part of your employees that could be interpreted as consent."

A top concern is that a center, if caught off guard, might over-comply with ICE demands, which could have profound implications for patients at the hospital. Ms. Baldwin said that hospitals have not yet seen an increase in visits from ICE, although the lifting of the "sensitive locations" limitation is a sign that an increase is likely. But in other locations, when ICE has arrived, it has been with an expectation of deference.

They are "seeing, in some areas, where they come in without any warrant and expect to have the door opened and have the red carpet rolled out for them because they are ICE," she said. They might be in plain clothes and gain access to a sensitive area when an unsuspecting staff member allows them in, or they might deliberately arrive at a late or overnight hour when there are likely to be fewer administrators to ensure the law is followed.

Another important point is to require a judicial warrant—one signed by a judge or magistrate—before allowing access to a patient. An administrative warrant—signed only by someone with the agency itself—is not sufficient. Ms. Baldwin said that some law firms give the advice to simply comply if there is any type of warrant so that a hospital is not seen as confrontational or obstructing justice. She said that is not the advice she gives because a judicial warrant demonstrates that there is a legal basis for detaining a patient.

"They should be able to get a judicial warrant if there's probable cause," Ms. Baldwin said.

If an administrative warrant is presented, the hospital doesn't have to say whether a patient is at the hospital or not and doesn't have to direct ICE to a room. ICE officials might say they need access to a patient to prevent imminent harm or risk, and the hospital needs to evaluate all factors.

Ms. Baldwin emphasizes how important it is to deny entry if the proper documentation isn't presented because if entry is allowed, it then becomes much easier for immigration officials to move about freely.

"Even if they had a judicial warrant and they had the ability to come in, there's a scope: It limits the area, it limits the target," she said. But, she added, "once they're in, they really can go beyond that scope, and the hospital staff wouldn't be able to stop them. They could say, 'It looks like you're going beyond the scope of this warrant,' but they can't physically stop them.... They have a lot of leeway once they are within a facility, once there's that consent."

Patient privacy is protected under the Health Insurance Portability and Accountability Act (HIPAA), and unfettered access to private areas could compromise that, Ms. Baldwin said. She says that immigration status should never be made a part of a patient's electronic medical record, and typically, there is little need for hospitals to collect it at all—although there are certain health assistance programs for which it might be needed.

She also cautioned that anything ICE officials might hear—with so-called "unassisted ears"—can be actionable information. Information on any document left in view can also be used, she said.

Waiting rooms, cafeterias, and parking lots are not private areas, and ICE officials are free to question people there. To maintain privacy and to minimize disruption, private areas should be designated for patients receiving care and their loved ones.

"A staff member can simply say, 'I can't give you permission to enter. You must speak with our designated representative,'" Ms. Baldwin wrote in her review.

She also advises clients to "document everything"—from getting the names, badge numbers, business cards, and contact information of the agents to seeing whether they comply with the terms of the warrant. She recommends recording all interactions.

If a patient is detained, find out where they're being taken, she said. A hospitalist or other staff members might be the final opportunity to know where loved ones or an attorney can find a patient who's been detained.

"If you don't ask, then you're definitely not going to get that information," she said. "And that's something that hospitalists can do."

Of course, hospitalists need to stand up for the patient's health as well, she said. If someone is about to be detained, but their removal from the hospital is inappropriate for health reasons, hospitalists have to speak up, Ms. Baldwin said.

"The physician also has a role of making sure that their health is not going to be negatively impacted by being taken into custody sooner than what would be medically prudent," she said. "You can't really stop ICE doing what they're going to do. But I think ICE would probably listen more to a physician than they would an administrator or a nurse, honestly."

She said that while hospitalists are not lawyers, they can let patients know that they are not required to speak with ICE officials.

"They can say they have the right to stay silent—'you don't have to answer questions,'" she said. "It can be as simple as that."

In the end, by implementing clear policies, educating staff, protecting patient privacy, and ensuring ethical care delivery, hospitalists can navigate ICE-related activities while maintaining patient trust and legal compliance. As immigration policies continue to shift, hospitals must remain proactive in safeguarding the rights and well-being of all patients, regardless of their legal status.

Ms. Baldwin said the need to prepare for an increase in these visits might be daunting, but a little work in advance can make a big difference.

"Our push toward making sure that hospitals are prepared and have a plan is not necessarily to scare everyone and make everyone very nervous—it's really to make sure that they have a little bit of control over how they respond," she said.

How many visits ICE will make to hospitals is unknown, she said.

"We don't know whether all of this initial stuff is kind of shock and awe and to add chaos and to make people just really, really frightened and then it's going to trickle away, because there's only so much staff and resources at ICE," she said. "Hopefully, they never have to deal with it." ■

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Reference

1. Baldwin T, Meilink K. ICE at healthcare facilities: what should you do. Husch Blackwell website. https://www.huschblackwell.com/newsandinsights/ice-at-healthcare-facilities-what-should-you-do. Published January 24, 2025. Accessed April 21, 2025.

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The Trials and Tribulations of Teaching Residents

Several disruptors have changed how students learn in recent years

By Karen Appold

The COVID-19 pandemic, advances in technology, and new views about work-life balance have all impacted how medical residents learn in recent years.

"Although the evolution of digital learning was already underway before the COVID-19 pandemic, the need for social distancing and the widespread adoption of remote communication technologies dramatically accelerated this transformation," said Eric Barna, MD, MPH, associate professor of medicine in the department of internal medicine at Mount Sinai Hospital in New York, an academic urban hospital with more than 1,100 beds. Simultaneously, new digital tools and learning platforms emerged and flourished.

Dr. Barna

Likewise, discussions around work-life harmony predated the pandemic. As it came to an end, trainees placed an even greater emphasis on achieving balance, Dr. Barna said.

Vignesh Doraiswamy, MD, FACP, FAAP, a med-peds hospitalist and assistant professor of internal medicine and pediatrics at Columbus' Ohio State University Wexner Medical Center in Columbus, Ohio, an urban academic hospital with more than 1,400 beds, believes a shift in learning started back in the 2010s, when smartphones and social media became prevalent. Medical educators have noticed more profound changes occurring in the last five years. These disruptors have brought both challenges and opportunities for teachers.

Dr. Doraiswamy

The impact of COVID-19

The pandemic had a great impact on learning in a short time. The deadly illness disrupted resident training when protocols needed to change quickly. "Clinical exposure diminished as elective procedures were postponed and non-urgent rotations were paused, limiting hands-on procedural and diagnostic experiences," said Dr. Doraiswamy, who is also the associate program director of Ohio State Wexner Medical Center's and Nationwide Children's Hospital's combined internal medicine and pediatrics residency training program in Columbus, Ohio. The latter hospital is an academic urban pediatric hospital with almost 700 beds.

Meanwhile, telemedicine use increased drastically, requiring residents to master virtual patient interactions, remote monitoring, and digital workflows, often without prior formal training, Dr. Doraiswamy continued. Educational formats shifted to virtual didactics, simulations, and online modules, reducing in-person work.

Inpatient units, such as intensive care units and medical wards, were often overwhelmed with patients, which led to intensified workloads. This shift accelerated the need for clinical decision-making skills while heightening burnout risks, Dr. Doraiswamy said. Although wellness suffered due to prolonged stress, isolation, and fear of infection, the pandemic ultimately fostered resilience and adaptability. Today, hybrid training models, virtual didactics, and tech reliance persist as a result of the pandemic.

With every challenge, struggles and opportunities exist, said Colby Feeney, MD, med-peds hospitalist and med-peds program director in the school of medicine, department of medicine, and department of pediatrics at Duke University in Durham, N.C., an urban hospital with more than 1,000 beds. She believes that COVID-19 forced programs, institutions, and even the Accreditation Council for Graduate Medical Education (ACGME) to re-examine how it does things and why, resulting in many positive changes. It provided an opportunity to forgo the unnecessary and respond to residents' and programs' current needs. Short-term, negative impacts on patient volumes and procedures occurred, but these have now returned to normal.

Dr. Feeney

Ensuring adequate clinical training

One of the greatest challenges of restricted in-person interactions was maintaining the engagement, excitement, and participation that a skilled educator naturally fosters in a room full of trainees. "In a virtual setting, it can be difficult to find creative ways to ensure trainees remain attentive, actively participate, and stay present despite the distractions of their own environments," Dr. Barna said.

During the pandemic, only essential team members entered patient rooms, Dr. Feeney said. However, some multidisciplinary team members could still perform virtual hospital rounds, allowing them to participate. Although the number of telehealth appointments has decreased significantly since the pandemic, she believes that they are still effective alternatives.

Duke's residents had virtual Zoom check-ins every two weeks to maintain connectedness. Socials were organized online, such as an online cooking class that residents could participate in from their own kitchens. "Finding ways to stay connected and support one another during an otherwise isolating time was very important," Dr. Feeney said.

Lasting changes included expanding access to mental health resources and implementing curricula focused on everything from peer

debriefs and dealing with professional grief to vulnerability and self-compassion, Dr. Feeney said.

Dr. Doraiswamy's institutions were fortunate to have the necessary support and personal protective equipment to allow residents to continue their clinical training, including seeing COVID-19 patients in the intensive care unit.

Notable changes in learning

As a result of multiple disruptors in recent years, Dr. Feeney has observed that residents are seeking greater variety in the ways they consume information and learn. Traditional didactics, such as lectures and modules, are less appealing, and instead, residents desire stimulation and interaction with peers when learning.

For example, Medical Twitter offers excellent diagnostic schemas or "Tweetorials" on medical topics compiled by experts. Regarding other asynchronous methods, residents seem to prefer podcasts over modules or reading assignments, Dr. Feeney said.

Dr. Doraiswamy has also seen a shift toward technology-driven, competency-focused learning (e.g., simulations, e-learning) and collaborative mentorship over hierarchical instruction. Residents prioritize digital resources (e.g., UpToDate) and social media (e.g., Twitter/X, Instagram, Bluesky) for just-in-time knowledge.

"The key is to know where to find answers quickly, rather than trying to know everything off the top of your head," Dr. Doraiswamy said. "Although that may have made sense decades ago, medicine continues to become more complex. Consider the fact that the number of treatments and medications for common conditions, such as type 2 diabetes mellitus and heart failure, has increased multifold over the last few decades."

Residents have proven that they're capable of withstanding significant changes within their learning environments. "They have shown tremendous flexibility and adaptability to a medical system that has undergone massive changes in a short time," said Maria Theodorou, MD, FACP, FHM, associate program director of the internal medicine residency program, medical director of the complex high admission management program, and assistant professor of hospital medicine in the department of hospital medicine at Northwestern University Feinberg School of Medicine in Chicago, an urban, academic hospital.


Dr. Theodorou

How teaching has changed with the times

As a member of Generation X, Dr. Barna grew up without smartphones and social media, and adapted to technological changes over time. "However, the pace of transformation in medical education in recent years has been unprecedented," Dr. Barna said.

Dr. Barna views learning as a multi-dimensional, non-linear process, significantly enhanced by technology. He engages with artificial intelligence (AI) regularly to enrich his teaching and has moved away from traditional didactic methods on rounds. Instead, he integrates technology, visual and audio media, and non-traditional resources—such as podcasts and YouTube videos—to engage learners more effectively.

In many ways, Dr. Barna said, he has become a student again—continuously learning about emerging AI-driven tools and interfaces while exploring innovative ways to incorporate them into teaching.

Dr. Doraiswamy has had to adapt to the increased demand for virtual educational offerings. His institution uses Tweetorials, medical podcasts, and simulation as well as point-of-care ultrasound to give learners more hands-on practice and experience.

Trends in learning

Today's learners expect more from their educators—they want to be inspired, engaged, and excited by their teaching. Trainees anticipate that educators will not only keep pace with evolving technology but also integrate it into their clinical expertise and deliver impactful learning experiences, Dr. Barna said.

As work intensity increases, residents naturally shift their focus toward clinical care, which makes it challenging to attend traditional educational conferences. This aligns with a broader desire for better work-life harmony, recognizing that improving clinical efficiency provides time for decompression and personal fulfillment beyond residency.

Additionally, residents favor interactive, problem-based learning led by enthusiastic educators who can foster deeper engagement over traditional didactic sessions, Dr. Barna said.

Dr. Doraiswamy has noticed some other learning trends, such as a rising interest in leadership and systems training. "Physicians need skills beyond clinical expertise, including quality improvement, healthcare economics, financial well-being, and leadership abilities," he said.

Further, residents are increasingly exploring non-traditional career trajectories that combine clinical practice with research, education, policy work, or entrepreneurship.

Similar to evidence-based medicine, residents now expect their educational experiences to be grounded in educational theory and proven methodologies, Dr. Doraiswamy said. Residents continue to have a big interest in medical education as a whole; they value programs that have medical education rotations, electives, and tracks.

A focus on mental health

Supporting mental health is an important component of maintaining work-life balance. To achieve this, Mount Sinai Hospital's residency program has designated wellness-champion faculty who regularly engage with house staff and establish clear channels for listening and responding to residents' needs.

To ensure comprehensive support, trainees have access to mental health resources, can take scheduled wellness days, and receive targeted interventions when needed. "Through close collaboration with residency advisors, the clinical competency committee, and chief residents, we proactively identify and support trainees who may be struggling, providing individualized care to promote their overall well-being," Dr. Barna said.

Northwestern's residency program aims to normalize emotional challenges among trainees through transparency. To be successful, educators within the program model this behavior. "Attendings disclose their struggles and vulnerabilities, which normalizes the universal toll that medicine can take on us as clinicians," Dr. Theodorou said. "Demonstrating to trainees that their challenges are not unique promotes a culture of psychological safety."

Northwestern's residents have flexible days off that they can take during outpatient or elective rotations. They can also take breaks from clinical duties to attend doctor's appointments and can take time off to recover from challenging clinical scenarios or to prevent duty hour violations on particularly taxing rotations.

Because time off promotes wellness, Dr. Doraiswamy's institutions try to give residents back as much time as possible in a variety of ways. For example, the ACGME has historically had patient caps (i.e., how many patients it's safe for a first-year resident to see or for a senior resident to supervise). To ensure that workloads are manageable while balancing the need for exposure to learn, his institutions' caps are lower than the ACGME's limits.

The joys of teaching

Although disruptors have brought both challenges and opportunities for residency educators in recent years, many professors continue to glean great rewards from teaching.

"Residents' blend of enthusiasm, curiosity, and fresh perspectives constantly reinvigorate my own practice," Dr. Doraiswamy said. "I appreciate how they challenge assumptions by asking such questions as, 'What if we approach this case differently?' This pushes me to refine my methods and stay current."

Dr. Doraiswamy enjoys guiding residents through complex procedures or diagnoses and witnessing "aha" moments when everything clicks. "Residents bring a collaborative spirit by prioritizing teamwork over hierarchy and openly discussing challenges such as burnout or sharing innovative tools they've discovered," he said.

Teaching residents isn't just imparting knowledge; it's a mutual exchange. "They keep me grounded, reminding me of medicine's human side through their empathy and patient-centered focus," Dr. Doraiswamy said. "Most importantly, watching residents evolve into skilled, confident physicians is incredibly fulfilling. Their growth reaffirms why I love this field—it's about nurturing the next generation while growing alongside them."

For Dr. Barna, residents' enthusiasm for learning, growth, and skill development is both inspiring and motivating, and often promotes self-reflection and a drive to continuously improve. "I'm consistently impressed by the accomplishments of our incoming intern classes and the remarkable achievements they have already attained early in their careers," he said. "Most of all, I'm in awe of our residents' talent, dedication, and ability to provide compassionate care to an extraordinarily sick patient population with both grace and passion."

Dr. Feeney loves seeing residents learn and grow. "They develop so much as clinicians, advocates, researchers, educators, and just as people in the formative years of training," she said. "Seeing them advance to caring for patients independently is extremely fulfilling. And doing that alongside them, supporting them in that struggle, meeting their loved ones and their babies born during residency … that's the cherry on top." ■

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 a newspaper and magazine editor.

Interpreting Pyuria on Urinalysis in Geriatric Patients: Context Matters

By Jared M. Giordano, MD, Nicholas A. Turner, MD, MHSc, FACP, and Thomas P. Shuman, MD

A 75-year-old female nursing-home resident with mild cognitive impairment is admitted to the hospital for two days of confusion, agitation, and weakness. She denies any genitourinary symptoms, abdominal pain, or fevers. Vital signs show a temperature of 37.7˚C (99.8˚F), heart rate of 90 beats per minute, BP 100/70 mmHg, respiratory rate 16 breaths per minute, and O_2 saturation 95% on room air. The workup included a white blood cell count of 11,000/μL and a clean-catch urinalysis with positive nitrite, 2+ leukocyte esterase, 18 white blood cells (WBC) per high powered field (HPF), and 5 squamous cells. Should antibiotics be initiated in this patient?

Brief overview

Urinalysis is the oldest laboratory test ever performed. It is a fast, easy, low-cost test for a variety of clinical applications, from screening for proteinuria or pyuria to monitoring hematuria. Pyuria, usually defined as >5 to 10 white blood cells per HPF, has traditionally been used as a screening test for bacteriuria. Leukocyte esterase (LE), an enzyme found in most neutrophils, is an indirect test for pyuria. Nitrite testing identifies bacteria in the urine that convert nitrates to nitrites, such as the gram-negatives *Escherichia coli*, *Klebsiella pneumoniae*, and *Proteus mirabilis*.

Hospitalists use urinalysis to determine the likelihood of bacteriuria, often leading to a diagnosis of urinary tract infection (UTI) and antibiotic treatment. UTIs are one of the most common infections in older adults, defined by bacteriuria (>105 colony-forming units [CFU]/mL) with symptoms attributable to the urinary tract. However, older adults commonly have bacteriuria without symptoms localizing to the urinary tract, known as ASB or asymptomatic bacteriuria. ASB only requires treatment if the patient is pregnant or has a planned urologic procedure, per guidelines of multiple societies, including Infectious Diseases Society of America; American Geriatric Society; American Urological Association; Canadian Urological Association; Society of Urodynamics, Female Pelvic Medicine, and Urogenital Reconstruction; and European Society of Urology. Despite these guidelines, antibiotic treatment based on initial urinalysis in the asymptomatic geriatric population remains commonplace,[1] as does the notion that such treatment will reduce the duration or intensity of a patient's nonspecific symptoms such as delirium.[2]

Overview of the data

Like all tests, urinalysis is susceptible to false-positive and false-negative results (Table 1).[3] For example, pyuria can be from sexually transmitted infections, medications, radiation, and even non-urinary infections. Similarly, nitrites can turn positive from medications or even exposure to air. Approximately 90% of urinalyses are not performed via the mid-stream clean catch method. However, evidence that this technique decreases contamination is uncertain.[4]

Retrospective studies have found that the degree of pyuria positively correlates with the odds of receiving antibiotics.[1] However, prospective and retrospective studies of emergency department patients and inpatients have found the positive likelihood ratio of pyuria, nitrites, or LE is very low (1.1 to 1.8) in predicting bacteriuria.[5] A study utilizing flow cytometry to accurately quantify pyuria revealed that the currently used pyuria cutoff with microscopy is 100% sensitive but only 36% specific in geriatric women with UTI or ASB.[3] Assuming a linear relationship between pyuria on microscopy and flow cytometry, cutoffs of approximately 57 WBC per HPF would be more accurate in this population (sensitivity 84%, specificity 88%) compared to the cut-off of 10 WBC per HPF used by most clinicians.

Despite society guidelines and the aforementioned shortcomings of urinalyses, pyuria and/or nitrites on urinalysis are often equated to UTI or "infected urine" in clinical practice, independent of the clinical context. This presumption leads to increased urine culture collection and antibiotic administration. However, all screening tests should be interpreted in the clinical context. For example, an elevated high-sensitivity troponin in a patient without a clinical correlate of acute coronary syndrome does not prompt intervention (heparin infusions, echocardiograms, and left heart catheterization). Instead, providers put the troponin values within the clinical context of the patient and then weigh the probability that such positive troponins represent a coronary event. Similarly, urinalysis showing pyuria or LE should not prompt urine culture and antibiotics but instead should prompt clinicians to consider such findings in the context of the patient's symptoms, age, comorbidities, and other diagnoses on the differential.

Longstanding clinical teaching purports a link between neurocognitive symptoms and UTIs


Dr. Giordano


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Dr. Shuman

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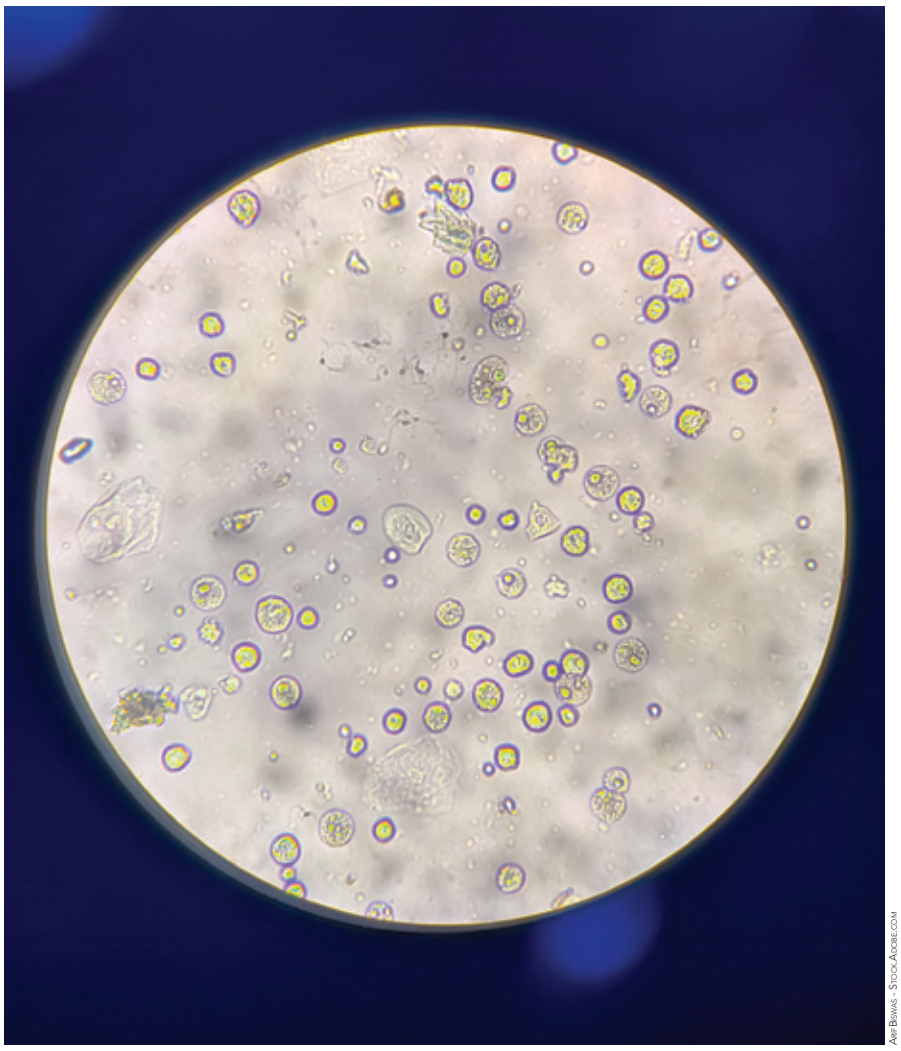
Key Points

- Assess for genitourinary symptoms that might suggest urinary infection
- Assess for sepsis
- Consider other potential explanations for the pyuria
- Ask for help! Reach out to your local antibiotic stewardship team or infections disease consultant

TEST	CAUSES OF FALSE POSITIVES	CAUSES OF FALSE NEGATIVES
Pyuria (>5-10 WBC per HPF) or leukocyte esterase (LE) positivity	• Asymptomatic bacteruria • Non-urinary infection (Hooker, et al. 2014) • CKD (Kwon, et al. 2020) • Recent instrumentation • Sexually transmitted infections • Glomerulonephritis • Bladder tumors • Radiation cystitis • Steroid use • Cyclophosphamide use • Non-bacterial pathogens (viral, fungal, parasitic, etc.)	• Dilute urine
Nitrite positivity	• Exposure to air • Contamination • Phenazopyridine use	• Frequent urination (less time for bacteria to produce nitrite) • Low-vegetable diet (a natural source of nitrates) • Bacteria that do not reduce nitrate (*e.g., Enterococcus, Staphylococcus saprophyticus*)

(the cystocerebral axis) in geriatric patients. Clinical teaching of common infections such as dental infections, osteomyelitis, and cellulitis does not include an association with neurocognitive symptoms. Decades of evidence suggest that UTI is no exception. In 1996, a double-blind placebo-controlled trial of geriatric post-acute care patients with bacteriuria found no difference in objective measures of behavior between norfloxacin-treated and placebo-treated patients.[6] A decade later, Dasgupta et al. conducted a prospective cohort study of hospitalized adults with or without delirium and found that treating ASB was not associated with benefits to function or objectively assessed delirium.[7] A single-center retrospective chart review of geriatric inpatients (more than 50% with dementia, more than 50% admitted from a facility, more than 25% with diabetes mellitus, and 15% with UTI in the past six months) with objective evidence of delirium and either positive LE or nitrites found no difference in delirium at one week independent of antibiotic use.[8] This is supported by a recent systematic review, which determined that treating ASB did not improve delirium.[9]

While these studies of neurocognitive symptoms, UTI, and ASB are helpful, they have considerable heterogeneity, ranging from the exclusion of patients unable to express their symptoms to the use of different definitions of UTI. Improved methodology, such as a randomized clinical trial, is needed; one such trial is currently enrolling patients.[10] Currently, the Infectious Diseases Society of America guidelines on ASB note correctly that there is no evidence to support associations between ASB and falls, confusion, or non-localizing symptoms. These guidelines were highlighted in the *Journal of Hospital Medicine's* "Things We Do for No Reason," which covered the folly of screening older patients with delirium using urinalysis and culture.[11] Instead, the authors recommend obtaining the history from a reliable informant, performing a thorough physical and neurologic examination, and evaluating for metabolic and electrolyte derangements. Current expert recommendations include taking these first steps in the first 24 to 48 hours as opposed to sending urine studies for stable patients without clear genitourinary symptoms. For patients with sepsis, hemodynamic instability, and or symptoms of a urinary tract infection, it is appropriate to obtain a urinalysis with urine culture and administer empiric antibiotics.



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Delirium is not the only unchanged outcome reviewed in the treatment of ASB. A retrospective chart review found that patients with sterile pyuria on pre-operative urinalyses who were treated with antibiotics had no improvement in postoperative outcomes.[1] More importantly, these patients had higher rates of *Clostridium difficile* infection postoperatively (adjusted odds ratio, 2.4).[1]

Quiz:

An 88-year-old female with dementia presents to the emergency department accompanied by her daughter, who is concerned about a change in the patient's urine color and odor as well as multiple falls in the past week. The patient cannot provide a history. The daughter denies her mother having had any recent concerns such as dysuria, abdominal pain, fatigue, fevers, or chills. Vital signs show a temperature of 37.0˚C (98.6˚F), heart rate of 88 beats per minute, blood pressure 120/60 mmHg, respiratory rate 18 breaths per minute, and O2 saturation 98% on room air. Workup included WBC of 8,000/µL and urinalysis with positive nitrite and LE, 12 WBC per HPF, and 0 squamous cells. What is the most appropriate next step?

a. Repeat the urinalysis
b. Neurologic exam and assessing for metabolic derangements on blood work
c. Collect urine culture and hold off on antibiotics until results are available
d. Collect urine culture and start trimethoprim-sulfamethoxazole for a five-day course

Correct option: B. This nonpregnant patient without clear genitourinary symptoms or upcoming urologic procedure does not require a urine culture to assess her falls. Given that there are no squamous cells on the urinalysis and she is not symptomatic, repeating a urinalysis (A) would not change her management. A urine culture (C) would also not change management as asymptomatic pyuria, with or without bacteriuria, does not require treatment (D) and puts the patient at risk for adverse events from antibiotics.

Application to the case

Our patient is at high risk for pyuria and bacteriuria but lacks symptoms of a UTI. Given her age and the presence of squamous cells, her pyuria has a low positive likelihood ratio for bacteriuria. Her positive nitrites could be from bacteriuria, but their presence is not a surrogate for the genitourinary symptoms necessary to diagnose UTI. Considering other causes of her delirium and weakness should start with a discussion with her caregivers to determine her baseline level of cognition and function, review of any recent psychosocial changes and medications, and thorough neurologic exam in addition to a review and workup for common causes of delirium and weakness such as metabolic derangements and electrolyte disturbances.

Additional Reading

- Advani SD, et al. Deconstructing the urinalysis: A novel approach to diagnostic and antimicrobial stewardship. *Antimicrob Steward Healthc Epidemiol.* 2021;1(1):e6. doi: 10.1017/ash.2021.167.
- Reppas-Rindlisbacher C, Kandel C. Are antibiotics helpful for older adults with delirium and pyuria or bacteriuria? *NEJM Evid.* 2023;2(9):EVIDtt2300119. doi: 10.1056/EVIDtt2300119.

Bottom line

Hospitalists must interpret pyuria and bacteriuria in the clinical context of individual patients. Multiple society guidelines do not recommend the treatment of ASB, as current research does not support an association between pyuria, bacteriuria, and neuropsychiatric symptoms. ■

References

1. Gupta K, et al. How testing drives treatment in asymptomatic patients: level of pyuria directly predicts probability of antimicrobial prescribing. *Clin Infect Dis.* 2020;71(3):614-621. doi: 10.1093/cid/ciz861.
2. Laguë A, et al. Investigation and treatment of asymptomatic bacteriuria in older patients with delirium: a cross-sectional survey of Canadian physicians. *CJEM.* 2022;24(1):61-67. doi: 10.1007/s43678-021-00148-1.
3. Bilsen MP, et al. Current pyuria cutoffs promote inappropriate urinary tract infection diagnosis in older women. *Clin Infect Dis.* 2023;76(12):2070-2076. doi: 10.1093/cid/ciad099.
4. Jacob MS, et al. Use of a midstream clean catch mobile application did not lower urine contamination rates in an ED. *Am J Emerg Med.* 2018;36(1):61-65. doi: 10.1016/j.ajem.2017.07.016.
5. Cheng B, et al. Correlation of pyuria and bacteriuria in acute care. *Am J Med.* 2022p;135(9):e353-e358. doi: 10.1016/j.amjmed.2022.04.022.
6. Potts L, et al. A double-blind comparative study of norfloxacin versus placebo in hospitalised elderly patients with asymptomatic bacteriuria. *Arch Gerontol Geriatr.* 1996;23(2):153-61. doi: 10.1016/0167-4943(96)00715-7.
7. Dasgupta M, et al. Treatment of asymptomatic UTI in older delirious medical in-patients: A prospective cohort study. *Arch Gerontol Geriatr.* 2017;72:127-134. doi: 10.1016/j.archger.2017.05.010.
8. Joo P, et al. Effect of inpatient antibiotic treatment among older adults with delirium found with a positive urinalysis: a health record review. *BMC Geriatrics.* 2022;22(1). doi: 10.1186/s12877-022-03549-8.
9. Stall NM, et al. Antibiotics for delirium in older adults with pyuria or bacteriuria: A systematic review. *J Am Geriatr Soc.* 2024;72(8):2566-2578. doi: 10.1111/jgs.18964.
10. Fralick M. Antibiotics for delirium in older adults with no clear urinary tract infection (A-DONUT); Identifier: NCT06004739. ClinicalTrials.gov website. https://inclinicaltrials.com/infectious-disease/NCT06004739/details/. Accessed April 23, 2025.
11. Memari M, et al. Things we do for no reason™: obtaining urine testing in older adults with delirium without signs or symptoms of urinary tract infection. *J Hosp Med.* 2021. doi: 10.12788/jhm.3620.

From Mistakes to Growth: How to Manage Medical Errors

By Ethan Molitch-Hou, MD, SFHM, Melissa Plesac, MD, Pooja Parekh, MD, Paula Skarda, MD

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Many entering the medical profession are perfectionists, unaccustomed to making serious mistakes.[1] Medical errors, however, are inevitable and multifactorial.[2] We fear errors due to the cost to our patients and our professional careers. We pledge to do no harm, but no practitioner is infallible. How we manage mistakes can shape our careers, especially when our first error occurs.

At each level of new responsibility, there is a transition to independent decision making that can be daunting and breed insecurity. With that insecurity, confronting near-misses and errors may feel personal, especially during the processes of closely examining the decisions that led to the mistake. This may build throughout a career, leading to burnout. Demystifying medical errors and creating a culture that allows for growth leads to best practices for patients and healthier clinicians.

The second victim

The second victim refers to the trauma experienced by healthcare practitioners in events that endangered a patient, or the first victim.[3] Clinicians often treat errors as a personal failure, making it difficult to process, learn, and improve. Qualitative studies describe the stages of confronting an error as the initial accident response, intrusive reflection, restoring personal integrity, enduring the inquisition, emotional first aid, and eventually moving on.[4] When physicians are unable to process errors, shame and guilt can progress, and recovery can be delayed or not possible.

It's important to acknowledge the cognitive burden, often a precursor to burnout, of processing medical errors. Most often, practitioners are balancing numerous clinical duties with initial analysis of the mistake and its consequences. The likelihood of making another error is directly related to factors that feed into burnout, including decreased confidence, anxiety, fear, and distraction.[5]

From the time the second victim phenomenon was described in literature, resources and structures have been developed to destigmatize the effects of mistakes on healthcare workers and connect them with appropriate support. There is no single strategy to recover from an error. However, we should be reassured that the emotional response is shared and expected, regardless of clinical experience or personal attributes of a clinician.

When medical error occurs

When a medical error occurs, it's an unsettling moment for everyone involved, but it can lead to an opportunity for growth, learning, and systemic improvement. Peer review often occurs after an error, in which a team of physicians evaluates the case in a confidential setting, discussing what went wrong, what could have contributed, and how similar incidents might be prevented in the future.[6] This process allows peers to learn from each other in a non-punitive environment, fostering personal and collective responsibility.

Cases with significant learning potential are often brought to a morbidity and mortality (M&M) conference, designed to encourage open dialogue, promote transparency, and support a culture of safety, enabling clinicians to confront mistakes without shame and discuss how they can collectively improve.[7] These conferences are often feared, as when done poorly, they can shift to practitioner blame. By focusing on education and preventive strategies, M&M conferences remind us that errors are part of the journey; that resilience and humility are essential to growth in medicine.

At a more formal level, hospitals may conduct a root cause analysis (RCA) to evaluate underlying systemic factors that may have contributed to an error through deep and methodical examinations of the incident.[8] RCAs look beyond individual actions toward hidden risks within the processes, protocols, or environments that can be modified to reduce future errors. The goal is safety and quality improvement, not individual error, reinforcing that medicine is a complex web of interconnected actions and decisions.


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Occasionally, a medical error may result in a medical malpractice claim, bringing the event under legal scrutiny. While this can feel daunting, it underscores the importance of transparency, accountability, and ongoing learning in healthcare. Malpractice cases highlight how deeply patients and families place their trust in healthcare and how critical it is to uphold that trust.

Disclosure of errors

Psychological safety extends to the admission of errors, and it is crucial that we create a space for ourselves, our colleagues, and our learners in which we can discuss our mistakes with candor and empathy. Physicians need tools to learn from errors and forgive themselves to move forward.

No matter what a practitioner's career stage, knowing the resources in the healthcare system for sharing and disclosing errors is vital to protect oneself, but also to process the emotions associated with the error. Errors must be disclosed to leadership, the risk management team, and the patient involved.[9] This can feel overwhelming and intimidating, especially when these errors are accompanied by guilt and shame.

Interdisciplinary teams extend beyond the hospital floor. When a mistake occurs, seeking out support from trusted leadership is the first step. This may be section or division leadership, the chief medical officer, or, for trainees, clerkship directors, chief residents, associate program directors, and the program director. The risk management team will help devise a strategy for disclosure to patients and their families. They are an excellent source of knowledge and support for questions about patients, even when a mistake has not occurred. Familiarity with the risk management team can mitigate the anxiety associated with contacting them after an error. A malpractice claim may feel like the ultimate failure, but practitioners should rely on the hospital's established processes and expertise for support.

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Career Hospitalist Advisement and Mentorship Program (CHAMP)

Empowering the next generation of hospitalists

By Agostina Velo, MD, Benjamin Hack, MD, Forough Hakimzada, MD, Krystle Hernandez, MD, Vasundhara Singh, MD, FACP, SFHM, Andrew Dunn, MD, MACP, FRCP, SFHM, and Eric Barna, MD, MPH

Between 2012 and 2019, the field of hospital medicine experienced rapid growth, expanding by 50%.[1] From 2019 to 2021 alone, there was an additional 10% increase, signaling continued growth over the next 10 to 15 years.[2] As hospital medicine becomes an established career path for trainees, new opportunities are emerging in leadership, medical education, and quality and safety. This growing interest in a rapidly expanding field highlights the need for initiatives to better guide residents through the often nebulous and competitive process of becoming a hospitalist.

Although most residents actively seek mentorship in specific domains, there remains an unmet need for comprehensive, curated, longitudinal mentorship programs during early career development. To address this gap, the Career Hospitalist Advisement and Mentorship Program (CHAMP) was launched at Mount Sinai Hospital (MSH) in 2023.

What is CHAMP?

CHAMP uses a four-phase approach to guide residents through the process of entering the field of hospital medicine.

In the first phase, each PGY-2 resident is paired with a faculty advisor who aligns with their interests and helps establish career goals, such as medical education, quality improvement, and healthcare leadership. Throughout the remaining phases, the assigned career advisor continues to serve as a source of support, checking in with the resident at least quarterly.

The second phase focuses on increasing residents' exposure to hospital medicine, primarily through a hospitalist elective rotation in which residents are given the opportunity to function as junior attendings and supervise advanced practice practitioners (APPs). Residents lead interdisciplinary rounds, attend departmental meetings, and guide decisions regarding patient management. They receive direct mentorship from their supervising hospitalist and didactic instruction on topics foundational to hospital medicine. This is supplemented by direct observation of case management and social work, as well as dedicated time learning billing and coding from the supervising hospitalist. Beyond the elective, residents attend the department of hospital medicine's Grand Rounds, participate in residency career tracks (e.g., healthcare leadership, medical education), and collaborate with faculty on quality improvement initiatives. They are even invited to high-level leadership meetings to foster a deeper understanding of the hospitalist's involvement in operations and planning.

The third phase provides structured guidance on securing a hospitalist position. Support includes an overview of the application timeline, curriculum vitae and cover letter review, connections with residency alumni, and developmental workshops on key topics such as interview preparation and practice. Residents also receive a comprehensive application guide, which is regularly updated by former residents and faculty.

The final phase focuses on longitudinal mentorship extending into the early career of the new hospitalist. This includes ongoing coaching for career development, assistance with scholarly projects, and collaboration across institutions. Additionally, didactic sessions focus on strategies for achieving success in a hospitalist role. The longitudinal phase is a core component, whether the trainee becomes a hospitalist at our institution or a different hospital system. Upon completing all four phases, participants are surveyed to provide feedback and improve the program for future residents.

Early implementation, expansion, and challenges

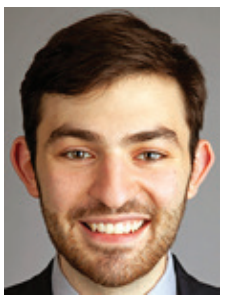
The development of CHAMP arose from a recognized gap in structured career guidance for internal medicine residents pursuing hospital medicine. This need was observed by CHAMP's founder and director Dr. Eric Barna's own transition from house staff to attending and his subsequent career as an academic hospitalist. Residents frequently sought informal guidance from hospitalist faculty on career options, job applications, and insights into the field. Having experienced both sides of this unstructured mentorship model, the importance of establishing a formal career advisement program became clear.

In 2022, this gap was addressed by designing a structured program to support residents interested in hospital medicine. After multiple brainstorming sessions, a phased approach to implementation was developed with a clear vision and concrete steps. A proposal was drafted for review by the division chief of hospital medicine and the internal medicine residency program director. Following their approval, the project team collaborated to establish goals, create tracking documents, and assemble a team of mentors. Two resident leaders from the program were recruited to support its development. CHAMP officially launched in the latter half of the 2023–2024 academic year with 17 enrollees and 10 mentors.

CHAMP operates without financial resources, driven entirely by the enthusiasm of house staff and hospitalist leaders. Two internal medicine residents serve as CHAMP leads each year, ensuring the program evolves to meet residents' needs. These leads maintain updated resources and facilitate scholarship opportunities to enhance the program's national visibility. A diverse group of 12 hospitalist mentors, representing various leadership roles within the institution, provides essential guidance and support. Their dedication remains integral to CHAMP's sustainability and growth.

Following its initial success at Mount Sinai Hospital (MSH), CHAMP spread to Mount Sinai Morningside and Mount Sinai West (MSMW). The expansion was led by two associate program directors, Drs. Vasundhara Singh and Krystle Hernandez, by identifying interested residents through surveys and feedback from residency leadership and chief residents. After compiling a list of potential candidates, the final


Dr. Velo

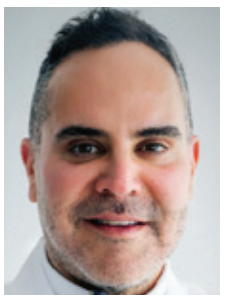

Dr. Hack


Dr. Hakimzada


Dr. Hernandez


Dr. Singh


Dr. Dunn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Mount Sinai Hospital graduating class of 2024 portraying their positions as hospitalists. L to R: Dr. Adrian Majid, Dr. Marlon Brewer, Dr. Mary Shimkus, Dr. Mitchell Gronowitz, Dr. Eric Barna, Dr. Benita Glamour, and Dr. Lodoe Sangmo.

cohort was integrated with CHAMP at MSH. Fourteen mentors were recruited and assigned based on mentees' interests, ensuring balance across hospital sites. Early in the academic year 18 third-year residents were assigned, while 12 second-year residents were assigned later. Introductory emails facilitated connections and outlined expectations. Although mentors and mentees are paired at their respective campuses, CHAMP events are offered to the entire group, fostering connections and networking across the health system.

The implementation of CHAMP encountered several challenges. One significant obstacle was defining the role of junior attendings during the hospitalist elective. Initially, residents struggled to assume attending-level responsibilities alongside their mentors without reverting to traditional resident duties. To address this, a structured handoff was introduced to outline responsibilities and expectations. Emphasis was placed on participating in multidisciplinary rounds with APPs and clarifying the principles of attending oversight.

Another challenge was determining the optimal timing for second- and third-year residents to participate in the elective. Third-year residents benefited from early exposure, while second-year residents performed better when scheduled in the second half of the year. Adjusting the timeline accordingly improved the learning experience. Additionally, certain didactic sessions, such as CV preparation and interview workshops, were found to be most effective earlier in the academic year to align with the job search process. By scheduling these sessions sooner, residents were better prepared for career opportunities.

CHAMP's successes

The value of CHAMP is best reflected in the testimonials and experiences of the alumni who completed the program over the last two years. Exit survey data reflects the benefits achieved by residents through a structured mentorship and career guidance program. All eight 2023-2024 CHAMP mentees responded, and 100% of this group felt satisfied with the support they received from the program. Alumni have already started to give back to CHAMP: they have provided advice directly to participants and program leadership and have led formal didactics for current enrollees.

The connection to mentorship was a critical success for the program. With a few exceptions, all participants felt that their mentor acted as a proficient guide leading up to and through the application process. Most had mentoring meetings quarterly or more frequently throughout the program.

Participants in the hospitalist elective felt it helped lay the foundation for attending-level skills beyond those gained in residency. They found the experience informative about the specific responsibilities of hospitalists, including collaborating with APPs. Additionally, they gained a better understanding of interdisciplinary rounds and increased confidence in writing attestation notes.

Another cornerstone of CHAMP is the hospitalist-specific didactic sessions, which received glowing feedback. The lectures and workshops focused on the application process clarified the most important aspects of CV building and interviews, which learners felt were crucial for their success in securing desirable positions. Later in the year, residents felt that the teaching they received regarding billing and documentation prepared them for the more practical aspects of hospital medicine, which are not taught elsewhere in the residency curriculum.

Perhaps most importantly, every resident enrolled in CHAMP secured a hospitalist position at an institution they were excited to join. This included several residents who were applying to hospital medicine as a transitional career with the intention of later pursuing fellowship, who benefitted from the skills and tools gained from CHAMP didactics regarding securing positions and providing excellent care as an early hospitalist. In 2024, CHAMP included 15 residents at MSH and 36 residents at MSMW. Of this larger group, all seven third-year residents at MSH and 21 at MSMW applied to and accepted hospitalist positions; one MSH third-year resident applied as a part-time hospitalist, and eight at MSMW identified as pre-fellowship hospitalists. At MSMW, career hospitalists represented a prodigious 16% of the graduating class, reflecting both the impact and importance of an initiative such as CHAMP.

Key Takeaways

- Addressing the growing need for hospitalist mentorship: With hospital medicine rapidly expanding, many residents face challenges in navigating career opportunities. CHAMP provides structured, longitudinal mentorship to guide residents in professional growth and career readiness.
- Four-phase approach: CHAMP's structured model includes career goal setting, hands-on hospitalist elective experience, application preparation, and ongoing mentorship beyond residency. This approach ensures that residents receive the necessary support at each stage of their career transition.
- Measurable impact and success: Feedback from participants highlights the program's effectiveness, with 100% of surveyed mentees expressing satisfaction. CHAMP has successfully helped residents secure hospitalist positions and provided them with critical skills in billing, documentation, and interdisciplinary collaboration.
- Scalability and future expansion: After its initial success at Mount Sinai Hospital, CHAMP has expanded to other Mount Sinai campuses and is being considered for implementation at other institutions. Future goals include further scaling the program and presenting its model at national conferences to share best practices in hospitalist mentorship.

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Manage Medical Errors

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A culture of openness

As a medical system, it is imperative that we create a culture in which the ubiquity of medical error is acknowledged and in which errors are discussed openly without fear of retribution and negative consequences. The culture of openness starts from the top of leadership and should permeate down to practitioners. This can be in the form of initial orientations, structures for routine check-ins, and systems for immediate support. Leaders can refer to additional resources such as peer support networks, counselors, and employee-assistance programs.

Some institutions have established multidisciplinary, second-victim, rapid-response teams to provide immediate relief for acute events.[10,11] When larger systemic structures are not available, it falls on local leaders to support colleagues and trainees. Infrastructure should proactively identify support needs in high-risk clinical areas. This expands the culture of safety in healthcare and can help rapidly address burnout from a universal phenomenon to prevent the cycle of further errors.

Emotional support from colleagues, mentors, and supervisors provides the biggest impact. Debriefing is crucial to coping with guilt, anger, loss, and other natural emotional responses.[12] Debriefs can be structured to provide support and additional resources, normalize the outcome, and develop a plan for closure and growth.

Conclusion

The methods and structures put in place to help us learn from our mistakes, while crucial to improving the quality of care our patients receive, will never eliminate the existence of medical error. Human nature, with its unique cognitive biases and imperfect systems, makes medical error universal. Peer review, M&M, RCA, and, in rare cases, legal review play a critical role in the process of learning from mistakes and safeguarding the quality of care we strive to provide. Support from leadership, risk management, and peers will aid the second victim in preventing burnout. A culture of openness and systems that respond to errors in real time can lessen the impact of medical errors on both providers and patients. ■

References

1. Johnson KM, et al. Excellent vs excessive: helping trainees balance performance and perfectionism. *J Grad Med Educ*. 2023;15(4):424-427. doi:10.4300/JGME-D-23-00003.1.

2. Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err is Human: Building a Safer Health System*. Washington (DC): National Academies Press (US); 2000. doi: 10.17226/9728.

3. Wu AW. Medical error: the second victim: The doctor who makes the mistake needs help too. *BMJ*. 2000;320(7237):726-727. doi:10.1136/bmj.320.7237.726.

4. Ozeke O, et al. Second victims in health care: current perspectives. *Adv Med Educ Pract*. 2019;10:593-603. doi:10.2147/AMEP.S185912.

5. Shanafelt TD, et al. Burnout and medical errors among American surgeons. *Ann Surg*. 2010;251(6):995-1000. doi:10.1097/SLA.0b013e3181bfdab3.

6. Margaron FC, et al. Peer review and its ethical implications. *Semin Pediatr Surg*. 2021;30(5):151098. doi:10.1016/j.sempedsurg.2021.151098.

7. Orlander JD, et al. The morbidity and mortality conference: the delicate nature of learning from error. *Acad Med J Assoc Am Med Coll*. 2002;77(10):1001-1006. doi:10.1097/00001888-200210000-00011.

8. Joint Commission on Accreditation of Healthcare Organizations. *Root Cause Analysis in Health Care : Tools and Techniques*. Oakbrook Terrace, IL: Joint Commission Resources; 2003. Available online at: http://archive.org/details/rootcauseanalysi0000unse. Accessed April 25, 2025.

9. Gallagher TH, et al. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*. 2003;289(8):1001-1007. doi:10.1001/jama.289.8.1001.

10. Edrees H, et al. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study. *BMJ Open*. 2016;6(9):e011708. doi:10.1136/bmjopen-2016-011708.

11. Scott SD, et al. Caring for our own: deploying a systemwide second victim rapid response team. *Jt Comm J Qual Patient Saf*. 2010;36(5):233-240. doi:10.1016/S1553-7250(10)36038-7.

12. Pratt SD, Jachna BR. Care of the clinician after an adverse event. *Int J Obstet Anesth*. 2015;24(1):54-63. doi:10.1016/j.ijoa.2014.10.001.

CHAMP

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Insights from CHAMP

One of the key lessons learned from the CHAMP project is the value of providing residents with structured support in areas beyond traditional medical education. Knowledge of the job application process, documentation, billing, and coding is crucial for preparing residents for their transition to attending roles in hospital medicine. Additionally, facilitating mentorship and professional connections among residents and faculty has proven to be instrumental in career development and long-term success.

For other programs considering a similar initiative, it is crucial to identify a core group within the internal medicine residency leadership and the hospital medicine department to spearhead the project. Engaging attending physicians who are willing to contribute through lectures, presentations, and mentorship will be necessary for the program's success. Selecting residents to serve as program leaders is also key, as it both aids in organization and provides leadership opportunities. Furthermore, involving newer faculty members in the process ensures program continuity, incorporates diverse perspectives across different career stages, and allows CHAMP to be sustained and expanded.

Next steps for the program

We plan to scale the initiative further across all hospital sites within the Mount Sinai Health System, ensuring broader access to its benefits.

MOUNT SINAI

CHAMP workshop at Academic Internal Medicine Week 2025. L to R: Drs. Rex Hermansen, Mitchell Gronowitz, Yonina Kirsch, Benjamin Hack, and Eric Barna.

Additionally, multiple university programs in New York and beyond are planning or considering the implementation of CHAMP, demonstrating its growing impact and potential for wider adoption.

As part of its continued evolution, CHAMP representatives led a workshop at the Academic Internal Medicine Week 2025 to introduce the initiative to an even wider audience. As we expand, we aim to refine the program based on feedback, optimizing its effectiveness and addressing any challenges that arise. By repeatedly improving CHAMP, we strive to develop a comprehensive and sustainable model that can be adapted by other institutions, ultimately enhancing patient care on a larger scale. ■

References

1. Lapps J, et al. Growth trends of the adult hospitalist workforce between 2012 and 2019. *J Hosp Med.* 2022;17(11):888-892. doi: 10.1002/jhm.12954.

2. Howell E. Hospital Medicine Now and in the Future: Ad Astra Per Aspera. *The Hospitalist.* 2024. https://www.the-hospitalist.org/hospitalist/article/38175/leadership/hospital-medicine-now-and-in-the-future-ad-astra-per-aspera/

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