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The Hospitalist

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IN THE NEXT ISSUE...
Working to improve healthcare for women

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SHM Advocating for Healthcare

SHM's Statement on Passage of One Big Beautiful Bill Act

SHM released a statement in July just after the signing of HR 1, or the One Big Beautiful Bill Act, expressing its extreme concern over the imminent impact it will have on healthcare. This budget reconciliation package contains significant cuts to the Medicaid program, a critical lifeline for nearly 20% of Americans, including a large share of pregnant women, children, people living with disabilities, senior citizens, and low-income adults. Medicaid is the safety net for millions of Americans, and these drastic cuts will jeopardize their health, well-being, and safety. Not only will the One Big Beautiful Bill Act result in fewer people having much-needed healthcare coverage, but it will also accelerate the closure of rural hospitals, limiting access to care for communities far beyond just the Medicaid population. SHM continues to oppose any cuts to Medicaid and reaffirms its commitment to advocate for programs that are vital to the health and well-being of patients.

SHM's Statement on Firing of Advisory Committee on Immunization Practices at CDC

In June, SHM released a statement conveying its strong opposition to the wholesale firing of the members of the Advisory Committee on Immunization Practices (ACIP) at the Centers for Disease Control and Prevention (CDC). As a guidance body to the CDC, the ACIP provides invaluable, non-partisan recommendations to the government for the use and application of vaccines. Severing the cycle of committee member terms spanning multiple administrations risks politicizing the committee and radically undermining confidence in vaccines and public health efforts. SHM urges the Secretary to reinstate the ACIP committee members now and follow the traditional process and cycle for appointing new members to this panel.

Vaccines are lifesaving tools with a wide and deep evidence base for their effectiveness and safety. They have dramatically improved health and well-being worldwide. This unilateral action makes CDC decisions less informed and, therefore, Americans less healthy and less safe. ■

From JHM

Hospitalists are increasingly witnessing the negative impacts of declining vaccination rates, which threaten to revive vaccine-preventable diseases like measles and pertussis. With vaccination rates slipping below the critical threshold needed for herd immunity, hospitalists must prepare to confront these diseases and advocate for community health.

To equip hospitalists for this challenge, the *Journal of Hospital Medicine* has introduced a series of short reviews on vaccine-preventable diseases. These reviews—to be published as Clinical Progress Notes over the coming months—will serve as a practical resource, offering concise updates on clinical presentations, diagnostic approaches, and evidence-based treatments for diseases like measles, diphtheria, pertussis, and polio. ■

The Hospitalist Wins Award!

SHM and Wiley are happy to announce that *The Hospitalist* has received an APEX Award of Excellence this year for content published in 2024.

The October 2024 issue was honored with an Award of Excellence for Magazines—Writing (entire issue). The Awards for Publication Excellence (APEX) program recognizes excellence in publishing by professional communicators. APEX Awards are based on excellence in graphic design, editorial content, and the ability to achieve overall communication excellence. APEX Awards of Excellence recognize exceptional entries in individual subcategories. ■

THE Hospitalist®

August 2025
Volume 29 | No. 8

THE ONLY COVID-19 ANTIVIRAL WITH
OUTCOMES ACROSS 3 KEY TREATMENT GOALS:

DISEASE PROGRESSION, RECOVERY TIME, AND READMISSION[1-3]

INDICATION

VEKLURY is indicated for the treatment of COVID-19 in adults and pediatric patients (birth to <18 years of age weighing ≥1.5 kg), who are:

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

THE ONLY NIH RECOMMENDED COVID-19 TREATMENT OPTION
included for adult patients hospitalized for COVID-19[4]

- Not requiring supplemental O_2 and
- Requiring low- or high-flow O_2

Turn the page for details

IMPORTANT SAFETY INFORMATION

Contraindication

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

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

VEKLURY® REDUCED DISEASE PROGRESSION AND RECOVERY TIME, AND DEMONSTRATED READMISSION OUTCOMES ACROSS A BROAD RANGE OF COVID-19 SEVERITY[1-3]

Disease progression[2]

10% **Absolute reduction in incidence of new mechanical ventilation or ECMO with VEKLURY in ACTT-1** (13%, n=402) vs placebo (23%, n=364) in patients who did not receive either at baseline (95% CI, -15 to -4)

Recovery time[1,2]

5 **Days shorter recovery time with VEKLURY in the ACTT-1 overall study population**

Median 10 days with VEKLURY vs 15 days with placebo; recovery rate ratio: 1.29 (95% CI, 1.12 to 1.49), $P < 0.001$

Adverse reaction frequency was comparable between VEKLURY and placebo—any adverse reactions (ARs), Grades ≥3: 41 (8%) with VEKLURY vs 46 (9%) with placebo; serious ARs: 2 (0.4%)* vs 3 (0.6%); ARs leading to treatment discontinuation: 11 (2%)† vs 15 (3%).[1]

ACTT-1 study design: a randomized, double-blind, placebo-controlled, phase 3 clinical trial in hospitalized adult patients with confirmed SARS-CoV-2 infection and mild, moderate, or severe COVID-19. Patients received VEKLURY (n=541) or placebo (n=521) for up to 10 days. The primary endpoint was time to recovery within 29 days after randomization. Disease progression was a secondary endpoint. Recovery was defined as patients who were no longer hospitalized or hospitalized but no longer required ongoing COVID-19 medical care.[1,2]

Real-world readmission data[3]

40% reduced likelihood of 30-day, COVID-19–related readmission was observed with VEKLURY; aOR: 0.60 (95% CI, 0.58 to 0.62), $P < 0.0001$

- In the overall cohort, 10,396 out of 191,816 (5.4%) non-VEKLURY patients compared to 7,453 out of 248,785 (3%) VEKLURY patients

27% reduced likelihood of 30-day, all-cause readmission was observed with VEKLURY; aOR: 0.73 (95% CI, 0.72 to 0.75), $P < 0.0001$

- In the overall cohort, 17,437 out of 191,816 (9.1%) non-VEKLURY patients compared to 15,780 out of 248,785 (6.3%) VEKLURY patients

A large, real-world, retrospective observational study examined 30-day COVID-19–related‡ and all-cause§ readmission to the same hospital after being discharged alive from the index hospitalization for COVID-19 in adult patients (≥18 years of age) who were treated with VEKLURY vs those not treated with VEKLURY across variant periods: pre-Delta, Delta, and Omicron, from 5/2020-4/2022. Data were examined using multivariate logistic regression.‖

- **Data Source:** PINC AI™ Healthcare Database
- This study was sponsored by Gilead Sciences, Inc.
- The study included index patients on room air, low- and high-flow supplemental oxygen, and IMV/ECMO
- VEKLURY-treated patients received at least 1 dose of VEKLURY during the index COVID-19 hospitalization¶

Study population and select characteristics[3]

- **440,601 patients** with a primary diagnosis of COVID-19 and who were discharged alive
- **248,785 VEKLURY patients** were compared to **191,816 non-VEKLURY patients**

Compared to nonreadmitted patients, readmitted patients:

- **Were older:** median 71 years vs 63 years
- **Had more comorbidities:** CCI ≥4: 36% vs 16%
- **Were more likely to have NSOc** (42% vs 39%) and **less likely to be on low-flow oxygen** (40% vs 42%)
- **Were less likely to be treated with VEKLURY:** 48% vs 57%
- **Were more likely to have received corticosteroid monotherapy during index hospitalization:** 38% vs 29%

Compared to non-VEKLURY patients, VEKLURY patients:

- **Were younger:** median 62 years vs 64 years
- **Were more likely to have received some level of supplemental oxygen support (any supplemental oxygen support, 1-NSOc):** 70% vs 48%

Study considerations[3]

Real-world studies should be interpreted based on the type and size of the source datasets and the methodologies used to mitigate potential confounding bias. Real-world data should be considered in the context of all available data. Results may differ between studies.

Strengths: This large study population enabled subgroup analyses across variant periods and supplemental oxygen requirements and considered a well-defined cohort of patients hospitalized for COVID-19.

Limitations: There exists a potential for residual confounding due to unmeasured variables, including differences in groups that could not be accounted for. The database did not capture data relating to time from symptom onset, infecting viral lineages, and prehospital care such as other treatments. Some patients who received supplemental oxygen could be misclassified as NSOc due to the absence of billing charges for supplemental oxygen.

*Seizure (n=1), infusion-related reaction (n=1).
†Seizure (n=1), infusion-related reaction (n=1), transaminases increased (n=3), ALT increased and AST increased (n=1), GFR decreased (n=2), acute kidney injury (n=3).
‡Defined as a readmission with a primary or secondary discharge diagnosis of COVID-19.
§Defined as readmission to the same hospital within 30 days of being discharged alive from the hospitalization for COVID-19.
‖The model adjusted for age, corticosteroid use, variant era, Charlson Comorbidity Index, maximum oxygenation requirements, and ICU admission during COVID-19 hospitalization.
¶Refer to the VEKLURY Prescribing Information for dosing and administration recommendations.

Veklury® remdesivir 100 MG FOR INJECTION | LEADING THE WAY

IMPORTANT SAFETY INFORMATION (cont'd)

Warnings and precautions

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

Adverse reactions

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

Dosage and administration

— Administration should take place under conditions where management of severe hypersensitivity reactions, such as anaphylaxis, is possible.

- **Treatment duration:**
  - — For patients who **are hospitalized**, VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19.
  - — For patients who are hospitalized and do not require invasive mechanical ventilation and/or ECMO, the recommended treatment duration is 5 days. If a patient does not demonstrate clinical improvement, treatment may be extended up to 5 additional days, for a total treatment duration of up to 10 days.
  - — For patients who are hospitalized and require invasive mechanical ventilation and/or ECMO, the recommended total treatment duration is 10 days.
  - — For patients who are **not hospitalized**, diagnosed with mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death, the recommended total treatment duration is 3 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19 and within 7 days of symptom onset for outpatient use.
- **Testing prior to and during treatment:** Perform hepatic laboratory and prothrombin time testing prior to initiating VEKLURY and during use as clinically appropriate.
- **Renal impairment:** No dosage adjustment of VEKLURY is recommended in patients with any degree of renal impairment, including patients on dialysis. VEKLURY may be administered without regard to the timing of dialysis.

Pregnancy and lactation

- **Pregnancy:** Available clinical trial data for VEKLURY in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes following second- and third-trimester exposure. There are insufficient data to evaluate the risk of VEKLURY exposure during the first trimester. Maternal and fetal risks are associated with untreated COVID-19 in pregnancy.
- **Lactation:** VEKLURY can pass into breast milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for VEKLURY and any potential adverse effects on the breastfed child from VEKLURY or from an underlying maternal condition. Breastfeeding individuals with COVID-19 should follow practices according to clinical guidelines to avoid exposing the infant to COVID-19.

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

Learn more at vekluryhcp.com

aOR=adjusted odds ratio; CCI=Charlson Comorbidity Index; ECMO=extracorporeal membrane oxygenation; IMV=invasive mechanical ventilation; NSOc=no supplemental oxygen charges.

PINC AI™ is a trademark of Premier, Inc. (formerly Premier Healthcare Database).

References: 1. VEKLURY. Prescribing Information. Gilead Sciences, Inc.; 2025. **2.** Beigel JH, Tomashek KM, Dodd LE, et al; ACTT-1 Study Group Members. Remdesivir for the treatment of COVID-19 — final report. *N Engl J Med*. 2020;383(19):1813-1826. doi:10.1056/NEJMoa2007764 **3.** Mozaffari E, Chandak A, Gottlieb RL, et al. Treatment of patients hospitalized for COVID-19 with remdesivir is associated with lower likelihood of 30-day readmission: a retrospective observational study. *J Comp Eff Res*. 2024;13(4):e230131. doi:10.57264/cer-2023-0131. **4.** National Institutes of Health. Coronavirus Disease 2019 (COVID-19) Treatment Guidelines. Updated February 29, 2024. Accessed February 6, 2025. https://www.ncbi.nlm.nih.gov/books/NBK570371/pdf/Bookshelf_NBK570371.pdf

GILEAD

VEKLURY® (remdesivir)
Brief summary of full Prescribing Information. Please see full Prescribing Information.
Rx Only.

INDICATIONS AND USAGE

VEKLURY is indicated for the treatment of COVID-19 in adults and pediatric patients (birth to <18 years of age weighing ≥1.5 kg), who are:

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

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

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

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

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

Treatment Duration:

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

Renal Impairment: No dosage adjustment of VEKLURY is recommended in patients with any degree of renal impairment, including patients on dialysis. VEKLURY may be administered without regard to the timing of dialysis.

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinical Trials Experience: The safety of VEKLURY is based on data from three Phase 3 studies in 1,313 hospitalized adult subjects with COVID-19, one Phase 3 study in 279 non-hospitalized adult and pediatric subjects (12 years of age and older weighing at least 40 kg) with mild to moderate COVID-19, four Phase 1 studies in 131 healthy adults, and from patients with COVID-19 who received VEKLURY under the Emergency Use Authorization or in a compassionate use program. The NIAID ACTT-1 study was conducted in hospitalized subjects with mild, moderate, and severe COVID-19 treated with VEKLURY (n=532) for up to 10 days. Study GS-US-540-5773 (Study 5773) included subjects hospitalized with severe COVID-19 and treated with VEKLURY for 5 (n=200) or 10 days (n=197). Study GS-US-540-5774 (Study 5774) was conducted in hospitalized subjects with moderate COVID-19 and treated with VEKLURY for 5 (n=191) or 10 days (n=193). Study GS-US-540-9012 included non-hospitalized subjects, who were symptomatic for COVID-19 for ≤7 days, had confirmed SARS-CoV-2 infection, and had at least one risk factor for progression to hospitalization treated with VEKLURY (n=279; 276 adults and 3 pediatric subjects 12 years of age and older weighing at least 40 kg) for 3 days.

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

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

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

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

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

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

Remdesivir and its metabolites are in vitro substrates and/or inhibitors of certain drug metabolizing enzymes and transporters. Based on a drug interaction study conducted with VEKLURY, no clinically significant drug interactions are expected with inducers of cytochrome P450 (CYP) 3A4 or inhibitors of Organic Anion Transporting Polypeptides (OATP) 1B1/1B3, and P-glycoprotein (P-gp).

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

Pregnancy

Risk Summary: Available clinical trial data for VEKLURY in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes following second- and third-trimester exposure. There are insufficient data to evaluate the risk of VEKLURY exposure during the first trimester. Maternal and fetal risks are associated with untreated COVID-19 in pregnancy. COVID-19 is associated with adverse maternal and fetal outcomes, including preeclampsia, eclampsia, preterm birth, premature rupture of membranes, venous thromboembolic disease, and fetal death.

Lactation

Risk Summary: A published case report describes the presence of remdesivir and active metabolite GS-441524 in human milk. Available data (n=11) from pharmacovigilance reports do not indicate adverse effects on breastfed infants from exposure to remdesivir and its metabolite through breastmilk. There are no available data on the effects of remdesivir on milk production. In animal studies, remdesivir and metabolites have been detected in the nursing pups of mothers given remdesivir, likely due to the presence of remdesivir in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for VEKLURY and any potential adverse effects on the breastfed child from VEKLURY or from the underlying maternal condition. Breastfeeding individuals with COVID-19 should follow practices according to clinical guidelines to avoid exposing the infant to COVID-19.

Pediatric Use

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

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

Geriatric Use

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

Renal Impairment

No dosage adjustment of VEKLURY is recommended for patients with any degree of renal impairment, including those on dialysis.

Hepatic Impairment

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

OVERDOSAGE

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

214787-GS-017

GILEAD

In the Literature

UT Health San Antonio Medical Research Reviews

By Jack Badawy, MD, FACP, SFHM, Michelle Brooks, MD, FACP, SFHM, John M. Cunningham, MD, FHM, Naga Venkata Rama Krishna Vura, MD, FACP, Raj Sehgal, MD, Soniya Abraham, MD, and Amith Skandhan, MD, FACP, SFHM

UT Health San Antonio, Texas

IN THIS ISSUE

By Jack Badawy, MD, FACP, SFHM

1 Operative Versus Non-Operative Treatment of Acute Cholecystitis in Older Adults with Multiple Comorbidities–Advocating for Definitive Care

CLINICAL QUESTION: In patients 65 years and older, with multimorbidity, and presenting with acute cholecystitis, is operative treatment more efficacious than non-operative treatment?

Dr. Badawy

BACKGROUND: Approximately one-third of elderly patients and those who are medically complex receive initial non-operative treatment for acute cholecystitis, given the perceived increased risks of operative treatment. Although some guidelines advocate for up-front laparoscopic cholecystectomy, these recommendations are not based on large comparative studies and are inconsistently applied in practice.

STUDY DESIGN: Retrospective, comparative effectiveness, cohort study

SETTING: U.S. Medicare inpatient database of beneficiaries 65.5 years and older, admitted through the emergency department (ED) with a primary diagnosis of cholecystitis, identified using ICD-10 codes, from 2016 to 2018.

SYNOPSIS: The cohort included 32,527 patients. The mean age was 78, and patients were predominantly white. Comorbid conditions selected were associated with higher rates of surgical morbidity and mortality. Patients with gallstone pancreatitis were excluded. Among all patients, 67% received operative treatment (90% laparoscopic cholecystectomy) and 33% received non-operative treatment. Of the non-operative subset, only 32% underwent percutaneous cholecystostomy tube placement; the rest received antibiotics or supportive care. The primary outcomes included 30- and 90-day mortality. Readmissions, ED visits, and overall cost were also tracked. In the propensity-weighted analysis, the authors concluded that patients in the operative group compared to those in the non-operative group had statistically significantly lower 30- and 90-day mortality (risk difference 3% and 4%, respectively), readmissions (risk difference 12% and 18%, respectively), and cost at 180 days (savings of $1,460). The authors applied a novel method of analysis called the instrumental variable model, which is meant to represent patients in clinical equipoise, and the findings were directionally consistent, though mortality differences failed to meet statistical significance at 30 and 90 days.

BOTTOM LINE: In this elderly, traditionally high-risk group of patients, those treated with operative management had similar or improved mortality rates with fewer readmissions, less ED utilization, and lower cost. There will always be patients in whom the surgical risk outweighs the benefit, but these data support consideration of definitive surgical management, even in medically complex patients.

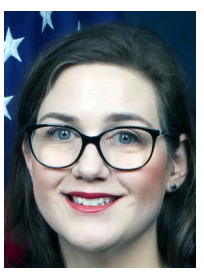
CITATION: Acker RC, et al. Operative vs non-operative treatment of acute cholecystitis in older adults with multimorbidity. *JAMA Surg*. 2025;160(6):656-664. doi: 10.1001/jamasurg.2025.0729.

Dr. Badawy is an academic hospitalist at UT Health San Antonio and an associate clinical professor in the division of internal medicine at Joe R. & Teresa Lozano Long School of Medicine in San Antonio.

By Michelle Brooks, MD, FACP, SFHM

2 Prescribed In-Hospital Sodium Intake for ADHF: A Systematic Review and Meta-Analysis

CLINICAL QUESTION: Does prescribed oral and/or IV sodium supplementation plus loop diuretic administration improve outcomes for patients hospitalized with acute decompensated heart failure (ADHF)?



Dr. Brooks

BACKGROUND: Standard inpatient care for ADHF traditionally involves dietary sodium restriction, but evidence for this approach is mixed. Despite concerns about exacerbating ADHF symptoms, previous studies proposed that supplemental sodium in combination with loop diuretics could improve diuretic efficacy, particularly in patients with diuretic resistance and worsening cardiorenal syndrome.

STUDY DESIGN: Systematic review and meta-analysis that synthesized evidence from randomized controlled trials and nonrandomized comparative studies. The 16 studies included were conducted across various regions worldwide.

SYNOPSIS: The review found that supplemental sodium (mostly IV hypertonic saline) with furosemide significantly decreased serum creatinine (pooled net mean difference [NMD]: -0.33 mg/dL) and brain natriuretic peptide (BNP) (pooled NMD: -62.84 pg/mL). It also led to a significant decrease in weight (pooled NMD: -2.48 kg) and a shorter length of hospital stay (pooled NMD: -2.68 days). There were no significant differences in N-terminal pro–B-type natriuretic peptide (NT-proBNP). Studies provided insufficient evidence on mortality and readmission outcomes, and no evidence for caloric intake or clinical congestion scores. No reports of worsening pulmonary edema or hypoxia were noted with sodium supplementation.

BOTTOM LINE: Sodium supplementation with loop diuretics for patients hospitalized with ADHF may improve kidney function, promote weight loss, and shorten hospital stay. This meta-analysis did not show serious renal outcomes or worsening congestive symptoms; however, further research is needed to confirm effectiveness and optimize strategies, as well as investigate mortality and readmission outcomes.

CITATION: Maih HJ, et al. Prescribed in-hospital sodium intake for decompensated heart failure: a systematic review and meta-analysis. *J Hosp Med*. 2025;1-9. doi:10.1002/jhm.70091.

Dr. Brooks is a hospitalist in the South Texas Veterans Health Care System and an adjoint associate professor in the division of internal medicine at UT Health San Antonio in San Antonio.

By John M Cunningham, MD, FHM

3 Hospital Addiction Consultative Service Increases MOUD Initiation and Linkage to Follow-up After Discharge

CLINICAL QUESTION: Does an addiction-focused consult service increase medications for opioid use disorder (MOUD) initiation during inpatient hospitalization and connect patients to follow-up care post-discharge?

Dr. Cunningham

BACKGROUND: Hospitalization is an opportunity to prescribe evidence-based treatments for opioid use disorder (OUD).

Despite the evidence for MOUD, medications are often not prescribed at the time of discharge. Prior studies have shown the benefits of an addiction-medicine team. This is the first parallel-assignment, randomized, controlled trial comparing the effectiveness of an addiction-medicine consult team to usual care.

STUDY DESIGN: Randomized controlled trial

SETTING: Three U.S. hospitals in separate healthcare systems

SYNOPSIS: This trial enrolled English- and Spanish-speaking patients aged greater than 18 years with a life expectancy of more than six months who were not currently being treated for OUD. Patients were randomized to the Substance Use Treatment and Recovery Team (START) intervention versus usual care. The START intervention consisted of an interprofessional team, including a physician and a case manager. The two primary outcomes were the proportion of patients who initiated MOUD prior to discharge and the proportion of patients attending at least one OUD-related follow-up visit within 30 days of discharge.

The 325 patients were randomized, 164 to START and 161 to usual care. START participants were significantly more likely to receive MOUD during their hospitalization compared to those receiving usual care (57.3% versus 26.7%; adjusted risk ratio, 2.1 [97.5% CI, 1.51-2.91]) and to be linked to follow-up care (72.0% versus 48.1%; adjusted risk ratio, 1.49 [97.5% CI, 1.15-1.93]).

BOTTOM LINE: The START interprofessional team increased the proportion of patients initiating MOUD during hospitalization and linkage to follow-up care at discharge for patients with OUD.

CITATION: Ober AJ, et al. Hospital addiction consultation service and opioid use disorder treatment: the START randomized clinical trial. *JAMA Intern Med*. 2025;185(6):624-633. doi:10.1001/jamainternmed.2024.8586.

Dr. Cunningham is a hospitalist at UT Health San Antonio and an associate clinical professor in the division of internal medicine at the Joe R. & Teresa Long School of Medicine in San Antonio.

By Naga Venkata Rama Krishna Vura, MD, FACP

4 Carvedilol Versus Propranolol for the Prevention of Decompensation and Mortality in Patients with Compensated and Decompensated Cirrhosis

CLINICAL QUESTION: Is carvedilol more effective than the classical non-selective beta-blockers (cNSBBs) propranolol or nadolol in preventing first decompensation and in reducing mortality in patients with clinically significant portal hypertension (CSPH) and both compensated and decompensated cirrhosis?

Dr. Vura

BACKGROUND: The study addressed a gap in the lack of direct comparative data to determine the optimal beta-blocker choice in patients with cirrhosis and CSPH.

STUDY DESIGN: Multicenter, retrospective, comparative effectiveness, cohort study for patients with cirrhosis referred for a baseline hemodynamic study before initiating non-selective beta-blockers from January 1, 2008, to July 1, 2021, in six hospitals across Europe.

SYNOPSIS: Patients with compensated or decompensated cirrhosis underwent hepatic venous pressure gradient (HVPG) measurement to assess acute hemodynamic response to IV propranolol before starting primary prophylaxis for variceal bleeding. Outcomes were analyzed using an inverse-probability-of-treatment weighting in a competing-risk framework. The study included 540 patients from multiple centers, with 256 (cNSBBs, n=111; carvedilol, n=145) patients in the compensated cohort and 284 (cNSBBs, n=134; carvedilol, n=150) in the decompensated cohort. Median follow-up was approximately 36.3 and 30.7 months, respectively. After covariate balancing, compared to cNSBBs, carvedilol significantly reduced the risk of decompensation in compensated patients (hazard ratio [HR], 0.61; 95% CI, 0.41-0.92) and a combined endpoint of further decompensation or death in decompensated patients (HR, 0.57; 95% CI, 0.42-0.77). A second HVPG was conducted in approximately two-thirds of the cohort, and among initial non-responders, carvedilol was associated with a higher likelihood of achieving a chronic hemodynamic response.

BOTTOM LINE: In this study, carvedilol was superior to cNSBBs for preventing first and further decompensation and mortality in patients with compensated, and selected decompensated, cirrhosis with CSPH, with similar safety. These findings support the preferential use of carvedilol in these populations, consistent with the evolving consensus and recommendations from the American Association for the Study of Liver Diseases. However, caution is advised in patients with decompensated cirrhosis and circulatory dysfunction or recurrent or refractory ascites.

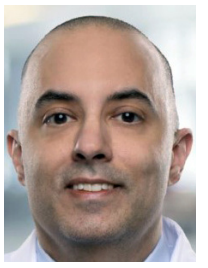
CITATION: Fortea JI, et al. Carvedilol vs. propranolol for the prevention of decompensation and mortality in patients with compensated and decompensated cirrhosis. *J Hepatol*. 2025;83(1):70-80. doi: 10.1016/j.jhep.2024.12.017.

Dr. Vura is an academic hospitalist in the division of hospital medicine at UT Health San Antonio and a clinical assistant professor in the department of internal medicine at the Joe R. & Teresa Long School of Medicine in San Antonio.

By Raj Sehgal, MD

5 Oral Versus Extended-Release Injectable Naltrexone for Hospitalized Patients With AUD

CLINICAL QUESTION: Is there a difference in effectiveness between oral and injectable naltrexone at discharge for alcohol use disorder (AUD)?



Dr. Sehgal

BACKGROUND: AUD is common among inpatients, and most do not receive medication or counseling at discharge, leading to high rates of post-hospitalization acute care utilization. Naltrexone has been shown to increase the likelihood of decreased alcohol intake and/or sobriety and is available as both a daily oral tablet and a monthly intramuscular (IM) injection. While the injection is more expensive, theoretically increased compliance might make it more cost-effective.

STUDY DESIGN: Open label, randomized, controlled trial in a single, urban, academic hospital in the U.S.

SYNOPSIS: Over a 4-year period, hospitalized patients with AUD were randomized to daily oral naltrexone or monthly extended-release IM naltrexone prior to discharge. Patients also had monthly follow-up with a study nurse after hospitalization to address medication management. Self-reported heavy drinking days (HDD) in the 90 days post-hospitalization (the primary outcome), decreased in both groups. There was no significant difference between oral (38.4% fewer HDD) and IM (46.4% fewer HDD) naltrexone. The mean Short Inventory of Problems Revision 2 score (an assessment of problems related to alcohol use) also improved in both groups, without a significant difference between groups. Medication adherence was poor overall with high adherence in only 27% of patients in the oral group and 41% in the IM group. Median healthcare costs were lower ($1,630 versus $5,208) in the oral naltrexone group. There was no difference in reported alcohol-related healthcare utilization between the groups.

BOTTOM LINE: Oral and IM naltrexone are similarly efficacious in terms of reducing self-reported HDD and alcohol-related problems for treatment of patients with AUD at hospital discharge. IM naltrexone is associated with higher adherence and cost.

CITATION: Magane KM, et al. Oral vs extended-release injectable naltrexone for hospitalized patients with alcohol use disorder: a randomized clinical trial. *JAMA Intern Med*. 2025;185(6):635-645. doi: 10.1001/jamainternmed.2025.0522.

Dr. Sehgal is the division chief of hospital medicine at the South Texas Veterans Affairs Healthcare System and an associate clinical professor at UT Health San Antonio in San Antonio.

By Soniya Abraham, MD

6 IV Ferric Carboxymaltose in Heart Failure with Iron Deficiency

CLINICAL QUESTION: Does IV ferric carboxymaltose improve clinical outcomes in patients with heart failure (HF) and iron deficiency?

Dr. Abraham

BACKGROUND: Iron deficiency affects up to half of patients with HF and is associated with worse symptoms, reduced exercise capacity, and increased mortality compared with those without iron deficiency. Although intravenous iron supplementation has been investigated as a therapeutic strategy, its clinical benefit remains uncertain due to mixed results from prior trials. Transferrin saturation below 20% has emerged as a potentially more specific marker of iron deficiency than serum ferritin alone. The FAIR-HF2 trial was conducted to evaluate the effects of intensive and consistent intravenous iron supplementation in this population.

STUDY DESIGN: Randomized, double-blinded, placebo-controlled, clinical trial in 70 clinic sites across six European countries

SYNOPSIS: This trial enrolled 1,105 patients with HF with reduced ejection fraction (left ventricular ejection fraction 45% or less) and iron deficiency (serum ferritin level under 100 ng/mL; or if transferrin saturation was under 20%, a serum ferritin level between 100 and 299 ng/mL) between 2017 and 2023. Participants were randomized to receive either IV ferric carboxymaltose (n=558), with an initial dose of up to 2,000 mg followed by 500 mg every four months,

or placebo (n=547). The primary outcomes were: time to cardiovascular death or first HF hospitalization; total HF hospitalizations; and time to cardiovascular death or first HF hospitalization in patients with transferrin saturation under 20%. At a median follow-up of 16.6 months, the first outcome occurred in 141 patients in the treatment group versus 166 in the placebo group (HR, 0.79; 95% CI, 0.63–0.99; *P*=.04). Total heart failure hospitalizations were 264 versus 320 (rate ratio, 0.80; 95% CI, 0.60–1.06; *P*=.12), and in the transferrin saturation under 20% subgroup, 103 versus 128 events occurred (HR, 0.79; 95% CI, 0.61–1.02; *P*=.07). Ferric carboxymaltose was well tolerated, with similar rates of adverse events in both groups.

BOTTOM LINE: In patients with HF and iron deficiency, ferric carboxymaltose did not significantly reduce the time to first heart failure hospitalization or cardiovascular death in the overall cohort or in patients with a transferrin saturation less than 20% or reduce the total number of heart failure hospitalizations versus placebo. Despite the *P* value of 0.04 for time to cardiovascular death or first heart failure exacerbation, the authors did not consider this statistically significant given they used more stringent criteria to control for multiple primary outcomes (Hochberg procedure).

CITATION: Anker SD, et al. Intravenous ferric carboxymaltose in heart failure with iron deficiency: the FAIR-HF2 DZHK05 randomized clinical trial. *JAMA*. 2025;333(22):1965-1976. doi: 10.1001/jama.2025.3833.

Dr. Abraham is an academic hospitalist at UT Health San Antonio and an assistant clinical professor in the division of internal medicine at the Joe R. & Teresa Long School of Medicine in San Antonio.

By Amith Skandhan, MD, FACP, SFHM

7 Feeding Tube Use Still Common in Hospitalized Older Adults with Dementia

CLINICAL QUESTION: How frequently are feeding tubes placed during hospitalization in older adults with dementia, and what patient or regional factors influence their use?

Dr. Skandhan

BACKGROUND: Feeding tube placement in advanced dementia has been discouraged by national guidelines due to lack of demonstrated benefit and potential harm. Nonetheless, there is limited recent data on inpatient placement trends across the U.S.

STUDY DESIGN: Retrospective cohort study using 100% Medicare fee-for-service claims from 2017 to 2023

SETTING: National cohort of hospitalized Medicare beneficiaries at least 65 years old with dementia, without prior feeding tube use.

SYNOPSIS: Among more than one million admissions, 2.4% of patients with dementia had a feeding tube placed during hospitalization. Placement was more common in patients with moderate-to-severe dementia, and in those hospitalized for pneumonia, sepsis, or dehydration. There was marked geographic variation in feeding tube use: some hospitals placed tubes in less than 1% of patients, while others exceeded 5%, representing a greater than five-fold difference even after adjustment for patient characteristics. From 2017 to 2023, feeding tube use declined modestly across all regions.

The primary outcome was inpatient initiation of a feeding tube (nasogastric or percutaneous endoscopic gastrostomy). Researchers assessed trends over time and variation by hospital, region, and patient characteristics. Strengths include the large nationally representative cohort and consistent findings across sensitivity analyses. Limitations include reliance on claims data to define dementia severity and lack of insight into patient preferences or clinical decision-making processes.

BOTTOM LINE: Despite longstanding recommendations discouraging feeding tube use in dementia, feeding tubes are still placed in roughly one in 40 hospitalizations, with wide variability across institutions. Rates are trending down slowly, but decision making often remains misaligned with palliative goals of care. This study underscores the ongoing need for shared decision making, especially during acute illness in patients with dementia. The significant variation in use across hospitals underscores the influence of local practice patterns. Hospitalists should reflect on whether feeding tube decisions at their institution are driven by patient goals or historical norms—and seek to realign care accordingly. Avoiding default tube placement in favor of comfort-focused care can better reflect patient values and improve outcomes.

CITATION: Hartford AM, et al. Use of feeding tubes among hospitalized older adults with dementia. *JAMA Netw Open*. 2025;8(2):e2460780. doi: 10.1001/jamanetworkopen.2024.60780.

Dr. Skandhan is a hospitalist at UT Health San Antonio and a clinical associate professor at the Joe R. & Teresa Long School of Medicine in San Antonio. ■

2025 National Hospitalist Day HM Voices Contest Winners

This year's annual National Hospitalist Day HM Voices contest asked participants to consider the ABCs—advancing care, building community, and creating opportunity—when crafting their submissions. Congratulations to this year's winners: Jennifer Li, MD, Mridula Nadamuni, MD, and Charmi Shah.

Room 12-240

By Mridula Nadamuni, MD

Dr. Nadamuni

Dr. Nadamuni is an oncology hospitalist and assistant clinical professor of medicine at Yale Smilow Cancer Center in New Haven, Conn.

"What's the story?" I ask as I walk into room 12-240. I've done this dance so many times today in so many different rooms all over the tower. The patient I face now is unknown to me. Strands of information are being volleyed back and forth, painting in the fuzzy lines that are rapidly shaping into a portrait of a sick man getting sicker by the minute. Heart rate, blood pressure, oxygen sat, meds, medical history, risk of infection, cancer treatments, access, pushing meds, pads on, shockable rhythms. I crack a few jokes with him, trying to keep it light and keep the room calm. It works for a little while, but soon he is tanking. The fatigue of fighting to breathe is taking its toll, and we are beyond the limits of the non-rebreather to rebreathe life into this man.

MICU arrives. Anesthesia, stat. Transfer orders are in. After the crowd has dispersed, the empty room is littered with the detritus of the frenetic activity of placing IVs, drawing blood, and hanging meds. I don't know this yet, but tomorrow by noon, he will be dead, our interventions unable to beat back the rapid pace of the bacteria that are ravaging his weakened body.

When I'm back tomorrow, caffeinated if not rested, every trace of yesterday's emergency will have been completely cleared by a housekeeper working diligently to restore the room to rights. Evidence that he was ever here will be erased, and the dramatics of the night before will be only a memory stored in the EHR. I'll walk into 12-240 again, this time with a sick patient getting sicker, and have a difficult conversation about the end of her life. The patient's daughter will quietly agree with her mother's wishes to die with dignity. The patient's son, who lives across the country, will arrive just in time to disagree violently. The conversation will go on, the right words ringing hollow in my dry mouth, too weak to extinguish the rage and grief and love of a man unprepared to lose his mother.

When I'm back tomorrow, I will realize that 12-240 isn't just a 12-by-12-foot room painted with bland sea foam green walls but is, in fact, a portal, much like Narnia. Opening the door each day unfolds a new landscape of heightened human emotions for me to navigate—grief, distress, panic, angst, rage, hope, and love.

When I'm back tomorrow, I will have a moment of crisis where I wonder why I signed myself up for a job where I always have to be the adult in the room, the responsible party, the one with the answers. I will take refuge in the office with my colleagues for a moment. They will understand immediately when I describe this conversation I've just had. They will murmur assent, and someone will throw out a story of their own, and we will have a moment of shared understanding. My faith will be restored, and my gratitude for my profession will be renewed. A few hours later, I'll be called back to 12-240 with the request to start hospice proceedings. The relief on the patient's face will be palpable, and she will be discharged home to finish her journey surrounded by family. I might shed a few tears in the office, partially relief and partially grief.

When I'm back tomorrow, I'll realize the privilege of being at the bedside, historian of the stories of yesterday and the unfolding of both life and death in a way that few outside our profession ever will. When I'm back tomorrow, room 12-240 will be occupied once more, and we will begin again once more, the same sea-foam green walls silently bearing witness to the new stories unfolding.

I will be back tomorrow. ■

Countertransference

By Jennifer Li, MD

He raises his head, fingers curled gently
around the tiny ankle of the child on the bed –
"I lost my grandson last year," he says,
quiet undertone to
rustle of sheets from the next room over.
"He was twenty-five."
His hands are firm, lined with
a soft sadness in how they move,
molasses-slow, deliberate stretches, reaching
for invisible hands he can no longer touch.
I, too, know the phantom of
hands I cannot hold anymore. The
ghost of losing someone who nestled a home in
my heart in spite of gaps in generation,
someone who taught me to behold beauty in
wispy steams of freshly brewed coffee,
pitchy string instrumentals amidst stereo static
I am so sorry, I hear my voice say,
no doubt an echo
of overused platitudes.
I am of the same generation as the
boy this man lost, the
devastation of an ending
he has been forced to
caress in his palms, carry
with him home every night,
every room he enters, every child
he has watched grow up
from their tiny-ankle ages
They tell us our own
projections onto patients
is *countertransference.*
But when I hand this man his papers,
stiff text in narrow margins,
our fingers brush
for a brief moment
It is not a transfer but an
understanding – our taciturn agreement
to remain silent, together, heavy with
the knowledge of
having to sit with the space
someone we loved once occupied,
grief overused with each passing year.
The child on the bed reaches
for me, gaze bright and questioning.
I offer him a finger. He grasps it,
small palms warm and dry
the sweet innocence of unknowing
"Hi," he quips. Beside him, his grandfather's brows furrow.
And how are you? I ask, words
stale on my tongue,
but he laughs, crooked teeth, exclamatory and
loud, the kind of loudness I have unlearned, and
it feels like an answer to a brand-new question.
A brand-new blossom of beauty in my chest –
the first sip of dark roast on my lips,
The ghost of my grandfather's hands
grasping mine, here in the broken silence. ■

Dr. Li

Dr. Li is an academic hospitalist at Grady Memorial Hospital and an assistant professor at Emory University School of Medicine in Atlanta. She currently serves on the editorial board of Intima: A Journal of Narrative Medicine.

By Charmi Shah

Heart in Bloom

By Charmi Shah

Shah

Ms. Shah is a rising 4th-year medical student at the University of Louisville School of Medicine in Louisville, Ky.

Lung POCUS: The Hospitalist's New Stethoscope

By Elian D. Abou Asala, MD, FRCP, GMBA

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In the time it takes to order, perform, and upload a stat chest X-ray, a skilled clinician with an ultrasound probe can diagnose an early pneumothorax, confirm pulmonary edema, or eyeball a pneumonia[1]—all at the bedside with zero radiation exposure to the patient and the doctor.[2] Welcome to an era where sound waves, with an expert hand, can sometimes perform better than other imaging and even physical exams.[3]

Lung point-of-care ultrasound (POCUS) has become an essential tool in hospital medicine, offering rapid bedside assessment of respiratory pathologies, often outperforming chest radiography.[4]

Lung POCUS enables early detection of conditions such as pneumothorax, pleural effusion, pulmonary edema, and pneumonia, thereby enhancing clinical decision making in real time, guiding targeted interventions, and reducing delays in care.[4]

Furthermore, its portability and repeatability make it particularly valuable in critically ill or immobile patients.[5]

As a result, lung POCUS is increasingly recognized as a core competency for hospital-based clinicians.

Hospital medicine is inherently dynamic. Patients can decompensate fast. Imaging can lag. But lung POCUS always rises to deliver answers in seconds. Below, we explore five brief clinical vignettes that reveal how this tool is transforming inpatient care and can perform as the clinician's third hand. Each scenario ends with a clinical pearl.

Invisible pneumothorax

Case: A 62-year-old man, post-renal transplant, is admitted for pneumonia, for which he is being treated with levofloxacin. While on the regular nursing floor, he suddenly develops dyspnea and chest discomfort. Chest auscultation is unrevealing. Chest X-ray is pending.

Bedside lung POCUS: No lung sliding in the upper lobes, no B-lines, but a positive barcode sign on M-mode—classic signs of a pneumothorax.

Action: Chest tube placed at bedside. Patient stabilizes before radiology even pages back.

Clinical Pearl: In the right clinical setting, absent lung sliding and a barcode sign on M-mode point towards a diagnosis of pneumothorax. POCUS was found to be superior to chest X-ray for early detection of this potentially fatal diagnosis.[6]

It is important to note that absent lung sliding is sensitive but not 100% specific to pneumothorax, as it may also be observed in conditions like severe emphysema, pleural effusion, main bronchial intubation, pleurodesis, and apnea.[7]

Quiet pneumonia

Case: An 80-year-old woman with dementia presents for shortness of breath. She is found to be in sepsis with fever and acute respiratory failure with hypoxia. Labs noted an elevated white blood cell count on the complete blood count. Some crackles are heard in the right lower lobe, with portable X-ray showing low lung volumes with right lower lobe haziness. Urinalysis is suggestive of possible infection.

Bedside lung POCUS: Subpleural consolidation with dynamic air bronchograms, indicating lobar pneumonia.

Action: Antibiotics are started, and the patient is made nil per os pending a swallow study. The swallow study is completed the next day and shows active liquid penetration indicating pharyngeal-phase aspiration.

Clinical Pearl: POCUS can help in the early identification of pneumonia.[8]

Dynamic air bronchograms are the sonographic signature of pneumonia—they appear like "moving shadows" where consolidation lives, and they help differentiate pneumonia from atelectasis, where consolidation can still be seen, but dynamic air bronchograms are absent.[9]

Lake of B-lines

Case: A 59-year-old man with morbid obesity, ischemic cardiomyopathy, and chronic systolic heart failure presents with worsening shortness of breath and orthopnea. He also notes a 10-pound weight gain. B-type natriuretic peptide (BNP) and initial troponin are mildly elevated.

POCUS: Bilateral, diffuse B-lines are seen in all lung fields, especially lower lobes. B-lines appear like laser-like rays from the pleura to the screen edge, suggesting pulmonary edema in the right clinical setting.

Action: High-dose IV diuretics are started confidently. Chest X-ray arrives later with "vague interstitial markings."

Clinical Pearl: Bilateral, diffuse B-lines indicate pulmonary edema in the right clinical setting.[10] Can be a helpful finding when labs are borderline (underestimated BNP in obese patients).

Note that diffuse B-lines can also be seen in interstitial lung disease. Focal B-lines can be a sign of pneumonia.

Parapneumonic complicated effusion versus simple pleural effusion

Case: A 44-year-old man undergoing chemotherapy for acute myeloid leukemia, and with nonischemic cardiomyopathy, presents for shortness of breath and cough. He is admitted for hypoxic respiratory failure requiring 2 L/min of O2 support. Labs show a high normal white cell count. Chest X-ray shows right-sided pleural effusion with right diaphragm elevation. BNP is slightly elevated on labs. The initial thought is acute decompensated heart failure. Diuretics are being considered.

Bedside lung POCUS: Anechoic, loculated pleural effusion with septations and adjacent consolidation and air bronchogram seen. Findings are concerning for complicated parapneumonic effusion.

Action: Interventional radiology thoracentesis is ordered, with fluid analysis indicating exudative process. Early infection is successfully detected, furosemide is held, and antibiotics are started, preventing progression to sepsis in an immunocompromised patient.

Clinical Pearl: Complex pleural fluids with septations and adjacent lung dynamic air bronchogram should raise alarm for complicated pleural effusion[11]—especially when X-ray is unable to differentiate complicated from simple pleural effusion.

Summary

Lung POCUS isn't just an imaging modality; it's a bedside extension of the physical exam for perfect clinical reasoning. It's democratized diagnosis—immediate, repeatable, and free of radiation. For hospitalists navigating diagnostic uncertainty, lung POCUS can be the difference between delayed and decisive care. ■

Dr. Abou Asala

Dr. Abou Asala is a hospitalist and associate staff physician in the department of hospital medicine of the Cleveland Clinic Foundation, and clinical assistant professor of medicine at the Cleveland Clinic Lerner College of Medicine, both in Cleveland.

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Beyond the Hospital's Four Walls

Other roles and settings for hospitalists

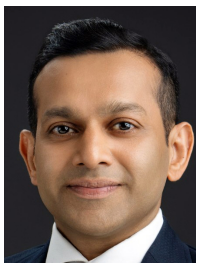
By Larry Beresford

When, in their classic 1996 New England Journal of Medicine article, Robert Wachter, MD, and Lee Goldman, MD, announced the emergence of the hospitalist concept, they defined it in terms of doctors working inside an acute care hospital.[1] At a time when primary care physicians were pulling back from making regular hospital visits, hospitalists spending their entire work day in the hospital were an alternative proposed to make the whole healthcare system work better.

In 29 years, this medical specialty has grown dramatically to approximately 60,000 physicians, according to estimates from SHM, plus physician assistants and nurse practitioners. They focus not just on the patient in front of them but also on how to improve quality and efficiency and promote patient safety for the hospital and health system as a whole.

But today their work setting is no longer confined by the hospital's four walls. One might say this fast-growing medical specialty has overflowed its banks in a variety of other directions. These can include rehabilitation hospitals and long-term care facilities, diverse outpatient clinic settings, hospice and palliative care, administrative roles, virtual and telehealth, and even hospital-at-home teams. "Hospitalists are primed to lead the way in advancing home-based acute and transitional care," including hospital at home, observes a 2024 article in the Journal of Hospital Medicine.[2]

For Thejaswi Poonacha, MD, MBA, FACP, SFHM, a staff hospitalist at M Health Fairview, clinical associate professor of medicine, and medical director for utilization management and clinical documentation integrity at the University of Minnesota Medical Center, all in Minneapolis, the evolution of hospital medicine reflects its origins in many hospitalists' internal medicine training. "That training meant they would have the capacity to work both inside and outside the hospital, including in clinics and nursing homes," all with the same medical board certification, he said.


Dr. Poonacha

"My own role encompasses five different things," Dr. Poonacha said. "I am a hospitalist, so I do clinical work in the hospital. At times, I oversee the skilled-nursing facility on our hospital's campus, so there's a nursing-home role, too. I am the medical director of utilization management for the University of Minnesota Medical Center, and I also oversee part of our DRG denials. And I am on the faculty at the University of Minnesota, so I have a teaching role as well."

"I'm constantly on the alert; I never know what's going to come next. But I enjoy the job because it gives a broad oversight of the overall workings of the hospital."

An Unsustainable Schedule

Robert Craven, MD, FACP, CHCQM-PHYADV, ACPA-C, SFHM, a physician advisor and the vice president of case management for McLeod Health in Florence, S.C., gave up his hospital practice entirely in late 2023. "But I still very much have my roots and identity as a hospitalist because I did it full-time for almost 10 years, plus an additional three where I was also dabbling in other things," he said. "I loved being a hospitalist, and I love SHM."


Dr. Craven

Dr. Craven said a lot of hospitalists he knows are thinking maybe the physical demands of hospitalist work aren't sustainable for a 30-year career. But what else is out there for them? "A lot of physicians will come and talk to me about the things I've tried, what has worked or not worked, and how they can take that first step into another career path," Dr. Craven said.

"I would just say the seven days on/seven days off scheduling model, which is very common in the hospitalist field, gives you a lot of flexibility on that week off to pursue other kinds of things. And that's what I did for several years until I found a niche for myself."


Dr. O'Glasser

For Avital O'Glasser, MD, FACP, DFPM, SFHM, professor of medicine in the division of hospital medicine and department of anesthesiology and perioperative medicine at Oregon Health Sciences University (OHSU) in Portland, these trends of working in diverse settings grew out of how the field of hospital medicine has grown and evolved, as well as the shifting landscape of healthcare. Positions outside the

hospital are built on recognition that hospitalists have the skills to take on these different roles, said Dr. O'Glasser, who is also the medical director of the Pre-Operative Medicine Clinic.

"SHM has done a phenomenal job, helping us recognize the abundance of other opportunities for the expertise of hospital medicine, whether quality improvement or medical education, or point-of-care ultrasound, and not pigeonhole ourselves into just one geography. There are just so many ways that hospitalists may be contributing to the care of patients within the hospital and beyond," Dr. O'Glasser said.

"I've been calling myself an outpatient hospitalist for probably five or six years, and doing outpatient work only for almost as long," she said. The dedicated pre-op clinic at OHSU has been in operation for 17 years, in its current iteration since 2008, and she's been with the clinic in some capacity since completing residency.

The clinic is where patients go to meet with a clinician before their surgery, to get questions answered and to talk about preparing for the operation—what's going to happen and why that's important, she explained. "We do not use the 'C word' (clearance for surgery). But pre-op medicine at its best is the opportunity to pause and conduct a thorough, patient-centered risk assessment, risk evaluation, and history, to confirm that they are medically appropriate for the planned surgery, and to make sure the interdisciplinary care teams have all the information they need to care for this patient," she explained. "We lean into the concept of optimization."

When Dr. O'Glasser became medical director of the clinic in early 2019, she found that it was time to shift all her clinical time to the outpatient setting and protect her bandwidth to focus on the clinic's needs. Trying to direct the clinic during two-week inpatient teaching service shifts was not sustainable. The different flexibility of a completely outpatient versus inpatient schedule was also appealing to her, with two young children, she said.

Dr. O'Glasser's role is an illustration of how hospitalists are working not only in the hospital. "I'm certainly not a primary care physician, and I don't feel like I'm the traditional model of a general internal medicine physician. I mean, I'm very general but also very niche at the same time," she said.

"Part of the reason why I've embraced this role is that, especially for older, complex, sicker patients who are going to be spending some time in the hospital after their surgery, I find myself thinking about their transitions of care. What that inpatient recovery period is going to be like, with complications anticipated or unanticipated, before the patient goes back to their family," she said.

"But I absolutely see myself as an extension of their hospital care. It's not only patient preparedness, it's also empowerment, and I use that term very liberally, empowering the entire care team to meet that patient where they are and take the best care of them possible. And that is literally what I tell every patient: It's not just getting you into the operating room and out, but the whole care spectrum and recovery process."

Differences and Similarities in LTC


Dr. Manolukas

Theodore Manolukas, DO, a hospitalist at the University of Cincinnati Medical Center in Cincinnati, said he spends most of his professional time working in the hospital as a traditional hospitalist, both solo and supervising residents. "But I also spend time working in SNFs and in our long-term acute care hospital (LTACH). So those are the three places where I divide my clinical time," he said.

"When I see a patient in the hospital, usually I'm addressing one acute issue: 'You know, you're here for pneumonia. We're giving you antibiotics. You can leave in two days.' At the skilled nursing facility, it's a different mix of what we're doing, focusing on several chronic issues at the same time, as well as dealing with any smaller acute things that could pop up," he said.

"When I work at the university hospital, I have access to all the consultants I could need. I have advanced imaging and things like that, which I can get very quickly, versus when I'm at the SNF or the LTACH, I have a lot less to work with. So, it's about navigating that process of knowing when to take a step back and say, all right, this patient is sick, let's just send them to the hospital, versus trying to manage their care onsite," he said.

"I would say that when we're looking at the evolution of the hospitalist concept and why it is such a popular branch of medicine, that has a lot to do with how complex inpatient care has become, both socially and financially as well as medically," Dr. Manolukas said. "And the skills you develop as a hospitalist, dealing with social workers and multidisciplinary rounds, things like that, also lend themselves very well to other areas of medicine. We have become the specialists in managing complex social situations."

When Dr. Manolukas took the opportunity to work in the LTACH as a young attending, it was a way to make some extra money. "But when I actually started doing it, I found it enjoyable, something I'd like to continue as part of my practice," he said.

"I've learned quite a bit, and I've been able to take some of that with me back to my main job in the hospital, primarily a better understanding of what it means to discharge a patient to a SNF—what these facilities can realistically do and the things they struggle with. I discharge a lot of my hospitalized patients to SNFs, and I think that's becoming increasingly common as our hospitalized population becomes older and sicker." Sometimes he sees the same patient in both sites.

A Pediatric Program


Dr. Kumar

When people ask Anika Kumar, MD, FAAP, FHM, a pediatric hospitalist at the Cleveland Clinic in Cleveland, what she does professionally, she replies that she is a pediatrician who works primarily but not exclusively inside the hospital with seriously ill pediatric patients. "I work at a tertiary-quaternary medical center, and some of my time is also at a regional hospital where I provide care to newborns. Some is at an acute pediatric rehabilitation hospital."

Pediatric hospital medicine programs vary, she said. Some may include outpatient services and address outpatient needs. "From a practice standpoint and guideline standpoint, practice is pretty uniform in that we try our best to develop and follow evidence-based guidelines. But the 'ask' of the hospitalist varies from hospital to hospital."

At the rehab hospital, the physiatrist consults on patients, and the hospitalist serves as the attending of record, Dr. Kumar said, "providing care to ensure that we are appropriately addressing the medical side of the patient's needs. We do our best to have robust care coordination."

Facility staff may not be trained, for example, in weaning patients off ventilator support. "This is something I'm comfortable doing. We're also taking care of sicker patients there. You know, patients who come in with something like Guillain-Barré syndrome, a demyelinating disease, or acute disseminated encephalomyelitis. For many of the patients I take care of in rehab, I speak to their primary care physician about what they've been through."

Administrative Advance

Dr. Poonacha said another important role that might lure hospitalists off the floors is administrative in nature. "You see, hospitalists have their fingers everywhere within the hospital, every department. They are typically the primary admitting service. Not only do they know their own medical responsibilities, but they also know the workflow, and they know the issues with various other departments. They are involved in discharge and length of stay. This enables them to be able to take administrative roles for the hospital," he said.

"So, you see hospital medicine naturally going into the area of utilization management, into quality. They are looking at quality metrics, perhaps catheter-related infections, sepsis, and so on. And in many hospitals, because they see the input and output, throughput and workflow, hospitalists have a consistent presence," Dr. Poonacha said.

"As a hospitalist, I am interested in how this patient got pneumonia, why the patient was treated and sent home last month, and then came back to the hospital. What did we do wrong previously when we discharged them? Did we not organize the follow-up accurately? Or did the patient not have enough resources to be able to meet their needs at home?"

For Dr. Craven, some of his career experimentation involved consulting with law firms and attorneys in the medical malpractice world and other areas of law. "I started doing some reviews for our state medical board about eight years ago. That kind of got my feet wet in the legal world. Over time, you get good at it. You learn the ropes because the legal world is very different. The language is different; the expectations are different." And you have to build your reputation.

"I did it all on my own. I didn't go to any training camp or seminar or conference," Dr. Craven said. As the work has grown, he has taken on false-claims cases, where entire healthcare systems are accused of flawed billing processes, sometimes intentionally to game the system. "My background as a hospitalist and as a physician advisor has given me a kind of expertise that your average doctor doesn't have."

He still does expert-witness work, but now largely in long-term care. To that end, he's also part of a post-acute medicine group, the Physicians Services Group of South Carolina, which has about 60 clinicians who round in nursing homes and acute rehab facilities across the state.

"I've been working with this group for a couple of years now. It was a connection I made through hospital medicine. The group specifically seeks seasoned hospitalists to staff these facilities, with the rationale that no one knows better how to prevent these patients from getting sick and being readmitted to the hospital than a seasoned hospitalist."

He spends several hours a week on expert witness work and legal reviews and four or five

Continued on page 23

SHM's Leadership Academy Turns 20

Leaders reflect on its impact and evolution

By Thomas R. Collins

Early in his career, Eric Howell, MD, MHM—now the chief executive officer of the Society of Hospital Medicine—was a "prototypical hospitalist," as he put it. He was young, and he was part of a growing, but still relatively small, medical division.

And when it came to certain parts of the job, he was, like so many of his peers, a bit in the dark.

Dr. Howell

"We'd been trained as physicians, not as leaders and businesspeople," said Dr. Howell, who was then a hospitalist at Johns Hopkins. "So we were often in the middle of those financial discussions—or, frankly, tense negotiations with other physicians or hospital leaders—and none of that was taught in medical school."

In 2004, SHM—which was helping hospitalists prepare for all the new field's demands, and until a year earlier had been the National Association of Inpatient Physicians—responded to a pent-up hunger for leadership training with a new, one-day pre-course held in New Orleans. Developed by co-directors Russell Holman, MD, MHM, and Mark Williams, MD, MHM, the course received rave reviews from the 100 attendees but was sold out and left many on a waiting list.

So SHM went bigger, with a four-day academy first held in Tucson in 2005. And this year, the SHM Leadership Academy is celebrating its 20th anniversary—demonstrating a longevity that doesn't seem surprising to those who experienced its impact first-hand in its early years.

Dr. Howell, who was among the academy's first faculty members, said the academy has had widespread effects.

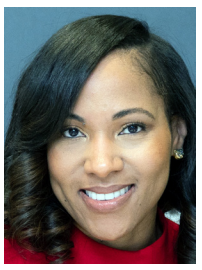
"My personal belief, and one of the reasons why I was so happy to do this more than 20 years ago, is that I think we need more physician leaders in medicine," he said. "And I think that it's probably not the sole reason, but one of the reasons, that there are so many hospital medicine leaders across the country."

The academy began with just one track, the more introductory track now known as Strategic Essentials. But after about five years, more advanced tracks—Influential Management and Mastering Teamwork—were added. And a few years after that, the Leadership Capstone course, which includes an ongoing, six-month component, was introduced in response to attendees who wanted a longer training experience to keep their skills sharp.

The academy's faculty members and course directors, while still focusing on teamwork, conflict resolution, finances, and other core concepts, are constantly assessing their content so that the details keep up with the times, in response to the realities of healthcare and to the feedback given by participants.

The academy—in which instructors balance bursts of lecture with hands-on discussions that put the lessons into practice—has sparked such enthusiasm and dedication from participants that it can be hard to imagine that it wasn't always a part of SHM's offerings. Attendees say it proved to be an indispensable part of their training and a vital piece in their career trajectory.

Kierstin Kennedy, MD, MSHA, SFHM, chief medical and quality officer at the University of Alabama at Birmingham Hospital, and the course director for the academy for the last several years, said she had just finished a fellowship in quality improvement in 2014 and was starting a post as director of quality improvement. Still, she said, she didn't quite feel ready.



Dr. Kennedy

"Despite having finished this fellowship—and also, by the way, having a master's in health administration, which I had finished in 2011—I didn't totally feel ready to be leading people, and I felt like I needed some more practical training," she said. "Not that there wasn't leadership training in those other programs—there absolutely was. But now it was sort of like, how do you take this very academic approach to leadership and implement it?"

So she looked for leadership training that would be applicable immediately and came across SHM's Leadership Academy. It raised her eyebrows, and that year's location in 2014 wasn't exactly a deterrent, she said.

"It did not hurt that it was in Hawaii," she said.

She attended the Influential Management level—because of her health administration degree, she opted out of the introductory Strategic Essentials level—and the effects were profound, she said.

"It was just a really transformational experience, I thoroughly enjoyed it," she said. "I had not had any training like that. The topics that we talked about — none of these were things that had been covered in my fellowship or in my master's program." She remembers discussions about being self-aware during tense moments—are you in the basement or on the balcony, with a wider vantage point—and conversations about feeling sandwiched between those who report to you and bosses to whom you report.

"I remember sitting in there thinking, 'Oh my god, this is my life—this is every day, I feel sandwiched.'"

She could, she felt, put the lessons to work back at home right away.

"It felt like, just add water and stir," Dr. Kennedy said. "It did immediately relate to going back to work and managing people, and managing up, and advocating for my area." Upon returning, she said, she and her colleagues developed a mission and vision for their department.

The next year, she attended the academy in Austin, enrolling in the Mastering Teamwork course. At dinner, she recalled, she discussed that day's lessons with her colleagues, some of whom were enrolled in different courses.

But after that, she said, there was a letdown: There were no more courses for her to take; she had aged out.

Then she learned that the Strategic Essentials course, which she had not taken, included facilitators who sat at participants' tables to answer questions and propel discussions.

At the annual meeting in Las Vegas, she "legally stalked" Dr. Howell, then the course director, and told him she would like to be one of those facilitators. He said she should forward her information. From a session room, she emailed him her CV, and she was a facilitator the following year.

For 10 years now, after Dr. Kennedy's suggestion, the University of Alabama has earmarked money to send its hospitalist leaders to the academy.

"That's an expectation of the role that you have to have leadership training, and that's how we invest in our leaders," Dr. Kennedy said.

As course director and an instructor in the course, she and the rest of the faculty work hard to respond to the evolving needs of attendees, she said.

"We've kept the things that are really relevant and that resonate and that don't need to go anywhere," she said. "But we take those evaluations really seriously. I mean, we obsess over those comments and the rankings, and we pay attention to themes."

Leonard Marcus, PhD, co-director of the National Preparedness Leadership Initiative at Harvard University, made changes to his Influential Management course teachings after the COVID-19 pandemic.

Dr. Marcus

"COVID-19 was a game-changer for hospitalist leadership," he said. "It turned every leader into a crisis leader. It was a stark reminder that hospitalists must be prepared and ready to guide their followers through whatever crisis confronts them. The seminar pivoted to provide content, examples, and applications of meta-leadership applicable to times of crisis."

He said the details of what needs to be emphasized in the coursework gradually shift over time.

"When I began teaching at SHM, hospitalists had to be advocates for their colleagues, their recognition, and their budget within the hospital," he said. "This relatively new function was

still fighting for acceptance across the healthcare system. It is, of course, different now. Now the fights are for adequate salaries, a reasonable workload, and the resources to do the job as it is meant to be."

Dr. Marcus said he enjoys teaching in the academy's environment.

"The Leadership Academy brings together really good people who are looking how to expand their work and mission in health care," he said. "I have the opportunity to speak and teach in many leadership programs around the world. The Leadership Academy is among my favorite venues."

Dr. Kennedy said the changes are noticeable in hospitalists after they've attended.

"I can definitely tell the difference between a leader that's been to Leadership Academy and one that hasn't yet," she said, "both in the way that they organize projects, the way that they think about engaging stakeholders, the way that they approach conversations—honestly, we see a little bit of the maturity in how they approach problems."

Dr. Howell said that, for many hospitalists, the academy has been the first step toward leadership roles.

While acknowledging that "it doesn't get all the credit," he said that "many of them began their careers as front-line hospitalists, clinical hospitals, and then built their skills and leadership in part because of the leadership academy. I think our academy has helped many young leaders in hospital medicine get their first step, and sometimes their first few steps, into their leadership and give them the skill sets to be successful as leaders outside of just the bedside." ■

Thomas R. Collins is a medical writer based in South Florida.

Practice Management

A Hospitalist's Preparedness Guide

Integration into Behavioral Health Centers

By Erica Grabscheid, MD, FACP, FHM, and Faraj Faour, MD

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Hospitalists began branching out from traditional general medical wards into specialized fields such as cardiology and oncology many years ago. One of the latest evolutions in hospital medicine is the expansion into behavioral health. By providing medical care to individuals with mental health conditions, hospitalists help bridge the gap between physical and psychiatric services, fostering a more comprehensive approach to patient care.

Similarly to their role on a general medical ward, a hospitalist in a behavioral health center is responsible for evaluating acute medical issues such as fevers and incidental lab abnormalities (e.g., abnormal thyroid and liver function testing), managing chronic conditions such as diabetes, and responding to emergencies, including rapid responses and codes when necessary. The essential distinction is that within a psychiatric unit, the hospitalist functions in a consultant role rather than as the primary managing practitioner.

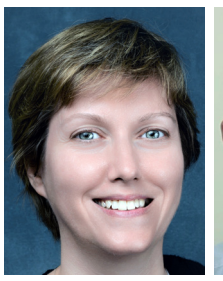
Adapting to the behavioral health setting presents hospitalists with a unique set of challenges. Entering this "subspecialty," if you will, may require some additional training and a mindful approach. To navigate this transition successfully, here are some fundamental considerations:

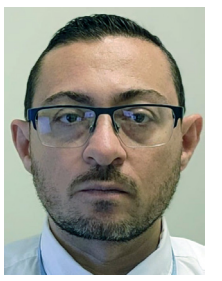
Training

- Check with administration or human resources to see if your center offers safety training courses, especially those addressing workplace violence, crisis prevention, and de-escalation techniques.
- Stay current with basic cardiac life support and advanced cardiac life support certifications, and whenever possible, take part in rapid response team workshops. As you may be the only medical professional on-site, you could be single-handedly responsible for managing emergencies, making thorough preparation essential. Familiarize yourself with the contents of the code cart, as the available medications may differ from those stocked on a general medical floor and could be much more limited.
- Hospitalists should consider becoming proficient in procedures traditionally performed by nursing staff, such as administering intramuscular epinephrine and intranasal naloxone.

Preparing for the Patient Encounter

- Review the patient's chart to familiarize yourself with their medical history and also to understand their psychosocial background. For example, does the patient have a history of violence or intermittent explosive disorder? Having a complete patient overview may help you make an accurate medical diagnosis and help ensure a safe encounter.
- Participating in daily interdisciplinary team rounds is highly beneficial. Here, hospitalists are often called upon to provide aftercare recommendations


Dr. Grabscheid


Dr. Faour

Dr. Grabscheid is a senior academic hospitalist at Mount Sinai Behavioral Health Center and a professor of medicine at the Icahn School of Medicine at Mount Sinai, both in New York. Dr. Faour is a hospitalist at New York Presbyterian Medical Group and Gracie Square Hospital, both in New York.

for discharge planning. Also, these huddles provide real-time updates on patient conditions, including changes in mood and any overnight incidents such as outbursts. Interdisciplinary team rounds additionally offer insight into broader institutional matters, such as staffing shortages, pest infestations, and outbreaks of infectious diseases, like COVID-19.

- Be strategic with coordinating the timing of your patient visit, as patients have an active and structured day. Availability to see the patient may be limited, as patients are busy with group or individual therapy, art and music therapy, visitation hours, etc. To maximize the patient's psychiatric treatment, it is preferable that one does not interrupt the flow of their set schedule.
- Familiarize yourself with the medical resources available on-site. A psychiatric ward or hospital may have limited medical capabilities, so it's crucial to understand what is accessible. Are blood draws offered, and if so, how frequently, and with what turnaround time for results? Are X-rays available, and if so, what types are available (e.g., a chest versus a joint X-ray)? Are intravenous fluids or medications possible, or are treatments limited to oral, intramuscular, and subcutaneous route options? Are physical therapists available? If consultants are available, are they on-site, and how often do they rotate through? Or is consultation provided strictly via telemedicine?

The Patient Encounter

- Prepare to manage a younger patient demographic with a higher prevalence of primary care concerns. You may be called to evaluate conditions such as rashes, positive rapid plasma reagin and other possible sexually transmitted disease tests, skin and soft tissue infections, otitis media, essential hypertension, musculoskeletal pain, and migraines, often at a greater frequency than on a traditional medical ward.
- Patients may require care due to infestations (e.g., bedbugs, scabies, lice), trauma, or injuries secondary to violence. Learning to manage basic wounds and suturing can help prevent emergency room visits for patients, which can interrupt their psychiatric care and be costly from an administrative perspective.
- Encounters may be challenging as histories may be unreliable or incomplete. The patient may simply be unable to provide a full history due to factors such as psychosis, catatonia, depression, schizophrenia, or antisocial personality disorder. As verbal communication and engagement may be limited, a comprehensive physical exam becomes essential, provided the patient is calm and cooperative.

The Work-Up and Treatment Plan

- Tease out the diagnosis by considering whether the etiology is primarily medical, psychiatric, related to substance abuse or withdrawal, due to neurological impairment, or the result of a traumatic brain injury. Prepare a broad differential diagnosis list that encompasses all these topics. For instance, when a patient presents with psychosis and transaminitis, consider whether these symptoms point to delirium tremens from alcohol withdrawal or if the psychosis is masking Wilson disease or porphyria. Some cases, such as unexplained weight loss, may be multifactorial, as diagnostic overlap is common; a patient might present with psychogenic nonepileptic seizures coexisting with epilepsy, for example.
- Psychiatric medications are potent agents with the potential for significant side effects. Illnesses may be secondary to the psychiatric medications themselves, some examples being clozapine-induced constipation and myocarditis or olanzapine-related transaminitis (drug-induced liver injury, or DILI).
- Be prepared for drug-drug interactions that could have substantial clinical implications. For example, rifampin may decrease the effectiveness of risperidone. Discussion surrounding this topic has recently intensified with the market introduction of Paxlovid for COVID-19 treatment, primarily due to its potential interactions with various psychiatric medications.
- Recognize that non-adherence may complicate clinical decision-making. Being called for diabetic management is common. However, this may be challenging if the patient declines fingerstick checks and medications. Develop a lower threshold to offer medications via an oral route when feasible, rather than intravenous or subcutaneous routes, in the hopes of improving patient compliance. Gaining expertise in the oral management of diabetes is highly relevant.
- Understand you may be called for some psychiatry-specific scenarios, such as optimizing a patient before electroconvulsive therapy, or ECT, or evaluating the risks and benefits of initiating antipsychotic medication in a patient with a preexisting prolonged QTc.
- Appreciate that the patient is at a behavioral health facility for a reason. The hospitalist's role is to evaluate a medical concern, determine its severity, and determine how urgently attention is needed. Can the patient's issue be completely addressed at the psychiatric facility? If not, can the issue be handled safely down the line via an outpatient primary care practitioner visit? Or does the patient need an urgent transfer to a medical facility? The hospitalist's role is to help minimize institutional transfers and admissions, with the principal goal being to preserve the continuity of the psychiatric treatment plan when possible.

Overall Systems Navigation

- Become familiar with your center's infection control policies. Does the facility have an isolation room if needed? Will the patient be allowed to remain at the center if they are unable to participate in group, art, or music therapy or eat in the communal dining hall due to the isolation? If a patient needs to be isolated, what is the plan if the patient is non-adherent to staying in their room? If a provider has to wear personal protective equipment, how is that equipment to be discarded, as disposable stethoscopes and such may be misused as weapons?
- Serving the community, it is inevitable that you will encounter a patient who is an acquaintance, friend, or even a family member. Navigating this delicately and always being mindful of HIPAA regulations is a trickier path than on a general medical floor.
- On the topic of HIPAA, maintain a heightened sensitivity to the confidentiality related to mental health. Even calling an outpatient provider in order to obtain prior medical records and saying you are calling from a behavioral health center may feel like a slippery slope of a disclosure. Sharing our approach, we reference the broader names of our overseeing institutions, such as Mount Sinai and Cornell/NYP, respectively, rather than divulging the names of our psychiatric centers. This method promotes discretion.

Like past hospitalist innovations that have transformed realms such as cardiology and oncology, hospitalist integration into behavioral health promises to bring the same high-level interdisciplinary care now to psychiatric patients. Utilizing the toolbox outlined above, hospitalists can seamlessly transition into the behavioral health arena. ■

An In-Depth Look at Locum Tenens Work

Hospitalists weigh the pros and cons of temporary assignments

By Karen Appold

Some hospitalists have found greener pastures working in locum tenens capacities. The freedom, flexibility, enticing pay, and the ability to work in a variety of hospital environments and medicine models are attractive. But finding the right recruiting agency, negotiating contract terms, surviving the onboarding process, and being self-employed can all present challenges if you choose this path.

"When looking to work in a locum capacity, embrace change and see challenges as opportunities," advised Stephanie Evans, MD, MPH, a clinical assistant professor of medicine at University of Arizona College of Medicine – Phoenix, hospital medicine physician at Banner - University Medical Center Phoenix, an academic hospital with 766 beds in Phoenix; and a locum hospitalist at multiple health systems in Arizona.

Dr. Evans

Look for a recruiting agency by researching online and asking colleagues for referrals. "A referral from someone already working in a locum capacity can go a long way—some built-in trust will exist from the start," said Dr. Evans, who worked as an employee of different groups for 13 years before pursuing locum work for more autonomy and variety.

"If you're employed full-time, ask an agency how long it will take to complete credentialing before resigning from your current position because it can take six months or longer if you need to apply for a license in a new state," said Charu Ramchandani, MBBS, MD, FHM, a locum hospitalist in the department of internal medicine at Montefiore St. Luke's Cornwall Hospital in Newburgh, N.Y., a 242-bed community hospital.

Dr. Ramchandani

Gwendolyn Williams, MD, FACP, FHM, assistant professor of medicine in the department of internal medicine at Virginia Commonwealth University in Richmond, an academic hospital with 865 beds, who has worked as a locum hospitalist in South Carolina, Virginia, and Wyoming, recommended keeping a comprehensive record of your professional documents, such as diplomas, residency certificates, and state licenses so it's up to date when needed. Be prepared to explain any gaps in your work history.

Dr. Williams

She uses a smaller physician-owned recruiting company, which knows specifically what hospitalists do and what terms are ideal. "They advise me on what questions to ask when interviewing with a hospital and are transparent about a site's shift rate, shift hours, and clinical responsibilities," said Dr. Williams, who worked a full-time job for nine years before returning to locum work.

Working with more than one recruiting agency can result in more opportunities, said Thomas Miller, MD, FHM, a hospitalist based in Chesapeake, Va., who has worked in a locum capacity at a variety of health systems in Colorado, Ohio, Virginia, and Minnesota. To avoid overlap, make sure your contract states that you can't be presented to a hospital without your permission.

Dr. Miller

Another reason to be careful about which hospitals you're presented to is that you most likely won't be able to contract with those hospitals for at least a year through another agency, even if you haven't worked a shift at that facility, Dr. Evans said.

If you have any doubts about a position, ask to speak to a group's medical director. "Recruiters can be great, but they may not understand the day-to-day realities which can make all the difference between a great assignment and a disaster," said Dr. Miller, who previously worked as an employed hospitalist for a private group and multispecialty network.

Reviewing contracts

Read contracts carefully, and make sure the terms are agreeable. "You can request and negotiate changes," Dr. Miller said. "If a locum agency or hospital is not open to changes, it may not be the best fit for you."

Contracts should be comprehensive. Obviously, pay rates are very important, and they may be negotiable. "Locum tenens physicians take greater risks in their schedules compared to employed physicians," Dr. Evans said. "We may also have to travel long distances to sites, so we typically get paid more for these reasons."

Dr. Wright

Make sure that you're paid time-and-a-half for federal holidays, which is often omitted from contracts, said Masina Wright, DO, a locum hospitalist at multiple hospitals including Christus St. Vincent, a community urban hospital in Santa Fe, N.M., Holy Cross Hospital, a rural hospital with 25 beds in Taos, N.M., and Sandoval Regional Medical Center, an academic community hospital and part of University of New Mexico Hospital in Rio Rancho, N.M. They are also employed as an internal medicine doctor at Cardiology Now in Toronto, Ontario, Canada.

Other contract terms may be negotiable as well. Although recruiting agencies typically make travel arrangements and find housing for locum physicians, Dr. Miller recommended requesting to make your own bookings and get reimbursed. "Travel reps may not take your needs into top consideration, plus you will accumulate a lot of airline, rental car, and hotel points, as well as higher member status if you do your own bookings," he said.

Malpractice limits should be reasonable and abide by state laws. Tail coverage is essential to protect you from future lawsuits, and always get a copy of your certificate of insurance for your own protection, Dr. Miller said.

Cancellation clauses are also necessary. "If a hospital cancels your shifts, make sure you still get paid if it's within a certain time window," Dr. Miller said. "You may have a tough time replacing shifts with only a few weeks' notice."

"I request 30 days' notice for a health system to cancel a locum shift, and I agree to give them the same amount of notice," Dr. Evans said.

Expect to find a non-compete clause in a contract. It may state that you can't work a certain number of miles from the facility you worked at for a specific time period. "You may want to negotiate this, especially if your locum work is close to home," said Masud Habibullah, MD, managing director of SMH Innovations LLC, a locum tenens hospitalist recruiting company in Savannah, Ga.

You might also see a clause that prevents you from becoming an employee at a health system after completing locum work there, or you may be prohibited from contracting with another

locum agency for a certain time period. "Generally, one year is the standard; negotiate a shorter time period if it's beyond that," Dr. Evans said.

Contracts may also include buy-out clauses, which would come into play if a locum were offered a permanent position. Typically, the hiring hospital will pay that fee, but sometimes it won't. "Again, this is something that you should negotiate upfront if you think this scenario could occur," Dr. Habibullah said. "You may be more successful in negotiating terms if you have a lawyer to back you up."

You may also want to retain a lawyer to review a contract, especially if you're not legally savvy.

"A locum tenens agency may not have your best interests at heart, so it's important to make sure everything is legitimate because this is a transactional relationship," Dr. Williams said. "If an attorney finds something concerning, they may save you a lot of money."

Dr. Evans had an attorney review a locum tenens contract early on, but now—as a physician who has done locum work for many years—she compares new contracts line by line with a good contract she had previously.

The onboarding process

Every hospital is different—some may provide locum hospitalists with a comprehensive orientation program while others may expect them to handle a full workload on day one.

"Ideally, an institution will forward me their policies and procedures—which I'm sure to read before starting—and a list of cell phone numbers I may need, as well as give me a tour of the hospital," Dr. Evans said.

"Try to find out as much as you can before your first day," Dr. Evans continued. "I always have a list of questions to ask, and if possible, I try to get a badge and make sure my log-in works in advance."

Because hospitals pay top dollar for locums, they may not want to spend time on orientation. "This is a big mistake for everyone involved," Dr. Miller said. He has worked at a few places that wanted to provide electronic health record orientation on the first day while also expecting him to pick up a full panel of patients, which he strongly advises against.

To overcome onboarding challenges, Dr. Wright—a second-career hospitalist who pursued locum work right after residency—recommended finding someone willing to help you navigate as a newbie, such as a house supervisor, charge nurse, or co-physician. Keep a notebook for each hospital with the notes you may need.

One of the biggest challenges of being a locum is that some colleagues may view you negatively, or at least skeptically, at first. "The key to being a successful locum is to see yourself as a full member of the team, even though you're an outsider," Dr. Miller said. "Offer to help your colleagues if you're caught up or offer to help with an extra admission, even if the rules state otherwise. The extra hour you spend, or even making the offer, will be positively viewed by those who thought you were 'just a locum.'"

While working as a locum, Dr. Evans has offered advice to hospital medicine groups based on what worked well at other facilities, which her colleagues have appreciated.

Regarding connecting with patients, when you approach them with compassion, respect, and dignity, as well as listen to them, it's easy to build rapport, Dr. Williams said.

Dr. Evans said it's important to find a personal connection to patients. "Get to know patients as people, and not just what their medical conditions are," she advised.

Managing your money

As a locum, you will work in a non-employee capacity. Given that, Dr. Williams recommended retaining a financial advisor who specializes in locum physicians' work. They can advise you on whether working in a sole proprietor, LLC, or S Corporation capacity would provide the best tax advantages for you.

They can also calculate your quarterly estimated taxes and which deductions you can write off, such as attire, medical equipment, travel-related expenses such as mileage and hotel rooms, health insurance premiums, and home-office expenses. They can also give insight into funding retirement accounts.

Open a checking account solely to deposit your locum payments and have a credit card dedicated to locum work. "For tax reporting purposes, don't mingle your independent contracting work and personal funds," Dr. Williams said.

Dr. Wright used a financial advisor to determine how many shifts they needed to work to achieve their income needs. They also work with a bookkeeper and keep clear records and paper receipts of all expenses incurred, which can help offset tax payments.

Dr. Evans recommended having an appropriate emergency fund in case you have leaner months. Line up several different facilities to work at, so if shifts become lighter at one, you can add shifts at another one.

Work-life balance

Some hospitalists who work in locum tenens capacities have found that temporary work brings balance to their life, while others have discovered the opposite.

Dr. Ramchandani, who previously worked as an academic hospitalist, pursued locum work when having her second child because she wanted scheduling flexibility. Now she can plan shifts around her husband's schedule, and he can pick up the kids when she's working. She doesn't have to work on holidays when the kids are home, and she can take time off to travel.

Having scheduling flexibility has been great for Dr. Evans, as well. "I could take off three months if I wanted to, or schedule around a family event," she said.

She admits that even though she loves traveling, the logistics of it can be tiring. She schedules a day to unwind after traveling.

As a locum, feelings of isolation can kick in when away on assignment. To combat this, Dr. Evans will prioritize socialization before leaving town, and she'll try to connect with colleagues during and after work.

Dr. Miller is active with his local SHM chapter, so he can remain connected with the hospitalists in his community when traveling.

Dr. Wright works as a full-time employee in Canada, in addition to locum work in the U.S. Not having the typical seven days off after working seven days as a hospitalist has made it difficult for them to find work-life balance, and they admit to feeling burned out. Moving forward, they will include time off in their locum schedule.

Dr. Wright has neglected their personal health and wellness when working a lot of 12-hour shifts and traveling. "I don't have my gym and my own kitchen, so I'm not cooking as much," they said. "I don't have my garden or get to the farmer's market when working away from home."

Some other downsides

In addition to impacting work-life balance in some negative ways at times, locum work has a few other drawbacks.

"I don't have a say in how the hospitalist program runs—I'm just a visitor there to do my job," Dr. Ramchandani said. "I can't push for changes, and even if I try, it's not always welcome."

"Most places that need locum hospitalists struggle to keep full-time staff, so there's usually a reason you're getting paid more—whether it's the location, workload, or something else," Dr. Ramchandani continued.

Because you're not an employee of a non-profit community hospital when working as a locum, you can't count locum work toward student loans, Dr. Wright pointed out.

Locum work has variable job security. "You have to rely on a recruiting agency to find you places to work and the shifts you want," Dr. Williams said.

Another drawback is that some people stereotype locums as physicians who just show up and don't care about being part of a group or providing great patient care. "One bad apple can spoil the bunch," Dr. Evans said. "As people have more experience working with locums, I think that perspective will change."

Lots of benefits

Sure, downsides exist. But there are many advantages to working as a locum tenens as well.

"The most rewarding aspect is having a well-paid bridge to other things in life," Dr. Wright said. "It's perfect for moonlighting. The flexibility has been great, especially when I was able to take two months off when moving from Canada to the U.S."

Dr. Evans loves to work in a variety of practice settings, both rural and urban, and to have different opportunities, such as teaching. "I've worked with different groups and have seen how they meet challenges," she said. "Driving around Arizona is absolutely gorgeous."

Dr. Williams has always experienced gratitude from others when working as a locum. "It's rewarding and fun to meet other hospitalists from across the country and to make human connections," she said.

Looking ahead

Dr. Evans foresees working in a locum capacity for the rest of her career. Others, such as Dr. Miller, have done it temporarily, or in conjunction with full-time employment, as Dr. Wright has.

"Working in a locum capacity is a good way to transition when you want to leave a position or test out a new hospital or location," Dr. Williams said. The possibilities are endless when you have a growth mindset about how your work life can look."

For Dr. Ramchandani, locum work is a temporary stage. "I plan to apply for an endocrine fellowship when my children are a little older," she said. "I'd like to go back to full-time work eventually, but with a manageable schedule."

As an early career physician, Dr. Wright is still figuring out what their future holds. "I will work locum shifts in the states to pay my student loans for the foreseeable future," they said. "It's a necessary stage for me right now in order to meet my financial obligations."

They expect locum work to continue to have a place in modern medicine because of the ongoing physician shortage. "Most per diems are grateful to have the shifts covered," Dr. Wright concluded. ■

Karen Appold is an award-winning journalist based in Lehigh Valley, Pa.

CAN Framework: Leadership Essentials for Early Career Hospitalists

"Leadership is the capacity to translate vision into reality."—Warren Bennis

By Farzana Hoque, MD, MRCP, FACP, FRCP

Hospital medicine leaders drive change, inspire teams, and shape the future of medicine. Early career hospitalists—those out of residency for five years or less—often face unique challenges in being chosen for leadership opportunities in both academia and community settings. A study highlighted that early career hospitalists expressed the importance of "being respected and recognized," and "dissemination of work," both of which are associated with career satisfaction.[1]

Leadership opportunities amplify positive, meaningful impact on a larger number of patients, learners, and the systems in which hospitalists practice. However, there is no roadmap to help early-career hospitalists learn how to advance toward leadership opportunities.

The pathway to leadership may seem daunting, but a structured approach can pave the way. The proposed CAN framework—a three-part approach—empowers early-career hospitalists to navigate the rewarding leadership journey. CAN stands for clinical excellence, awareness, and new opportunities. The benefits of this framework are threefold:

1. Building credibility and trust through clinical excellence, positioning early-career hospitalists as respected leaders
2. Fostering collaboration and accelerating team development by enhancing self and social awareness
3. Embracing innovative projects, enabling hospitalists to expand their influence and drive impactful innovation

Clinical Excellence

Particularly after joining a new organization, the clinical excellence of an early-career hospitalist is a cornerstone of reputation and leadership potential. Clinical care is a key source of career fulfillment for early-career hospitalists.[1] A strong clinical background enables leaders to make informed decisions, understand the complexities of patient care, and gain credibility with peers and teams. During clinical service, physicians directly observe the impact of established hospital policies and can identify care gaps—critical insights for implementing effective changes.

To build and maintain clinical excellence, hospitalists should regularly update their knowledge through continuing medical education, medical journals, conferences, and discussions with consultant teams to understand their clinical decision-making processes, rather than simply following recommendations. Furthermore, involving advanced practice practitioners, residents, and medical students during clinical decision making sharpens clinical knowledge and team-building skills. Leadership is not a destination but a continuous journey of learning and growth.

Awareness

Technical skills and individual talent alone are not sufficient for excelling in leadership positions. In today's dynamic healthcare environment, leaders need both self-awareness and social awareness to navigate complex hospital teams and systems effectively.

Self-awareness involves understanding and accepting yourself, including your emotional triggers, biases, and strengths.[2,3] Self-aware individuals tend to be more fulfilled, confident, and likely to advance in their careers. Pausing briefly during emotionally charged moments—a practice common among successful leaders—can lead to more effective decision making.[4]

Social awareness is the ability to understand others' motives, non-verbal cues, tone, and body language. Without social intelligence, leaders risk miscommunication and unnecessary conflict.[2,3] While pursuing new leadership opportunities, it's important to be aware that not having all the answers is okay and mistakes are an inevitable part of growth. Together, self-awareness and social awareness complement technical expertise, accelerating both personal and professional development.[2,3] Seeking feedback and reflection exercises can further refine these skills, positioning hospitalists for leadership success.

New Opportunities

A willingness to embrace new opportunities often lays the foundation for leadership growth, enabling early-career hospitalists to discover new career paths. Senior leadership teams seek individuals they trust to get the job done, who demonstrate a proactive, solutions-oriented mindset. Saying "yes" to new opportunities can serve as a steppingstone for learning and networking, demonstrating a commitment to innovation. However, not all opportunities are equally beneficial—selecting the right ones requires a realistic evaluation of current commitments, personal goals, and professional priorities.[5]

Declining an opportunity does not reflect a lack of ambition but rather a strategic approach to career advancement. Hospitalists should align their choices with their long-term aspirations, leveraging mentorship and peer support to make informed decisions. As our career goals and aspirations evolve, the opportunities we pursue may also change. Being intentional about career choices, remaining adaptable, and maintaining a continuous learning mindset will ensure long-term professional growth.

Transitioning into leadership requires a dynamic skill set and a strategic approach to professional development. The CAN framework provides early-career hospitalists with a practical, actionable pathway to rise above challenges, seize opportunities, and inspire others to follow their lead. By focusing on clinical excellence, awareness, and new opportunities, hospitalists can forge a meaningful leadership journey—one that fosters innovation, elevates patient care, and shapes the future of hospital medicine.

Dr. Hoque

Dr. Hoque, associate professor of medicine and physician lead of patient experience at Saint Louis University and the inaugural medical director of Bordley Tower at SSM Health Saint Louis University Hospital, both in St. Louis, oversees four inpatient units. She is also the medical director of patient experience for the SSM Health region, driving initiatives across seven hospitals. X @Farzana_HoqueMD

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SIG Spotlight: Perioperative/Co-Management

By Richard Quinn

Every SHM special interest group (SIG) is focused on the future, but not every initiative is seeing the kind of growth trend lines of the society's Perioperative/Co-Management SIG.

"The tremendous value of the special interest group for perioperative and medical co-management is that even though this is growing in many, many places...usually there are one or two people who have been put in charge of it, or expected to direct it," said SIG co-founder and chair Kurt Pfeifer, MD, chief of the section of perioperative and consultative medicine in the department of medicine at the Medical College of Wisconsin in Milwaukee. "And they may not feel like they have as much mentorship and support locally as they need to be able to effectively lead within this space. It's so important for professional societies to help fill that void."

Dr. Pfeifer

SIG co-founder and former chair Steven Cohn, MD, MACP, FRCP, SFHM, says that as co-management has transitioned from surgeons to hospital medicine leaders, the group has been helpful in answering the necessary questions.

Dr. Cohn

"Who would be admitting? Who would be following? Who would take care of which problems when they came up?" said Dr. Cohn, a professor emeritus at University of Miami Miller School of Medicine in Miami. "It expanded from orthopedics to other fields: neurosurgery, vascular surgery, ENT [otolaryngology]. And there's actually medical co-management within the department of medicine, for example, for oncology. So, it's expanded, and it continues to expand, as far as the co-management part of it goes."

Whether it's formally set up as co-management of a patient or more just perioperative discussions, the SIG continues to provide value to members even as they spend years involved.

"When I started working in the perioperative space, I was all about learning how to manage complex conditions, but my learning has now evolved as I advanced in my career to lead our pre-operative clinic," said SIG vice-chair Smita Kalra, MD, who directs the hospitalist-run pre-operative clinic at University of California Irvine Medical Center in Orange, Calif. "Now, I look for conversations that I might be having at the leadership level, and at the level I'm looking for advice on how I can handle a logistical problem better, or how can I handle my pre-op clinic census in a better way? I think we all are going to evolve in our own careers, so the questions we had a few years ago change as we grow, and our SIG can help bridge all of these questions."

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Dr. Kalra

Dr. Pfeifer also sees the SIG as having great academic value, particularly as the hospital medicine field continues to mature.

"Establishing an identity and having some niche that they can work within is imperative if you're an academic hospitalist but is also very valuable for our hospitalists practicing in the community," he said. "And within the SIG, we've been able to organize ourselves and help junior members in the group find and get connected with scholarship opportunities. Whether that's within SHM, such as getting them authorship on our learning portal modules, or connecting them with others for doing review articles or other workshops, or even initiatives that are outside the society."

Part of the group's pedagogical passion is its monthly journal club, structured as webinars where an author of a timely study discusses the findings with the SIG.

"We're getting hot-off-the-press articles in top journals, and we're getting the lead author to actually voluntarily present to our group, taking an hour of their time at no fee ... they just like to do it," Dr. Pfeifer said. "And I think it's really nice to be able to have these people present what they did, what their studies were, and have us, and our audience, able to ask whatever questions we have, because you can't always get the information you want from the journal article. It's somewhat unique that we have that ability."

Dr. Kalra added that the webinars also give hospitalists a chance to work with other societies, further broadening members' relationships and giving them a chance to learn from other specialties.

"We have collaborated with the Society of Perioperative Assessment and Quality Improvement," she said. "We've had anesthesiologists present their work, we've had surgeons present. It gives us an opportunity to collaborate across different specialties as well, and they bring a unique perspective from their standpoint."

Dr. Cohn says that moving forward, the SIG wants to capitalize even more on its popularity. The SIG is one of SHM's largest, with more than 500 members.

"A lot of them are sort of passive learners, passive people, not actively getting involved," he said. "What we would like to see is more and more people get involved, more people showing up for the webinars, more people responding to our question of the month. And more people having just some chat and questions and things like that on our online message board. I think that would be helpful for everyone." ■

Richard Quinn is a freelance writer in New Jersey.

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Chapter Spotlight: Maine

Sharing great ideas to improve patient care and career satisfaction

By Richard Quinn

When you know, you know—and Taylor Roberts, MD, knows the value of an SHM chapter.

So after a few trips to SHM Converge during her residency in Dallas, she knew when she moved to Maine two years ago she had to get involved in the state chapter.

Dr. Roberts

"For me, the appeal is dedicating time to learn with my colleagues about things that are particularly relevant to our career," said Dr. Roberts, now the incoming chapter president. "And having the opportunity to sit down with people outside of work, at an SHM dinner, and get to know people better, and get to know people's career journeys better. As I'm young in my career, I really appreciate learning from other people's examples and having that networking connection."

As an earlier-career hospitalist, Dr. Roberts, who practices at MaineHealth's Maine Medical Center in Portland, says that another benefit of being active in the chapter is seeing the pathways that lead to hospital medicine.

"Some of my colleagues have worked in hospice care. Some have run skilled nursing facilities. Some have been primary care doctors. Some have been hospital administrators. And some helped pioneer the concept of career hospitalists. I think it's really interesting to learn about what skills people bring to the table," she said.

Those skills don't stop when the automatic doors close behind chapter members at day's end, either.

"I love learning about the amazing work people do outside of their clinical work," Dr. Roberts said. "The projects people are doing, whether it's quality improvement, or research, or medical education, or helping to run our pre-op clinic, or homeless outreach missions in Portland. I think it is really interesting hearing where people invest their talents, and it inspires me to think about what possibilities there are for me to grow professionally."

The chapter holds multiple in-person events a year, which Dr. Roberts believes is key to success. "Our chapter's mission is to provide a hospital medicine home for its local members," she said. "I want our chapter to be a place for hospitalists throughout the state to share ideas and resources."

"My vision is that chapter members will get to know each other's faces, get to know where our fellow members practice, and be able to respond together to challenges. Whether that's the next pandemic, or a disaster event, or just sharing great ideas to improve patient care and career satisfaction."

Like most chapters, a highlight of that camaraderie is the annual poster contest, which boasted 14 entries in 2024. Dr. Roberts sees the event as both a recruitment and an educational tool.

"For younger members like med students and residents, it's really important to have experiences like a poster presentation for their residency applications or job interviews," she said. "That's definitely beneficial to them.

"Additionally, through the process of working with a faculty member on an interesting case or a project, learners get more exposure to what being a hospitalist means and what our lifestyle looks like. It is a way to grow interest in our field."

Dr. Roberts says her top focus this year is to grow engagement throughout the state. Currently, the chapter has some 137 members, concentrated in the southern part of Maine, which makes sense given the population center that is Portland. Another focus, she says, needs to be hosting more informal meetings, dinners, and social events in other areas of the state, including more rural stretches that can be a five-hour drive away, to build a bigger tent (referring to one of SHM's missions to cultivate an inclusive community for hospitalists and support career growth and well-being).

"This year we're really going to work on reaching out to the other regions of our state and hosting a meeting outside of the southern region so we can get more involvement and bring together people practicing in different places," she said. It's "creating that sort of interconnectedness between the hospital systems in our state that we would like to invest time and energy into this year."

Passion is not a problem for the chapter. Member Liz Herrle, MD, sits on *The Hospitalist's* editorial board and SHM's academic committee. Member Katie Liu, MD, founded SHM's special interest group on environmental health. Meagan Clark, MD, was appointed to the trainees and early career physicians in hospital medicine advisory council. And member Claudia Geyer, MD, is an advocacy wonk who regularly attends SHM's Hill Day. Oh, and 24 chapter members traveled to the most recent Converge conference. That's nearly 20% of the group.

"I think there is a lot of energy here," Dr. Roberts said. "And I'm really excited to see what the next year holds for Maine." ■

Richard Quinn is a freelance writer in New Jersey.

Beyond the Hospital's Four Walls

Continued from page 14

hours a week as medical director of the long-term care facility, rounding there twice a week, usually in the early morning hours before commencing his current full-time job as physician advisor. This role is somewhat variable, Dr. Craven said, "but the general premise is the physician advisor is a mediator, a go-between from the finance department, or the revenue cycle department, of a hospital system and the doctor."

And it is a natural match for hospitalists, he said. There is now a physician advisor special interest group within SHM, which meets at the annual Converge conferences, as well as the American College of Physician Advisors professional association.

"Physician advisors are here to explain to the hospital's finance people why the doctors are doing what they're doing. And we're here to explain to the doctors why the finance people want them to do something different, or why they are being queried on their documentation by a clinical documentation expert when they feel like their documentation suffices. We're here to be that kind of go-between," he said.

"But with it comes this whole space of utilization management and denial management, because the Centers for Medicare and Medicaid Services requires a certain level of appeal in the denials process to be done directly from physician to physician. And that responsibility largely gets placed on the physician advisor," he said.

"Back when I was a full-time hospitalist, I was on some quality committees and other committees alongside some senior leadership of my system. I didn't really view it this way, but in hindsight, I can see rather clearly how it was almost like a prolonged interview or audition for future jobs down the road," Dr. Craven said.

"A lot of times, hospitalists are asked to be engaged and to participate in committee work. I would encourage them to do it, even if it's a subject matter that they're not that interested in. Get out there, get exposure, and learn how healthcare systems work, how the quality-improvement process works, and how healthcare finance works. All those things are special skillsets that, if a physician fully understands and masters them, are valuable in other positions down the road."

Changing Language

"When I was in residency, hospital medicine was barely 10 years old," Dr. O'Glasser said. "I remember the language that was used: 'Well, I don't want to pursue fellowship training or a medical specialty, and I don't want to do primary care. So I'll just be a hospitalist.'"

In reality, no one is *just* a hospitalist, she said. "In the last 15 years, the conversation has absolutely shifted from hospital medicine being a fallback, because you didn't know what else you wanted to do, to being something intentionally sought out and cultivated, not just as a career pathway but as a skill set to be gained in residency. And that absolutely thrills me."

She added that the COVID-19 pandemic helped to solidify the fact that hospitalists have this special skill set in systems-based medicine. "I feel like we were starting to get that recognition before COVID-19 struck, but then hospitalists demonstrated their skills and unique role in managing the pandemic." ■

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

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