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IN THE NEXT ISSUE...
Improving health literacy for patients

Women in Medicine—Progress and Opportunity

Amplifying support

By Dahlia Rizk, DO, MPH, and Amira Del Pino-Jones, MD

Dr. Rizk

Dr. Del Pino-Jones,

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SHM is dedicated to improving care for hospitalized patients through innovation and collaboration and is committed to supporting all hospitalists in achieving this goal. There are many reasons to focus on elevating and supporting women in medicine, given some of the unique barriers and challenges they have faced over time.

It is understood that even from ancient Greek and Egyptian times, women functioned in medical roles for their society. In Ancient Egypt, Isis was worshipped as the goddess of medicine, and in Ancient Greece, Hygeia and Panacea were likely practicing physician healers.[1] Yet in more modern times, women were barred from matriculating in schools until 1849, when our first female medical graduate, Dr. Elizabeth Blackwell, paved the way, refusing the advice to pretend she was a man despite numerous school rejections. Even by 1960, less than 6% of medical school matriculants were women. It wasn't until we saw a big push during the feminist movement of the 1960s and 1970s that we saw any real progress. In 1972, Congress passed legislation barring any institution receiving federal funding from discriminating based on gender. Today we can celebrate that since 2017 women matriculating in medical schools have exceeded 50%, with the latest data at 57% nationally.[2] There is much reason to recognize the value of having women physicians, with studies showing such benefits as: more women going into OB-GYN, pediatrics, and primary care; improved surgical outcomes; enhanced patient satisfaction; and even improved 30-day readmission and mortality benefits.[3-6]

Despite the progress made and the clear benefits of women pursuing careers in medicine, significant challenges persist in achieving true gender equity in medicine in a variety of concrete measures. The most recent report from the Association of American Medical Colleges (AAMC) shows that while matriculation into medical school for women has grown, we see a steady step down in women achieving academic promotion and positions of leadership, which can help shape the culture of a department or organization.[2]

Additionally, over time, we see a drop-off in the ratios of women versus men in academic medical centers as full-time faculty. It is important to recognize potential causal factors associated with this drop-off, as women still report high rates of bullying and harassment, salary discrepancy, gender bias, more limited grant applications and funding, less recognition in awards, fewer publications and citations, more limited promotion and growth opportunities, and higher rates of burnout in the workplace—for a variety of reasons.[7-10] Additionally, while applicable to anyone with caregiving responsibilities, studies have shown that women are responsible for childcare much more frequently than men, with the COVID-19 pandemic bringing this to the forefront.[11,12] The persistent drop-off of women in medicine and the discrepancy in multiple measures is an important story in itself and requires further evaluation, organizational transparency, and reflection, as many causes are interrelated and potentially exacerbate the problem of declining women faculty and fewer women in leadership roles overall.[7-10]

The history and extensive data published in this area help to inform and guide the work of SHM. The SHM Diversity, Equity, and Inclusion Committee holds gender issues as part of its core mission and supports other efforts across SHM. Some of the main areas SHM has focused on include:

- Special Interest Groups (SIGs): Though open to everyone, SIGs

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Veklury®
remdesivir 100 MG FOR INJECTION

LEADING THE WAY

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).

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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.

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GILEAD

Women in Medicine

Continued from page 2

have provided networking and learning opportunities where women in hospital medicine can find support and mentorship and share challenges and facilitators for success.

- Programming for women leaders: SHM offers programs and resources focused on women's leadership in hospital medicine. This includes "on-demand" sessions (available at annual conferences and learning portals) that highlight how women are transforming hospital medicine, and ongoing discussions on practical solutions for balancing the demands of family and career.
- Development of best practices: As outlined in the paper "SPEAKers at the National Society of Hospital Medicine Meeting: A Follow-Up Study of Gender Equity for Conference Speakers from 2015 to 2019. The SPEAK UP Study," the SHM annual meeting has historically used an open-call peer review process for workshop speakers, and they expanded this process for didactic speakers in 2019. From 2015 to 2019, the overall representation of women speakers increased, as did their evaluation scores. Open-call processes continue to be used by SHM and serve as a model to other organizations of strategies that can effectively help close the gender gap among speakers. Additionally, the annual conference features dedicated spaces for nursing mothers, which highlights SHM's commitment to supporting families and caregivers. Lastly, the Hospitalist Well-being Advocates Toolkit provides resources and strategies for promoting well-being within hospital medicine, which is helpful to all hospitalists.

What can women in medicine do? Educate yourself on factors that align with your goals in seeking job opportunities, including:

- Asking about leadership roles and support received
- Looking at staff turnover and understanding associated factors
- Seeking out mentors and sponsors to help support your career growth and promotion opportunities (This includes strong allies and sponsors, both men and women, who have important organizational roles.)
- Creating clear pathways, timelines, and structures for your own academic and professional career growth
- Understanding local market forces and finding hard data on salary compensation and transparency through resources like MGMA/Sullivan Cotter, AAMC, and State of Hospital Medicine reports

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- Participating in local and national leadership development workshops, courses, and other networking opportunities
- Creating community through organizations such as the Women in Medicine SIG and those at your home institution, allowing people to share candidly on issues related to women in medicine, such as fertility, caregiving for both children and elders, and other sensitive issues
- Joining a national committee—these contacts can help with academic promotion in the future and help create connections to understand cultures at other organizations
- Creating networks through professional social media sites like LinkedIn or Doximity to help create a network of women (and men) to support you in professional development, job opportunities, and promotion
- Understanding family leave policies and culture, as well as part-time or job-sharing opportunities if those align with your goals of family planning

Lastly, we encourage everyone to share their thoughts with SHM or with committee representatives or leaders to help identify ways the organization can support everyone. If you sit on a recruiting or conference committee, or any leadership role at an organization, (or even if you don't) be sure to recognize and modify culture even in small groups and everyday practices to help move the needle forward. Every voice counts in making progress. ■

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In the Literature

Yale School of Medicine Medical Research Reviews

By Angela Kang-Giaimo, MD, MPH, Erin McKnight, MD, Nathaniel Parker, DO, FACP, Anisha Advani, MD, Jensa Morris, MD, Fabiola Molina, MD, MHS, Chris Sankey, MD, SFHM, Janjenali Villaflor, MD, Sharon Ostfeld-Johns, MD, IBCLC, Thilan P. Wijesekera, MD, MHS

Yale School of Medicine, New Haven, Conn.

IN THIS ISSUE

By Angela Kang-Giaimo, MD, MPH

1 Lower Threshold Blood Pressure Associated with Reduced Postpartum ED Visits

CLINICAL QUESTION: Does tighter blood pressure (BP) control postpartum reduce emergency department (ED) visits for postpartum patients, and if yes, what are the cardiovascular risk implications?

Dr. Kang-Giaimo

BACKGROUND: More than 60% of maternal deaths occur during the postpartum period, of which hypertension is a major contributor. The current guidelines for managing postpartum hypertension are based on case series from 1987. Outside of pregnancy, new guidelines recommend more stringent blood pressure control, and it is plausible that reducing blood pressure in the postpartum period would mitigate cardiovascular disease risks in this population as well.

STUDY DESIGN: Prospective cohort study with propensity–score-matched retrospective cohort

SETTING: Two tertiary hospitals in New Jersey

SYNOPSIS: Between March 2023 and March 2024, an original cohort of 1,596 patients diagnosed with hypertensive disorders of pregnancy were enrolled in the study. After propensity score matching, 429 patients were treated in the retrospective, usual BP control cohort (titrating antihypertensive medications to goal of less than 150/100 mmHg), and 276 patients were enrolled in the prospective treatment cohort with tight BP control (restarting pre-pregnancy antihypertensive, continuing on labetalol, or treating with nifedipine, with a goal no more than 130/80 mmHg). Remote patient monitoring was used to monitor and titrate medication. In the intervention group, 18.8% of patients were taking antihypertensive medication, as were 18.2% in the control group. Mean highest BP was 141.8 mmHg in the intervention group and 147.8 mmHg in the control group. At 6 weeks postpartum, ED visits occurred in 10 patients (3.6%) in the prospective cohort and 36 patients (8.4%) in the retrospective cohort (risk difference, −4.8). Although limited by the propensity–score-analysis design, tight blood pressure control resulted in a reduction in postpartum ED visits by 68%.

BOTTOM LINE: The American Heart Association Guidelines' recommended blood pressure target of under 130/80 mmHg for the general population may be a goal that, when applied to the postpartum population, can improve cardiovascular outcomes.

CITATION: Rosenfeld EB, et al. Management of postpartum preeclampsia and hypertensive disorders (MOPP): postpartum tight vs standard blood pressure control. *JACC Adv*. 2025;4(3):101617. doi: 10.1016/j.jacadv.2025.101617.

Dr. Kang-Giaimo is an assistant professor of medicine, a hospitalist, and the director of the internal medicine clerkship at Yale School of Medicine in New Haven, Conn.

By Erin McKnight, MD

2 Early Thoracentesis Does Not Improve Clinical Outcomes in Acute HF

CLINICAL QUESTION: Does upfront thoracentesis improve short-term clinical outcomes for patients with acute heart failure (HF)?

Dr. McKnight

BACKGROUND: Thoracentesis is being performed at increasing rates in patients with pleural effusion in the context of acute HF. No randomized controlled trials have been done to evaluate the effects of thoracentesis on patient-relevant outcomes.

STUDY DESIGN: Multi-center, unblinded, randomized, controlled trial

SETTING: 10 cardiology centers at academic medical centers across Denmark

SYNOPSIS: Patients with new-onset HF or acute decompensated chronic heart failure with left ventricular ejection fraction (LVEF) under 45% were referred for enrollment if they had a sizable pleural effusion suitable for thoracentesis. A total of 135 patients (median age 81 years, median LVEF 25%, 33% female) were enrolled 1:1 to either upfront thoracentesis plus standard therapy or standard therapy alone.

There was no difference noted in the primary outcome of number of days alive out of the hospital in the 90 days following randomization, with a median of 84 days for thoracentesis versus 82 days for the control group (P=0.42). Additionally, there was no difference noted in median duration of index admission (five days for each group), total symptom score, or all-cause mortality at 90 days (13% for each group).

This is the first randomized controlled trial to assess the effect of thoracentesis in hospitalized patients with reduced LVEF and pleural effusion. There was greater than expected variation in the primary outcome, which may limit the statistical power.

BOTTOM LINE: Upfront thoracentesis is not routinely recommended as it did not improve short-term clinical outcomes in patients with acute HF and pleural effusion compared to standard medical therapy alone.

CITATION: Glargaard S, et al. A Randomized controlled trial of thoracentesis in acute heart failure. *Circulation*. 2025;151(16):1150-1161. doi: 10.1161/CIRCULATIONAHA.124.073521.

Dr. McKnight is an associate director of the hospitalist service at Yale New Haven Hospital and an assistant clinical professor at Yale School of Medicine, both in New Haven, Conn., and current president of SHM's Connecticut Chapter.

By Nathaniel Parker, DO, FACP

3 Albumin-Adjusted Calcium: Poorly Predictive, Yet Routinely Used

CLINICAL QUESTION: Is albumin-adjusted calcium a reliable surrogate for determining true calcium status, particularly when compared to ionized calcium, in adult patients?


Dr. Parker

BACKGROUND: Albumin-adjusted calcium is widely used in clinical practice to estimate true calcium status, despite limited empirical evidence supporting its accuracy. Ionized calcium is the physiologically active form and the gold standard for assessing calcium status, but it is measured less frequently due to issues of cost, convenience, and limited availability in certain clinical settings.

STUDY DESIGN: Retrospective cross-sectional study

SETTING: Tertiary hospitals across Alberta, Canada

SYNOPSIS: This population-based cross-sectional study included 22,658 adults (median age 60 years, 52.5% female) who underwent simultaneous measurement of serum total calcium, albumin, and ionized calcium between 2013 and 2019. The study compared the correlation and agreement of unadjusted total calcium and albumin-adjusted calcium (using 10 formulas, including Payne and James) with ionized calcium, the reference standard. The greatest discrepancies between albumin-adjusted and ionized calcium were observed in patients with hypoalbuminemia (albumin under 30 g/L), where adjustment formulas led to increased discordance and frequent misclassification of true hypocalcemia as normocalcemia, and less commonly normocalcemia as hypercalcemia. Using the original Payne formula, patients were misclassified by one category in 40.0% of cases and by two categories in 1.3% of cases, compared to 25.3% and 0.1%, respectively, for unadjusted total calcium. The James formula showed slightly better correlation, but no adjustment formula outperformed unadjusted total calcium, especially in low albumin states. Overall, unadjusted total calcium had a stronger correlation (R^2=71.7%) and higher agreement (74.5%) with ionized calcium. Limitations included retrospective design, lack of clinical outcome data, and single-geographic scope.

BOTTOM LINE: Albumin-adjusted calcium often misclassifies clinically significant disturbances, supporting a shift toward using unadjusted total calcium or direct ionized calcium, particularly in patients with low albumin.

CITATION: Desgagnés N, et al. Use of albumin-adjusted calcium measurements in clinical practice. *JAMA Netw Open*. 2025;8(1):e2455251. doi: 10.1001/jamanetworkopen.2024.55251.

Dr. Parker is an oncology hospitalist at Smilow Cancer Hospital at Yale New Haven and an assistant clinical professor of medicine at Yale School of Medicine, both in New Haven, Conn.

By Anisha Advani, MD

4 Pre-Treatment with IV Calcium Prior to IV Diltiazem Prevents Hypotension in AF

CLINICAL QUESTION: Can pre-treatment with IV calcium prevent hypotension in patients receiving IV diltiazem for atrial fibrillation (AF) or atrial flutter?

BACKGROUND: AF is the most commonly treated arrhythmia in EDs. Diltiazem is a first-line agent for rate control of AF with rapid ventricular response (RVR, heart rate over 120 beats per minute [bpm] at rest) due to its negative chronotropic effects at the sinus node. However, it can also cause vasodilation by acting on vascular smooth-muscle calcium channels, often resulting in hypotension. While the efficacy of IV calcium in mitigating verapamil-induced hypotension is well established, data supporting its use alongside diltiazem has been limited. Prior studies were constrained by the use of relatively low doses of IV calcium (90 mg).


Dr. Advani

STUDY DESIGN: Double blinded, prospective-cohort, placebo-controlled, single-center, randomized, controlled trial

SETTING: University of Haseki Emergency Department, Istanbul, Türkiye

SYNOPSIS: A total of 217 adult patients presenting to the ED with atrial fibrillation or flutter, heart rate over 120 bpm, and systolic blood pressures (SBP) between 90 and 180 mmHg were randomized to receive either saline placebo, 90 mg IV calcium chloride (CaCl), or 180 mg IV CaCl prior to receiving IV diltiazem. Patients requiring cardioversion due to hemodynamic instability and those taking beta-blockers or other rate-control agents were excluded. Blood pressure and heart rate were recorded at five, 10, and 15 minutes post-diltiazem.

The placebo group experienced a maximum mean SBP drop of 15 mmHg, compared to 9 mmHg in the 90 mg CaCl group, and no SBP change in the 180 mg CaCl group. All groups achieved heart rate reduction to less than 110 bpm. However, the mean heart rate at 15 minutes was slightly lower in the placebo and 90 mg groups (96 bpm and 99 bpm, respectively) than in the 180 mg group (105 bpm). There were no significant differences in the need for repeat diltiazem dosing across groups.

BOTTOM LINE: In this small, single-center study, pre-treatment with IV calcium, particularly at a dose of 180 mg, successfully blunted the hypotensive effects of IV diltiazem without substantially impairing heart rate control. Hospitalists may consider using IV calcium gluconate, when available, instead of calcium chloride due to its lower risk of infusion-related adverse effects.

CITATION: Az A, et al. Reducing diltiazem-related hypotension in atrial fibrillation: role of pretreatment intravenous calcium. *Am J Emerg Med*. 2025;88:23-28. doi: 10.1016/j.ajem.2024.11.033.

Dr. Advani is an associate director of the hospitalist service at Yale New Haven Hospital, an assistant clinical professor at Yale School of Medicine, and co-firm chief of Yale's Hospital Medicine Firm, all in New Haven, Conn.

By Jensa Morris, MD

5 Therapeutic-Dose Anticoagulation Shortened the Duration of ACS in Sickle Cell Disease Without Increasing Major Bleeding Risk

CLINICAL QUESTION: Does therapeutic-dose anticoagulation, compared to prophylactic dosing, improve clinical outcomes in adults with sickle cell disease hospitalized for acute chest syndrome (ACS)?

BACKGROUND: ACS is a leading cause of morbidity and mortality in sickle cell disease, with pulmonary microthrombosis implicated in its pathogenesis; current practice typically uses prophylactic anticoagulation, but the benefit of therapeutic dosing has not been established.


Dr. Morris

STUDY DESIGN: Double-blinded, multi-center, prospective, randomized, controlled trial

SETTING: 12 hospitals in France

SYNOPSIS: The TASC trial randomized 172 adults with sickle cell disease and ACS (without initial thrombosis on CT pulmonary angiogram) to receive either prophylactic or therapeutic doses of low-molecular-weight heparin tinzaparin for seven days, or until hospital discharge. The primary outcome of time to ACS resolution was significantly lower in the therapeutic group (hazard ratio [HR] 0.71; 95% confidence interval [CI], 0.51 to 0.99; *P*=0.044), with a mean reduction of 1.3 days. No major bleeding events occurred in either group. The therapeutic group also had lower cumulative parenteral opioid use. Other secondary outcomes, including transfusion rates, mortality at discharge, and six-month readmissions, were similar. Limitations include the trial's restriction to adults and its single-country setting, which may affect generalizability. The sample size (172 patients) may limit its power to detect rare adverse events, particularly major bleeding, which did not occur in either group. Finally, the trial used a specific low-molecular-weight heparin (tinzaparin), so results may not be directly applicable to other anticoagulants or dosing strategies.

BOTTOM LINE: Therapeutic-dose anticoagulation with tinzaparin shortens ACS duration and reduces opioid use in adults with sickle cell disease hospitalized for ACS, without increasing major bleeding risk.

CITATION: Dessap AM, et al. Comparison of prophylactic and therapeutic doses of anticoagulation for acute chest syndrome in sickle cell disease: the TASC randomized clinical trial. *Am J Respir Crit Care Med*. 2025;211(5). doi: 10.1164/rccm.202409-1727OC.

Dr. Morris is a hospitalist at Yale New Haven Hospital in New Haven, Conn. She directs the Smilow Hospitalist service, a hospital medicine group dedicated to the care of oncology patients.

By Fabiola Molina, MD, MHS

6 Hospital-Initiated MAUD: Oral and Extended-Release Naltrexone are Similarly Effective in Reducing Alcohol Use

CLINICAL QUESTION: Is there a difference in alcohol consumption between the oral and extended-release formulations of naltrexone when initiated in the hospital for patients with alcohol use disorder (AUD)?


Dr. Molina

BACKGROUND: Alcohol use disorder (AUD) is common (as many as 19% of inpatients), and 94% of people with AUD do not receive medication or counseling. Despite the availability of medications for AUD (MAUD), few hospitalized patients receive them. The comparative effectiveness of initiating oral versus

extended-release naltrexone in this context is not known.

STUDY DESIGN: Randomized clinical trial

SETTING: Teaching hospital in Boston

SYNOPSIS: Among hospitalized patients with AUD and recent heavy drinking, 248 participants were randomized to receive oral naltrexone supply on the day of discharge or extended-release injectable naltrexone. Both arms received real-world outpatient medical management with a three-month follow-up period. The majority of participants were middle-aged men, 50% self-identified as Black, and almost half had experienced recent housing insecurity. Most were insured by Medicaid. Approximately 90% had severe AUD. The study assessed as its primary outcome the three-month change in heavy drinking days (HDDs) in the preceding 30 days. The study found that both groups had a reduction in HDDs compared to baseline, with no significant difference between groups (38.4% reduction in oral naltrexone group versus 46.4% reduction in injectable naltrexone group). A limitation of the study is the lack of a third group that was referred for outpatient naltrexone initiation rather than in-hospital initiation. Nonetheless, the study's findings are a critical addition to the evidence supporting hospital initiation of MAUD and should encourage hospital-based providers to tailor options to patients' preferences.

BOTTOM LINE: When initiated in the hospital, both daily oral naltrexone and injectable extended-release naltrexone were similarly effective in reducing alcohol use. Patient preference, adherence with oral naltrexone, and cost should be considered when deciding between formulations.

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.

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By Chris Sankey, MD, SFHM

7 Competencies for Those Who Coach Physicians: A Modified Delphi Study

CLINICAL QUESTION: What competencies are essential for coaching physicians effectively?


Dr. Sankey

BACKGROUND: Physician coaching is founded on a supportive approach that empowers individuals and organizations to develop essential skills for success in healthcare. Coaching for faculty and trainees is becoming an increasingly common practice in medicine to foster physician growth, optimize performance, enhance wellness, and reduce burnout. However, no consensus standards exist for competencies for those who coach physicians.

STUDY DESIGN: Modified Delphi consensus study

SETTING: U.S. and Canada; expert panels and a survey of stakeholders in physician coaching

SYNOPSIS: An expert panel developed a list of coaching competencies tailored to those who coach physicians, which was validated by 97 stakeholders through a structured Delphi process. The resulting 129 competencies span six domains: physician-specific coaching; healthcare context; coaching theory; diversity, equity, and inclusion; well-being; and leadership. Consensus exceeded 85% in all domains, highlighting broad agreement on the need for standardization in physician coaching.

BOTTOM LINE: Physician coaches may improve physician well-being, and this study establishes the first standardized competencies for those who coach physicians, offering a foundation for training, certification, and coach selection in healthcare.

CITATION: Passarelli AM, et al. Competencies for those who coach physicians: a modified Delphi study. *Mayo Clin Proc*. 2024;99(5):782-794. doi: https://doi.org/10.1016/j.mayocp.2024.01.002.

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By Janjenali Villaflor, MD

8 As-Needed BP Medication and Increased Adverse Outcomes in VA Hospitals

CLINICAL QUESTION: What are the adverse effects of as-needed BP medication on asymptomatic hypertension in hospitalized patients at risk of ischemic events due to high cardiovascular disease burden?


Dr. Villaflor

BACKGROUND: Asymptomatic BP elevations in hospitalized patients are often managed with as-needed medications due to the lack of clear guidelines. Prior studies have suggested potential risks, such as acute kidney injury (AKI), associated with this practice.

STUDY DESIGN: Retrospective cohort study

SETTING: Veterans Administration hospitals, excluding intensive care unit settings and surgical floors

SYNOPSIS: Veterans who received at least one as-needed BP medication during hospitalization between October 1, 2015, and September 30, 2020, were compared to those who received only scheduled BP medication. Reasons for admission between the two groups were matched to enhance generalizability. The primary outcome measured was the incidence of AKI, with secondary outcomes including rapid BP drops and a composite of myocardial infarction, stroke, and death. The findings demonstrated that veterans who received as-needed BP medication were 23% more likely to develop AKI (HR, 1.23 [95% CI, 1.18 to 1.29]), with a higher risk associated with IV administration compared to oral treatment. Additionally, in veterans who received as-needed BP medications, there was a 1.5-fold greater risk of rapid BP reduction (95% CI, 1.39 to 1.62) and a 1.7-fold increase in the risk of a composite outcome of MI, stroke, or death (relative risk, 1.69 [95% CI, 1.49 to 1.92]). Limitations include potential residual confounding and focus on a veteran population, limiting generalizability.

BOTTOM LINE: As-needed BP medications for asymptomatic hypertension were associated with increased risks of AKI, rapid blood pressure drops, myocardial infarction, stroke, and death in hospitalized veterans.

CITATION: Canales MT, et al. As-needed blood pressure medication and adverse outcomes in VA hospitals. *JAMA Intern Med*. 2025;185(1):52–60. doi: 10.1001/jamainternmed.2024.6213.

Dr. Villaflor is a hospitalist and quality improvement deputy for the hospitalist service at Yale New Haven Hospital, and an assistant clinical professor at Yale School of Medicine, both in New Haven, Conn.

By Sharon Ostfeld-Johns, MD, IBCLC

9 Equivalent Mortality Regardless of Decision to Admit Versus Not to Admit in the 30 Days After an Index ED Visit

CLINICAL QUESTION: Do patients who are admitted to the hospital benefit from hospitalization, especially when the likelihood a given patient is admitted is highly dependent on the relative propensity of the ED physician to admit patients of similar acuity?


Dr. Ostfeld-Johns

BACKGROUND: Usually, the decision to admit a patient to the hospital is made by ED physicians, and there is significant variability between individual ED physicians in how likely they are to admit a given patient. The authors questioned whether there are differences in outcomes in patients being cared for by ED physicians with high propensity to admit versus low propensity to admit. The corollary to this, from a hospitalist perspective, is how well we inpatient physicians are matching the range of hospitalization services and supports to the range of acuity of patients who are admitted to our service.

STUDY DESIGN: A national, multi-site, retrospective, cross-sectional study

SETTING: 105 Veterans Affairs (VA) EDs

SYNOPSIS: Using national VA data encompassing more than 2 million ED visits seen by more than 2,000 ED physicians, patients were split into cohorts by the following chief concerns: chest pain, shortness of breath, or abdominal pain. Within each cohort, several variables were controlled for, including time of arrival, location within the ED, and Emergency Severity Index, to normalize the patient's health status prior to the ED visit. Patients cared for by high-rate-of-admission ED physicians had similar rates of mortality as those cared for by low-rate-of-admission ED physicians (regardless of whether they were admitted or not) at every time point evaluated after ED visit through one year. Patients cared for by high-propensity-to-admit ED physicians were more likely to have more tests ordered in the ED, to be admitted, to have a hospital stay less than 24 hours, and to spend more days (2 versus 1.5) in an ED or hospital in the 30 days after the index ED visit (indicating that high-acuity care was not simply deferred).

BOTTOM LINE: Variability in admission practices among individual ED attendings can lead to increased resource utilization without corresponding improvements in outcomes or reductions in return visits. Hospitalists address this variability by triaging admissions and tailoring length of stay based on the risks and benefits of continued hospitalization. Future studies may

explore a more proactive role for hospitalists in ED triage and care coordination to promote early, safe discharges directly from the ED.

CITATION: Coussens S, Ly DP. Variation in emergency department physician admitting practices and subsequent mortality. *JAMA Intern Med*. 2025;185(2):153–160. doi: 10.1001/jamainternmed.2024.6925.

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SHORT TAKES

LLM Can Aid Clinicians by Drafting Discharge Summary Narratives

By Angela Kang-Giaimo, MD, MPH

In this cross-sectional study of 100 discharge summaries, there was no significant difference in large language models (LLMs) and physician-generated discharge narratives when rated by blinded reviewers. LLM-generated narratives were more concise and coherent but contained more errors with low potential to harm.

Citation: Williams CYK, et al. Physician- and large language model-generated hospital discharge summaries. JAMA Intern Med. 2025;185(7):818–825. doi: 10.1001/jamainternmed.2025.0821. ■

Dr. Kang-Giaimo is an assistant professor of medicine, a hospitalist, and the director of the internal medicine clerkship at Yale School of Medicine in New Haven, Conn.

By Thilan P. Wijesekera, MD, MHS

10 GPT-4 Assistance for Improvement of Physician Performance on Patient Care Tasks: A Randomized Controlled Trial

CLINICAL QUESTION: Does large language model (LLM) assistance improve physician performance on open-ended management reasoning tasks compared to conventional resources?

Dr. Wijesekera

BACKGROUND: Management reasoning is a newer field in clinical reasoning that includes decision making around testing, treatment, goals of care, and availability of resources. Unlike in diagnostic reasoning, there is often not a single correct answer in management, which requires prioritization, ongoing monitoring, and communication with the patient. While LLMs have shown effectiveness in diagnostic reasoning, little is known about their performance in management reasoning.

STUDY DESIGN: Prospective, randomized, controlled trial

SETTING: Virtual, either remotely or at an in-person computer laboratory

SYNOPSIS: A total of 92 physicians were enrolled from November 2023 to April 2024, the majority of whom were attendings and those with internal medicine training. The physicians completed a total of 400 clinical vignettes—176 using LLMs and 199 using conventional resources (e.g., UpToDate, Google). LLM alone completed 25 cases. An iterative modified Delphi process was used to refine the management rubric to score each case. Physicians using LLM (43.0%) scored higher than those using conventional resources (43.0% compared to 35.7%, 6.5% difference, P <0.001). There was no statistical difference between physicians using LLM and LLM alone (-0.9%, P=0.8). Physicians using the LLM also spent more time per case (801.5 versus 690.2 seconds, 119.2-second difference, P=0.022). Post-hoc sensitivity analysis adjusting for time still showed a 5.4% increase in score (P=0.004).

BOTTOM LINE: Use of LLMs may help improve the performance of inpatient management reasoning, a crucial part of every hospitalist's clinical practice.

CITATION: Goh E, et al. GPT-4 assistance for improvement of physician performance on patient care tasks: a randomized controlled trial. *Nat Med*. 2025. 31;1233–1238. doi: 10.1038/s41591-024-03456-y.

Dr. Wijesekera is a hospitalist at Yale New Haven Hospital and an assistant professor of medicine at Yale School of Medicine, both in New Haven, Conn. Disclosure: Dr. Wijesekera is a consultant on clinical reasoning content for McGraw-Hill and the National Board of Medical Examiners. ■

SHM's Unsung Hero Award Winners

Chapter leaders recognized for their contributions

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By Karen Appold

Some individuals significantly contribute to a cause or need without seeking accolades or fame. In 2023, SHM began recognizing a chapter leader who did just that with its annual Unsung Hero Award. These leaders have positively influenced SHM from behind the scenes, have shown a willingness to help in whatever capacity is necessary, and have supported other chapter members. So far, three hospitalists have received this honor.

2022: Gwendolyn Williams, MD, FACP, FHM

Dr. Williams began her journey in hospital medicine in 2015 at Sentara Health as a hospitalist. Today, she is a hospitalist and assistant professor of medicine in the department of internal medicine at Virginia Commonwealth University, an academic hospital with 865 beds in Richmond, Va.

Dr. Williams

"Throughout my career, I have become increasingly driven to address the systemic challenges that affect both patient care and provider well-being," she said. "As a first-generation American and woman of color, I believe that my lived experiences shape how I lead, connect, and advocate. These perspectives allow me to navigate health care with cultural humility, empathy, and a deep commitment to ensuring that all voices—especially those historically underrepresented—are heard and valued. This evolution led me to develop a strong focus on physician advocacy, gender equity, health justice, and inclusive leadership."

Dr. Williams believes she received the Unsung Hero Award because of her commitment to serving others. "To me, leadership is not about visibility; it's about impact," she said. "Many of my contributions may never be known, and that's exactly how I want it. Whether I'm connecting colleagues with opportunities, supporting a peer, or quietly laying the foundation for others to succeed, I do it from a place of compassion and commitment. I work to create a culture where all members feel empowered, seen, and valued—because when we uplift others, we all rise. This award affirms that work done quietly, mindfully, and with integrity truly matters."

As SHM's Hampton Roads Chapter president, Dr. Williams has centered her leadership on service, inclusion, and advancing a shared vision for change. In fact, she led an all-female executive board for the first time in the chapter's history.

In 2024, the chapter launched a diverse calendar of events, including continuing medical education in accredited clinical lectures, wellness retreats, a yoga series, and collaborative chapter events across state lines. "We elevated conversations on urgent issues such as health disparities, climate change, racial and gender equity, and bias in medicine," Dr. Williams said.

The chapter also expanded access and engagement by offering hybrid formats for education, community volunteer days, and inclusive family events. Dr. Williams led efforts to create networking opportunities that fostered collaboration across institutions and highlighted underrepresented voices throughout her chapter. Developing leaders, creating new board roles to shorten leadership pathways, and empowering rising leaders were all priorities.

This collective effort led to the Hampton Roads Chapter being named the 2024 SHM Outstanding Chapter of the Year at Converge. "But even more meaningful was the culture we've cultivated—a chapter defined by authenticity, allyship, sponsorship, and belonging," Dr. Williams said.

As a visionary connector, bridge builder, and catalyst for progress, Dr. Williams is committed to cultivating systems where healing is mutual, well-being is foundational, and every person—whether delivering or receiving care—can truly thrive. Through thought leadership, collaboration, writing, and speaking, she aims to ignite meaningful progress and drive lasting structural and cultural change that uplifts the entire health care community and helps shape a more equitable, just, and human-centered future.

As a Dr. Lorna Breen Heroes Foundation ambassador, Dr. Williams advocates fiercely for the healthcare workforce's well-being and champions national policy efforts, including the reauthorization of the Lorna Breen Health Care Provider Protection Act, to ensure enduring support for those serving on the front lines.

2023: Farzana Hoque, MD, MRCP, FACP, FRCP

Dr. Hoque became an associate professor of medicine at Saint Louis University School of Medicine, an academic hospital in St. Louis, in 2018.

As president of SHM's St. Louis Chapter from May 2022 to April 2025, she focused on strengthening the chapter's strategic vision, fostering development, and expanding regional collaboration.

Dr. Hoque

She began her term as the only female board member and led efforts that tripled the number of women board members and added hospitalists from both academic and community hospitals. "This brought fresh perspectives that strengthened decision making," Dr. Hoque said. She also established two new leadership roles—the director of membership development and an advisory board—to ensure sustainability and broaden engagement.

Dr. Hoque also championed academic and career advancement by launching multiple educational initiatives, including interactive workshops on scholarly writing and a high-impact career development panel. The chapter expanded participation in its annual abstract competition by including medical students, residents, and early-career hospitalists, sparking enthusiasm for hospital medicine and encouraging scholarly growth.

To meet evolving interests in hospital medicine, the chapter hosted point-of-care ultrasound workshops with standardized patients and introduced educational sessions on emerging topics such as hospital-at-home models and financial management for hospitalists. "These programs included built-in networking opportunities that assembled hospitalists across various career stages, creating space for peer connection, mentorship, and collaboration," Dr. Hoque said.

Dr. Hoque also prioritized collaboration beyond her SHM chapter. The chapter held multiple joint meetings with the Kansas, Hampton Roads, and Charlotte Metro chapters. Further, the St. Louis Chapter launched its first "Hospi-

talist Day" in partnership with the American College of Physicians Missouri Chapter—a milestone collaboration that brought hospitalists together to share knowledge and build community.

"Through impactful initiatives like these, consistent mentorship of emerging leaders, and a strong commitment to fostering a culture where everyone can succeed, I have strived to embody the spirit of the Unsung Hero Award—lifting others to elevate the entire hospital medicine community," Dr. Hoque said.

Over the next decade, Dr. Hoque plans to amplify her impact on patient care, medical education, and patient experience. As the medical director of patient experience for the SSM Health St. Louis Region, she collaborates with multidisciplinary leaders to implement evidence-based initiatives across seven hospitals, transforming data into actionable strategies that drive measurable improvements in patient care.

Concurrently, as the inaugural medical director of Bordley Tower of SSM Health Saint Louis University Hospital, she spearheads operations to deliver patient-centered care aligned with the health system's mission of providing exceptional healthcare. As the acting internship co-director of Saint Louis University School of Medicine, she feels privileged to mentor medical students, residents, and early career faculty.

Dr. Hoque's professional passion lies in projects that strengthen physician-patient relationships. Notable examples include Bedside Trio Rounds, which foster real-time team communication and shared decision making, and Commit to Sit, which encourages clinicians to engage more intentionally at the bedside. "In the years ahead, I will scale these and other high-impact models to boost trust and patient experience across our health system," she said.

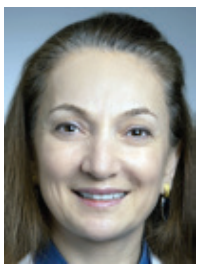
Dr. Hoque draws her strength and passion to lead from the values her parents instilled in her. "They taught me the power of consistency, the importance of positivity, and the belief that progress—no matter how small—comes from dedication, perseverance, and trying one more time," she said. "If we're not moving forward, we're not standing still—we're falling behind."

2024: Maia Nizharadze, MD, CPE, FHM

Dr. Nizharadze joined Sentara Norfolk General Hospital, a 525-bed academic, tertiary medical center in Norfolk, Virginia, as a hospitalist in 2008. In 2015, she became the chief hospitalist in its department of hospital medicine.

"I've always loved problem solving and driving quality excellence," Dr. Nizharadze said. "Under my leadership, we've built a strong, high-performing team with a collaborative culture."

As an SHM member, Dr. Nizharadze has found value in connecting with peers outside of Sentara who shared similar challenges. She has served as an SHM Hampton Roads Chapter steering committee member and its vice president.


Dr. Nizharadze

In these leadership roles, Dr. Nizharadze has helped to support event planning, identify speakers, and shape agendas that align with hospitalist education and practice needs. She helps to coordinate yearly programming and mentors younger members, including residents from Eastern Virginia Medical School who are considering hospitalist careers.

She is passionate about community engagement, expanding membership, and creating a sense of belonging in her chapter. "I believe our collective efforts have created a dynamic and well-connected hospitalist network," she said.

Dr. Nizharadze believes the Unsung Hero Award reflects the example she has tried to set. "I never ask my team to do something I wouldn't do myself," she said. "During the COVID-19 pandemic, I led daily huddles, developed early local guidelines, and prioritized team safety. I led with integrity and focused on learning, improvement, and patient-centered care. I believe my team felt supported and empowered during those uncertain times."

Dr. Nizharadze gets her strength and passion to make a difference and be a leader from her colleagues and patients. She believes that hospitalists play a vital role in shaping hospital care. "I feel a responsibility to use my experience to improve safety, quality, and operations," she said.

"Collaborating with SHM members has sharpened my leadership skills and deepened my appreciation for teamwork," she said. "Seeing our chapter thrive and my hospitalist group perform at a high level inspires me to keep pushing to be a better clinician, partner, and leader."

Dr. Nizharadze expects to be increasingly involved in hospital leadership in the future. "I remain deeply connected to patient care and my identity as a hospitalist," she said. "I want to continue solving complex problems, leading performance initiatives, and building collaborative teams. I don't pursue titles—I take on challenges that make an impact and push me to grow."

In the next decade, Dr. Nizharadze hopes to keep evolving, taking on bigger responsibilities, and driving innovation while staying grounded in her purpose—delivering excellent, patient-centered care. ■

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

SHM

SHM's 2025 *State of Hospital Medicine* Report

SHM is excited to announce the publication of the 2025 *State of Hospital Medicine* Report. The Report, based on data from 2024, is a snapshot of what is happening across hospital medicine groups. We retained much of the traditional data groups rely on and added new questions relevant to this ever-changing environment. The Report provides valuable insights into the specialty of hospital medicine.

In addition to the compensation and productivity data licensed from the Medical Group Management Association that's included in the Report, we expanded our *SoHM* compensation and billing data to include the frequency that compensation plans are benchmarked, expanded the question on compensation breakdowns so we can now report on daytime and nocturnist physicians, as well as NPs and PAs. The Report includes data on 18 common nonproduction performance incentives and whether they are used in the assessment of individual hospitalists, the group, or both.

The Report included questions that measure some of the ever-expanding roles that hospitalists have in their organizations. The results include information on new co-management specialties, such as trauma and urology, novel and expanding scopes of practice that groups lead or participate in, such as telemedicine and post-acute care. The Report also included a brand-new question on how structures, strategies, and initiatives that hospital medicine programs employ to address challenges with emergency department boarding.

We know that many readers of the Report use the data found within as a benchmark. It is a great resource for measuring and comparing operations internally over time and externally to other organizations' experiences. We encourage readers of the Report to read the Introduction, particularly "Using the Survey Report," to understand how best to compare their data to that in the *SoHM*. We also suggest survey participants compare how they responded to questions to the results in the Report, giving them a picture of where their group stands.

Due to the group-level nature of the Report, the results don't include many metrics that we know hospitalists themselves value. But there are a few data points we can tie into the priorities and needs of hospitalists, and here we see that the Report should not be used as a benchmark, but as a call to action.

As reported in the 2024 *Hospital Medicine Workforce Experience* Report, fewer than a quarter of hospitalists met the criteria for professional fulfillment, and 45% met the criteria for burnout. At the same time, the *SoHM* Report found that supportive leadership substantially improves scores. However, there was no improvement in the Report on questions of whether groups measured well-being and burnout or if they had an employee with a non-clinical focus on well-being, engagement, and burnout. The *Hospital Medicine Workforce Experience* Report also found that time off and PTO access are important tools in combating burnout. While the 2025 SoHM showed an increase in the proportion of groups offering PTO, it is still not the majority.

There are many other challenges we face and obstacles to overcome in hospital medicine and medicine as a whole. We hope this *State of Hospital Medicine* Report gives readers the data they need to make informed decisions in the coming year, to advance and streamline operations in groups across the country, and to improve care for hospitalized patients. In addition, SHM's Practice Management Department plans to weave *SoHM* data insights into articles and new programming and resources on pressing issues for the field throughout the year.

Scan the QR code for more information about SHM's 2025 *State of Hospital Medicine* Report. ■

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Celebrating Women Working to Improve Women's Healthcare and Careers

Professional and personal experiences drive these women physicians to advocate for better care

by Vanessa Caceres

Women hospitalists have seen advances in the care of female patients, but also in their careers within hospital medicine. However, there are still some bridges to cross to ensure that female patients feel fully heard and seen and that female hospitalists feel they can pursue their careers with equity.

The Hospitalist recently spoke with five female hospitalists who paved the way in making healthcare and healthcare careers for women easier to navigate. Here are some highlights from what they shared.

Lessons from Childbirth

Dr. Defoe

Maya Defoe, MD, assistant professor of medicine and recruitment director in the division of hospital medicine at Northwestern University Feinberg School of Medicine in Chicago

Dr. Defoe can recall returning to work at Northwestern University about eight years ago after having her first child and feeling like "a total mess." She was also struggling with postpartum depression.

"I felt like I needed to keep up with my roles and all my clinical tasks, and I was just starting to make a name in my division," she said. "I had to pretend like I was fine."

It wasn't until she went to a national conference six or seven months into her work return that a fellow female physician at a speed mentorship session heard what Dr. Defoe had been going through and let her know she shouldn't be expected to maintain the steep trajectory curve for her career for at least a year or perhaps longer.

"I thought, 'I wish someone had told me that,'" she said. "That started my desire to help other women in the same position."

That led Dr. Defoe to work on a multicenter, survey-based study that compared the career paths of men and women academic hospitalists.[1] That research found that women academic hospitalists experienced more adverse impacts on their personal lives and careers compared to men who took extended leaves and non-traditional work arrangements.

"Essentially, women just have far more negative effects from non-linear careers than men do," Dr. Defoe said. "That can include maternity leaves and other gaps."

Dr. Defoe says that women are at a disadvantage because in most cases, parenting duties fall on the mother, even if the father is able to take off for a few weeks after a baby's birth, and that "invisible workload" continues throughout the child's life.

Her second child was born around the start of the COVID-19 pandemic; she also experienced post-partum depression then, but she took more time off rather than powering through it. "I think the reason I'm still here five years later is because I took that break," she said.

In addition to her study findings, Dr. Defoe has helped pave the way for women hospitalists by helping to create a manual for women within her hospital system going on maternity leave. It addresses items like when maternity leave actually starts (on your expected due date, even if you deliver late) and ways to potentially extend your maternity leave (e.g., working more shifts during pregnancy or decreasing total full-time equivalents for the year).

Dr. Defoe strongly encourages women hospitalists who are planning a family and are new to the specialty to find a mentor in advance. "You don't have to be alone in trying to strategize if you're having trouble," she said.

Also, don't feel as if you need to do everything all at once. "Look at your career as a marathon. Focus on what you need to focus on and do what you need to do. There are always opportunities when you want to jump back in and make a name for yourself," she said.

She also has hope for the future of women in hospital medicine within the realm of starting a family. "I feel like things are (getting better) because people are actually talking about it," she said. Although she worries about the current political climate that puts less of an emphasis on diversity, she also says that a focus on starting families should be a concern for everyone.

Advancing Women's Health

Dr. Barrett

Eileen Barrett, MD, MPH, senior medical director and vice president of quality at WorkItHealth, and president of the American Medical Women's Association

Like many hospitalists, Dr. Barrett is internal medicine trained, so she went through residency without a significant focus on women's health. Instead, she had to seek out training and experiences on her own to provide the care that women deserve.

"That ranged from a trauma-informed approach, to pelvic exams to offering family planning, to medically complex patients, to adopting communication strategies that acknowledge that many women have had negative experiences with the healthcare system because of bias and discrimination," Dr. Barrett said.

One challenge she continues to find is that sex- and gender-specific care is often an afterthought, whether that means finding a speculum on an internal medicine ward or difficulties providing an intrauterine device or Depo-Provera because they are not reimbursed in the hospital, or the simple fact that women's symptoms are often dismissed or minimized.

Dr. Barrett's passion for better women's health led to successfully advocating for the ability to administer Depo-Provera prior to discharge for women who desired it, even if it was not reimbursed, and then helping to coordinate outpatient care for ongoing contraceptive access.

"I am passionate about people having control over their reproductive health, and with increasing difficulties accessing this quickly, it's important that all clinicians provide desired contraception or a referral when someone wants it," she said.[2]

Dr. Barrett's passion also led to involvement with the American Medical Women's Association, which focuses on advancing women in medicine and improving women's health. She is currently the group's president. Dr. Barrett said she started by participating on committees, partnering with mentees on abstract submissions, and attending the group's annual meeting.

There's another piece of the women's healthcare puzzle that Dr. Barrett would like to find more often. "I hope more allies lean into their courage to support a future with more hospitalists embracing women's health and also by advancing the careers of women in medicine. We all do better when women get comprehensive care and when women leaders are in environments where they can reach their potential," she said.

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Using QI to Improve Care

Dr. Humes

Kathryn Humes, MD, FACP, assistant professor of medicine and associate program director for quality improvement and patient safety curriculum at Augusta University's Medical College of Georgia in Augusta, Ga.

Due to a hospital system issue, while a resident, Dr. Humes and several others at the hospital made a mistake in the dosing of a dangerous medication. Although there was no lasting damage, she learned that even providers with the best intentions are capable of negative outcomes.

That's led to her own focus on quality improvement in her role at the Medical College of Georgia, where she founded and spearheads the quality improvement (QI) curriculum.

On a practical level, Dr. Humes' focus on women's healthcare often comes down to advocating for female patients. "Many times, it feels that the complaints of women go unnoticed or less noticed than those of their male counterparts," she said. "I've seen many women endure significant pain or hardship due to their concerns not being taken as seriously." She has also made similar observations as a female clinician, with her own ideas or concerns not acknowledged as often. "Sometimes, I've felt like an 'annoying little girl' rather than a female faculty leader and QI expert," she said.

Through her mentorship of resident physicians and work within QI, Dr. Humes says she has helped other women feel empowered to speak up and has served on leadership committees to support conferences and support groups for women.

Dr. Humes has also supported resident-led QI projects to make a women's health curriculum for residents and to refer potential victims of domestic abuse or assault and human trafficking. The latter project was able to show a significant increase in the level of comfort residents have when addressing this topic with patients and fostering an awareness of available resources and referral options.

"By being visible and showing others that our voices matter as women, we can make lasting change in the medical profession and medical education," she said.

With women outnumbering men in medical school, Dr. Humes is optimistic about the future for female clinicians as well as female patients. "I hope to see more support for working moms with more flexibility and acknowledgement of the challenges of balancing family and high-intensity careers," she said.

When someone asked her how she is able to do it all as a working mom and a hospitalist leader, she used to say, "I don't!" and would emphasize all the types of help she gets.

"All of that is still true, but I've come to learn to give myself more credit and grace," she said. "Maybe 'all' means different things to different people, and I'm not the class mom at school every week. But I'm showing my kids what it means to be a strong female role model, and I'm grateful to get to prioritize what makes my family and me happy, which includes having a successful career and being blessed with the opportunity to help people every day."

Guiding Future Leaders

Dr. Awosikba

Bi Awosika, MD, FACP, SFHM, assistant dean and phase 1 and 2/3 career advisor at the University of Cincinnati College of Medicine, chair of the resident clinical competency committee, associate program director of the internal medicine residency program, hospitalist, and associate professor of medicine at the University of Cincinnati Medical Center in Cincinnati

Early in their career, many women hospitalists may feel pressure to have everything figured out, which can lead to self-reflection filled with angst and uncertainty, says Dr. Awosika. "It can also lead to passively following the motions with years passing, looking back, and trying to find additional joy and purpose. Because of this and depending on the environment, women in hospital medicine confront the challenge of being able to find the right mentor(s) who can help facilitate their development to align with their needs and goals," she said.

Dr. Awosika became involved in hospital QI

processes early in her career, when she was at MedStar Georgetown University Hospital in Washington, D.C. She would take part in hospital committees to address challenges related to patient throughput and facilitating smooth care transitions. "This experience opened my eyes to how a multidisciplinary team approach, involving diverse expertise, can bridge gaps in health disparities and promote equitable care," she said.

To help women hospitalists and those new to the specialty find their way, Dr. Awosika wears many hats. She participates in task forces focused on creating equitable and inclusive learning and working environments. She is an official faculty mentor to provide guidance to junior faculty. She was also part of SHM's Physicians-in-Training Committee.

Dr. Awosika says she values the chance to guide women at all levels, whether it's providing support for peers to share the joys of hospital medicine, assisting undergraduate medical education students as a career advisor, or sharing the scoop on hospital medicine with pre-health students.

"It's been a true privilege to know that these efforts help not only further their dreams but to bridge the gap to improve equity for women as they cultivate their skillsets and competencies to propel them towards success in their potential roles in the future," she said.

Dr Awosika is also active in the nonprofit Greater Cincinnati Women Walking West, which supports women who were born internationally and continue to pursue their education in the U.S. As a first-generation Cameroonian American and the first in her family to pursue medicine, she has found it inspiring to share stories and encouragement with those interested in careers in medicine.

Dr. Awosika says that she is hopeful as women physicians continue to rise within the specialty and that awareness of inequities helps to open doors and allow them to be seen. Her advice for women aspiring to work in hospital medicine? Take your time to intentionally cultivate your niche in hospital medicine. "Your crafting may take involvement in several activities at first within the early phases of your career, but continue to truly reflect on what drives you and brings you back to your 'why'," she said.

She also recommends focusing on the career path that suits you best, versus feeling competitive with others. "Remember that the closing of one door may just be the impetus needed for you to thrive when another one opens," she said.

Expanding your village through mentorship and sponsorship is also crucial, she adds.

Elevating Career Paths for Women

Dr. O'Toole

Jennifer K. O'Toole, MD, MEd, SFHM, associate dean for graduate medical education at the University of Cincinnati College of Medicine, designated institutional official at the University of Cincinnati Medical Center and West Chester Hospital, vice chair of faculty affairs in the department of internal medicine, and tenured professor of internal medicine and pediatrics at the University of Cincinnati in Cincinnati

Meds-peds hospitalist Dr. O'Toole became interested in elevating the career paths for women hospitalists early in her career, when she often found herself one of the few women in a leadership position in various spaces. Her first child was still young at that time, so she was navigating the career-life challenges many women encounter during that time of life.

A few years into her career, she received a substantial salary adjustment when her hospital medicine group became an independent division. The reason? She had a lower salary compared with others within the division, and it was caught during an equity review. "I started my job as a hospitalist right out of my chief resident year and didn't know I had the opportunity to negotiate my salary," Dr. O'Toole said. She estimates that she lost a few years of the extra salary because she didn't know to ask for more.

As a result of these experiences and a strong desire to help other women entering the field of hospital medicine, Dr. O'Toole began to get involved with different national projects with a focus on helping elevate women in medicine and leadership. Her current role as designated institutional official and associate dean for graduate medical education has given her a platform with great exposure to hospital leaders through which she can continue to advocate for opportunities for women in medicine.

Dr. O'Toole was also chair of the 2018 Pediatric Hospital Medicine meeting that featured a plenary on gender differences in medicine. That plenary led to a discussion with a group at the meeting about how to continue to advocate for advancement and leadership opportunities for women in pediatric hospital medicine, a specialty that is about two-thirds women. This led Dr. O'Toole and other colleagues to form ADVANCE PHM, an organization committed to promoting advancement and leadership opportunities for women in hospital medicine.

That group has since evolved to focus on promoting allyship and developing modern leaders in hospital medicine. "It's not about *fixing the individual* to allow them to be more successful in the system. It's really about how to *change the entire* system to promote advancement and opportunity for all," she said.

Dr. O'Toole advises women entering hospital medicine to find mentorship early on and get leadership training—even if you don't plan to pursue a leadership role. Leadership training helps you function effectively on the multidisciplinary teams you are a part of and benefits your advocacy efforts for patients, colleagues, and learners. Dr. O'Toole praises the course Hedwig van Ameringen Executive Leadership in Academic Medicine® (ELAM®) fellowship program at Drexel University College of Medicine, which she just finished in May, as a pivotal leadership training experience in her career.

She also believes it's important to give yourself grace. "Our jobs are hard, and our patients, colleagues, and bosses expect the best from us. Sometimes, this requires giving yourself some grace when you can't do it all, but recognizing that you can still do a lot," she said. ■

Vanessa Caceres is a medical writer in Bradenton, Fla.

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Fired on the Floor: Should We Allow it?

By John Hoyle, MD and Yasmin Marcantonio, MD, MPH, FACP, FAAP

FLIP SIDE

As healthcare professionals, we have a responsibility to promote patient autonomy and self-advocacy. Modern healthcare has shifted to prioritize a culture that is increasingly patient-centered, with a focus on shared decision making and therapeutic alliance.[1]

Most medical professionals and patients would presumably agree that this is a positive change. Still, the patient-clinician relationship is complicated, particularly in the hospital setting, where patients do not feel well physically and are simultaneously managing the disruptive consequences—practical, emotional, and financial—of an unplanned hospitalization. Compounding these challenges is the physically and mentally demanding nature of inpatient medicine, with long hours and high stakes that often place clinicians under large amounts of stress, at times leading them to feel rushed, fatigued, and indifferent during their interactions with patients.[2]

When these factors accumulate, they can lead to conflict and patient dissatisfaction. A patient may fire the current hospitalist and request a new clinician to take over their care, in the hope that this will improve their inpatient experience. Outside of extreme situations involving allegations of abuse or discrimination, or in which the standard of medical care is not being met, the decision whether or not to grant such requests is controversial. In this installment of The Flipside, we present opposing viewpoints on the topic of patients' right to fire their hospitalists.

Firing the hospitalist should not be tolerated (Dr. Marcantonio)

When a dissatisfied patient chooses to fire the hospitalist, it's important first to understand the reasons for the mismatch in therapeutic alliance. A patient may cite a variety of concerns about the clinician, including inadequate communication skills, lack of trust in the individual, unaddressed symptoms, unhappiness with the outcome of medical decision making, or simply the desire for a second opinion.

Whether or not a new hospitalist is likely to meet the patient's expectations and improve satisfaction is an important consideration, especially if the standard of medical care is already being met. Some may argue that simply allowing the option to switch may be validating to patients and can help preserve their sense of autonomy. However, this pauses the plan of care, potentially leading to care delays and longer length of stay—all without guarantee that the new hospitalist and patient will be a good match. Rather, hospitalist clinicians should use alternative methods of empowering patients and promoting their autonomy.

When medically appropriate, patients can and should help inform the aspects of their care that may be flexible; for example, the choice between two medications with similar efficacy but differing side effect profiles, timing of morning lab draws, or whether to first wean the dose or frequency of pain medications.[1] Simply asking a patient's opinion or suggestions related to the proposed plan of care can go a long way toward building trust and promoting patient autonomy. Often, lack of control leads to feelings of frustration and helplessness, and when we give control back in small doses—ideally from the beginning of the hospital stay—patients are less likely to reach a breaking point.

When they do express dissatisfaction with care and request to switch their hospitalist, encouraging them to maintain the existing partnership challenges both parties to find common ground and also helps create boundaries, which are inarguably essential to any professional or personal relationship. Equally important is the hospitalist's sincere efforts to reflect on prior interactions, seek opportunities to improve their care delivery and bedside manner, and validate the patient's negative experiences during a difficult time.

It is also important to note that in most hospital systems, the patient-clinician relationship is a temporary one, and if the patient remains admitted to the hospital, then another individual will eventually take over care. Thus, when patients with unmet medical or personal needs continue to require hospitalization, the system will ultimately allow for exposure to fresh eyes, additional opinions, and differing skill sets and communication styles among clinicians.

When circumstances arise such that the patient's request for a new hospitalist is time-sensitive (i.e., before an upcoming procedure or in disagreements over discharge timing), other resources should be used to offer the patient support and ensure that the standard of

Dr. Hoyle

Dr. Marcantonio

Dr. Hoyle is a clinical instructor in the department of medicine at Duke University and an adult hospitalist at Duke Regional Hospital, both in Durham, N.C. Dr. Marcantonio is an assistant professor in the departments of medicine and pediatrics, and of family medicine and community health at Duke University, and a medicine-pediatrics hospitalist at Duke University Hospital and Duke Regional Hospital, all in Durham, N.C.

care is being met. Such resources may include specialty consultant input, patient advocacy teams, and hospital ethics committees.[3] If feasible within a particular setting, a second opinion might be offered via consultation from a different hospitalist, an alternate hospitalist group practicing in the system, or hospital medicine leadership.

Some may raise the additional concern that being fired is demoralizing and leads to physician burnout, which certainly carries important implications for the sustainability and longevity of a career in hospital medicine. We must also consider the potential consequences this situation creates for patients. Patients who fire their hospitalist often unknowingly place themselves in a vulnerable position, that is, susceptible to bias and stigmatization from subsequent clinicians, nursing staff, and other members of the healthcare team. In handing off or receiving these patients, team members often label them as "difficult." Even with the best intentions, the individual assuming care will most likely maintain some form of bias toward the patient.[3] Similarly to patients who leave against medical advice, a history of firing physicians is likely to be written in the discharge summary, preserved in the medical record, and potentially disseminated in future documentation.

Lastly, and arguably the most practically relevant point, is that the infrastructure of hospital medicine is currently not built to sustain the practice of switching hospitalists if it were to be universally accepted. In smaller, more resource-limited hospitals, only one individual might be working at any given time. In larger hospital systems with multiple hospitalists working simultaneously, the transition of patients from one clinician to another can be time-consuming, inefficient, burdensome to the accepting provider (who may feel scrutinized and under pressure to satisfy an already dissatisfied patient), and inequitable from a census standpoint.

More widespread acceptance of requests to switch hospitalists will inevitably lead to increased frequency of requests, further compounding the logistical challenges of reassigning patients. Similarly, the patient who fires a clinician but remains unhappy with the replacement may feel compelled to make another request to switch. Most hospital medicine systems will be unable to meet these demands. Certainly, extreme circumstances exist in which we may need to honor a patient's request to change practitioners; however, these individualized decisions should be made thoughtfully and truly be considered necessary exceptions. Otherwise, we run the risk of perpetuating a system that is marked by inequity and bias.

Firing the hospitalist clinician should be allowed (Dr. Hoyle)

Many hospitalists are opposed to the practice of allowing patients to fire their inpatient clinicians and experience a strong, immediate, and instinctive aversion to the idea. This may have its roots in how clinicians view themselves—as compassionate healers, and reasonable and fair-minded people. They imagine being fired by a patient and consider how that would sting, how it would seem unfair and unreasonable. They cannot imagine the situation where being removed and replaced by a colleague would truly benefit the patient. And it would certainly come with a cost or psychological toll. It would feel like failure at best, or public humiliation at worst. Colleagues would probably understand, but they also might wonder. Medical professionals already often experience stress, moral injury, and burnout in the modern healthcare environment, so assuming limited benefits to the patient and significant negative effects on the hospitalist, it makes perfect sense not to allow firing.[2,4] Case closed.

However, hospitalist switching may not need to be a burden for the clinician, and the potential benefits for the patient could be greater than initially perceived. Many hospitalized patients experience disempowerment and a lack of autonomy.[5,6] Establishing a strong therapeutic alliance with a patient can be difficult, especially in situations of recurrent hospitalization, severe debility, and dependence on external caregivers, which may further erode patient autonomy and self-determination.

Patients often make choices that may be considered irrational, such as declining medications or procedures, or even self-directing discharge. A patient's decision to fire the hospitalist certainly could fit this pattern of behavior—grasping to expand one's severely restricted autonomy—but with one key distinction: it's much less dangerous. Since the practice of hospitalist firing is not well documented or researched, there is no data to demonstrate its effectiveness at restoring patient autonomy or improving the physician-patient relationship afterward. However, it seems likely that such benefits do exist even if only as a placebo effect.

The clinician who chooses to step humbly aside might create the golden opportunity a patient needs to reclaim autonomy and forge a therapeutic alliance with a different healthcare professional. The concern for negative psychological impact on the clinician could be alleviated by normalizing hospitalist switching within the culture of medicine such that stepping down from a patient's care is not viewed as a failure, but a beneficial exercise of humility, wisdom, and emotional maturity. In fact, permitting both parties to proactively address relationship tensions by attempting to find a better therapeutic match might alleviate distress on the part of the hospitalist as well. Culture change at a systems level has been identified as a promising avenue for the promotion of patient-centered care, and the issue of firing in hospital medicine presents a perfect opportunity to advance such work.[1]

One major consideration is practicality, or "cost of implementation" in a systems-based practice framework. Is it truly practical to allow patients to dictate switching their hospitalists? Clearly, there should be some constraints on clinician firing in order to avoid creating substantial systems inefficiencies, but the specific limitations will depend heavily on one's particular setting. Regardless, drawing a clear distinction between "not practical" and "not acceptable" is essential. A system might exist in which firing is not allowed in settings where it is not logistically feasible, but permitted in other situations where it is. As with many policy decisions in healthcare, this may be best addressed not by overarching policy but at the ground level, taking into account the specific circumstances of the request.

Those who oppose the practice of firing the hospitalist often argue that it should be allowed only for good reason, such as when a clinician is not meeting the standard of care; however, adjudicating what qualifies as good reason or when the standard of care is not being met is fraught with difficulties. Patients may be reluctant to fully express their true reasons for pursuing a clinician change, perhaps out of courtesy, out of fear, or for various other reasons. The hospitalist in question may be the only party with the situational knowledge and the medical expertise to determine whether the patient's stated reason is valid or whether the patient has the capacity to make the request, creating a conflict of interest. The most practical solution is simply to allow clinician-change requests when logistically feasible without attempting to judge or validate the stated reason.

Discussion

The inpatient setting presents a uniquely challenging situation in which a patient and clinician are paired without the opportunity for the patient to express preferences or ensure mutual consent. In examining the arguments surrounding hospitalist firing, there are certainly areas of consensus. Patient-centeredness is essential in the practice of hospital medicine, and this should be made a priority as soon as the relationship begins. Therefore, even in the event of conflict or moral injury on the part of the hospitalist, all requests to reassign the clinician should be met with humility and compassion, with a focus on the reason for dissatisfaction and sincere effort to resolve tensions. Whether or not a switch is made, involvement of a third party, such as a patient advocate or consulting clinician, may help ensure equity in the decision-making process, facilitate common ground, and potentially resolve the situation.

The question of whether or not to allow patient-directed hospitalist firing should come down to a case-by-case assessment of the risks and the benefits to both parties, with the understanding that this determination in itself may not be straightforward. Those who ascribe the highest importance to patient autonomy and self-determination are more likely to support the practice of switching hospitalists, while those who more strongly prioritize clinician advocacy, systems efficiency, and predictability might be opposed. The potential benefits to the patients may be difficult to predict in advance and are certainly difficult to quantify, assuming there was never any overt mistreatment or clinical negligence.

Regardless of medical and ethical concerns, logistical and practical considerations of the hospital system in question may ultimately dictate whether or not a request to change hospitalists can be granted. Further research surrounding patient autonomy and satisfaction in hospital medicine may be able to illuminate this discussion further and inform decisions, whether at the individual, hospital-wide, or policy level. ■

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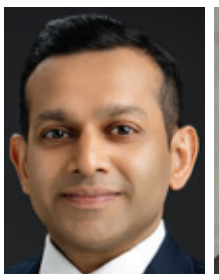
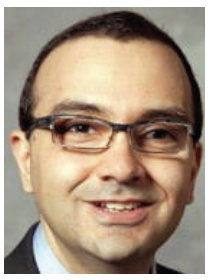
The Case for Hospitalists' Involvement in Hospital Contract Negotiations

By Thejaswi Poonacha, MD, MBA, SFHM, and Fady Chamoun, MD, FHM



Dr. Poonacha



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"...as contracts increasingly dictate clinical practices, the absence of direct hospitalist input poses risks to clinical integrity, financial stability, and patient care outcomes."

Physician advisors and hospitalists bring indispensable value to contract negotiations between hospital systems and payers. Traditionally, contracting has been managed primarily by finance and administrative teams. However, as contracts increasingly dictate clinical practices, the absence of direct hospitalist input poses risks to clinical integrity, financial stability, and patient care outcomes.

Hospitalists possess a unique understanding of patient care realities, evidence-based medical practices, and regulatory standards. This expertise positions physician advisors to effectively negotiate terms that are not only financially appealing but also clinically appropriate and achievable. For instance, when contract language about clinical denials or observation status definitions is ambiguous, hospitalist input ensures clarity aligned with the Centers for Medicare and Medicaid Services (CMS) regulations and real-world care scenarios.

Consider the issue of observation care: without hospitalist involvement, contracts often contain vague definitions allowing payers to deny inpatient status unfairly. A physician advisor or hospitalist would advocate for clear contractual language aligning with the CMS two-midnight rule, ensuring inpatient approval if the payer cannot demonstrate patient care delays or justify observation beyond two midnights.

Hospitalists can also advocate for clear policies around post-acute authorizations, insisting on explicit timelines and consequences if payers fail to authorize necessary care within 24 hours. Such clarity reduces administrative inefficiencies and ensures timely patient care.

Physician advisors significantly enhance the peer-to-peer (P2P) process by advocating for clearly defined expectations, streamlined scheduling, and efficient, meaningful conversations between clinical peers. Hospitalists' involvement in this process reduces administrative burdens, improves communication efficiency, and decreases the frequency of inappropriate claim denials.

Furthermore, hospitalists understand clinical validation denials and medical necessity criteria better than non-clinical staff alone. When physician advisors participate, contracts can explicitly reference widely recognized medical necessity guidelines—such as Milliman Care Guidelines (MCG) criteria used at M Health Fairview, a large healthcare organization in Minnesota—to ensure consistency, fairness, and transparency, thereby minimizing arbitrary denials.

Clinician involvement also safeguards fair treatment in readmission denials. Hospitalists can ensure contracts clearly define readmission policies aligned with CMS and local health department standards, distinguishing truly preventable readmissions from unavoidable rehospitalizations. This protects hospitals from unjust penalties and revenue losses.

Audit frequency is another contentious area where hospitalists and physician advisors add significant value. They can advocate for contractual limits on audit frequency, clearly defined review timeframes, and caps on the percentage of cases subject to audits. This ensures fair practices and reduces the hospital's administrative burdens and resource drain.

Hospitalists can help ensure contracts explicitly define qualifications for medical directors responsible for reviewing and denying claims. In alignment with Minnesota statute and Medicare guidelines, insurers should disclose their reviewing medical directors' names, specialties, and state licensure. Reviews must be performed by a physician of the same specialty, maintaining quality, accountability, and integrity in the denial process.

Additionally, physician advisors are well-positioned to negotiate clear and effective appeal processes within contracts, establishing firm timelines and explicit consequences for non-compliance by payers. This accountability is vital for hospital financial planning and resource allocation.

Joint Operating Committee meetings are another essential aspect that hospitalists can champion. Regular meetings between hospital clinical leaders and empowered insurance decision-makers can quickly address disputes, foster collaboration, and enhance transparency.

Integrating physician advisors and hospitalists into contracting leads to smarter, more equitable agreements. Their involvement ensures clinical practicality, regulatory compliance, and patient-focused perspectives in negotiations, resulting in contracts that improve hospital operational efficiency, enhance care quality, and secure appropriate reimbursement.

As financial margins tighten and the complexity of healthcare increases, hospitalists and physician advisors are essential for ensuring hospitals remain clinically effective and financially viable. It's time to consistently include hospitalists in the contracting room—not just to support contracts, but to shape them. ■

Key Operational Question

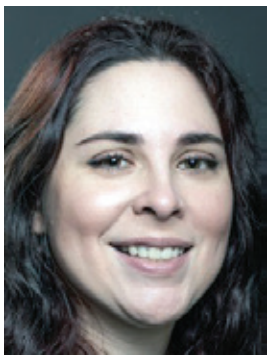
What are the Risks, Challenges, and Solutions to Medical Gaslighting in Hospital Medicine?

By Nikhil Sood, MD, Kryss Shane, PhD, MBA, MSW, LMSW, and Anthony D. Slonim, MD, DrPH, FCCM

Case

Emily is a 35-year-old woman with no substantial medical history who presents to the emergency department (ED) due to severe headaches that have worsened in recent weeks. She also experiences dizziness, difficulty concentrating, and disturbed sleep. After receiving medication for her headaches, she is advised to reduce stress both at home and work, with a recommendation to follow up with her primary care doctor. During this follow-up, the physician attributes her symptoms to anxiety and stress at home, discussing the possibility of prescribing a different headache medication along with an antidepressant without any further investigation. Not convinced, Emily declines the antidepressant. Her symptoms persist, affecting her ability to carry out daily activities, prompting her to consult a neurologist three weeks later. A scan ordered by the neurologist reveals a mass in the basal ganglia, and further tests confirm the presence of a benign brain tumor. The journey from her initial ED visit to the final diagnosis spans nearly three months, leading to challenges at work and home and significantly impacting her daily life.

Dr Sood



Dr. Shane

Dr. Slonim

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Medical gaslighting occurs when healthcare providers downplay or dismiss a patient's symptoms or concerns, causing them to question the validity of their experiences. This phenomenon can lead to delayed diagnoses, ineffective treatments, and increased distress for patients.[1] It has become especially prominent in various patient populations, particularly women, racial minorities, and individuals with chronic health conditions. In hospitals, where patients frequently show acute symptoms, this problem can significantly impact care delivery. It can manifest in several ways, such as:

- Invalidation of symptoms: Clinicians may dismiss symptoms as being psychosomatic or exaggerated, leading patients to question the legitimacy of their own experiences.
- Denial of knowledge: Patients' knowledge about their own bodies and conditions may be disregarded, with clinicians assuming a superior understanding without considering the patient's perspective.
- Disbelief and dismissal: Patients' reports of symptoms or adverse reactions may be met with skepticism or outright disbelief, often documented in medical records with language that suggests doubt, such as using quotes or judgmental terms.
- Attribution to psychological causes: Symptoms may be attributed to psychological factors without adequate investigation of potential physical causes, particularly in marginalized groups.

Key Diagnoses and Symptoms Prone to Medical Gaslighting

Hospitalists often encounter conditions and symptoms prone to medical gaslighting due to their complex and nonspecific presentations. These include:

- Autoimmune disorders: Diseases like lupus, rheumatoid arthritis, and multiple sclerosis often present with vague symptoms like fatigue and joint pain, leading to delayed or missed diagnoses.
- Chronic pain syndromes: Fibromyalgia and chronic fatigue syndrome are frequently dismissed as psychological issues despite their recognized physiological underpinnings.
- Persistent fatigue or weakness: Women or minority groups presenting with vague yet debilitating symptoms like chronic fatigue, muscle weakness, or general malaise may be told they are "just stressed" or "depressed."
- Unexplained neurological symptoms: Migraines, dysautonomia, and early multiple sclerosis can be mistakenly attributed to stress or anxiety, especially in younger patients.
- Cardiac conditions: Women presenting with atypical chest pain often have delays in the diagnosis of myocardial infarction.
- Rare diseases: Conditions like Ehlers-Danlos syndrome, long COVID-19 syndrome, chronic infections like Lyme disease, or mast cell activation syndrome are easily overlooked or dismissed.

These examples highlight the need for a comprehensive and unbiased approach to patient evaluation, emphasizing the importance of listening to patient concerns and avoiding premature diagnostic closure.

Application of the Data

As the gatekeepers of inpatient care, hospitalists play a crucial role in identifying gaslighting and addressing it promptly. This issue is especially significant for hospitalists in the acute care environment, where complex symptoms and high-stress conditions can occasionally result in premature diagnostic conclusions.

Given the emphasis on value-driven healthcare and the need to manage clinical care alongside costs and duration of hospitalization, there is frequently a tendency to expedite the discharge of patients. When a patient reports fatigue, pain, or other non-specific symptoms, they might be told that their issues are merely due to stress, anxiety, or even overreacting. These assumptions invalidate the patient's experience and delay critical diagnostic processes, leading to potential harm.[2] As frontline care practitioners, hospitalists must be aware of these dynamics and strive to avoid them through active listening, comprehensive assessments, and a willingness to explore all diagnostic possibilities.

Factors contributing to medical gaslighting can include uncon-

Table 1: Training and policy interventions to address gaslighting

INTERVENTION	DESCRIPTION	EXAMPLES
Implicit bias training	Awareness of biases in care	Workshop series, simulation-based case studies
Patient advocacy tools	Empower patients to voice concerns	Educational pamphlets, support groups, PFAC meetings
Diagnostic protocols	Standardized approaches to care	Sepsis pathways, chest pain protocols
Quality improvement initiatives	Analyze cases of delayed diagnoses	Case reviews and root cause analysis, patient feedback survey, interdisciplinary care conferences
Role of hospital leadership	Promoting systems for patient advocacy	Establish patient advocate teams that hospitalists can consult and organize group discussions on strategies to counter

scious biases, cognitive overload, and systemic pressures in hospital settings. Hospitalists often work under high pressure with limited time for each patient, and implicit biases related to gender, race, and socioeconomic status may impact decision making.[3] Additionally, time constraints and workload demands may lead to rushed assessments, leaving patients feeling dismissed. Hospitalists must be equipped to combat these pressures and prioritize thorough patient evaluation to ensure accurate diagnoses and reduce the risk of gaslighting.

The effects of medical gaslighting on patients are significant, especially for those with chronic illnesses. When their symptoms are misunderstood or dismissed, it often leads to heightened frustration and disillusionment toward healthcare providers. Hospitalists, who typically encounter patients at their most vulnerable moments, must serve as empathetic advocates by ensuring that patients' concerns are genuinely acknowledged and that they receive comprehensive care. By recognizing symptoms and practicing active listening, hospitalists can empower patients and help restore their confidence in the healthcare system.[4]

Hospitalists' Role in Preventing Gaslighting

Hospitalists often face patient situations with unusual presentations or symptoms that are out of proportion to the examination. Below are practical strategies hospitalists can implement to mitigate gaslighting and improve patient outcomes:

- Active listening and patient validation: Hospitalists can effectively combat medical gaslighting by actively listening to their patients. This involves dedicating adequate time and focus to genuinely understanding their concerns and avoiding interruptions or hasty conclusions. Using simple yet impactful phrases such as "I understand you" or "Let's take the time to explore what's happening" can help make patients feel validated and supported. It's crucial for hospitalists to prioritize ensuring that patients feel heard and respected during every interaction.
- Exploring symptoms holistically and asking open-ended questions: Hospitalists should take the time to fully explore symptoms and avoid jumping to conclusions based on limited information. Instead of immediately attributing symptoms to psychological causes, hospitalists should ask open-ended questions such as, "When did these symptoms start?" or "What factors seem to make your symptoms better or worse?" This approach allows for a comprehensive assessment and a more accurate diagnosis.

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- Addressing unconscious biases and promoting equity in care: Implicit biases often unintentionally influence clinical decision-making. Hospitalists must engage in self-reflection and bias recognition training to better understand and address these unconscious biases. Regular cultural competency training is essential in reducing disparities in care and ensuring that all patients, regardless of gender, race, or socioeconomic status, receive equal attention and respect.
- Fostering patient-centered care: Hospitalists must focus on patient-centered care by viewing each individual holistically in every interaction. This involves evaluating physical symptoms while considering mental health, lifestyle choices, and the patient's preferences when determining treatment options. By integrating patients' viewpoints into decision-making, hospitalists can build trust and empower patients, reducing the risk of medical gaslighting.
- Collaborative and team-based care: Hospitalists should work with multidisciplinary teams, including specialists, social workers, and patient advocates, to offer holistic care for patients. This collaborative approach guarantees that patients receive a comprehensive assessment, decreasing the chance that their symptoms will be overlooked or downplayed.
- Advocating for systemic change: Hospitalists must advocate for policies and procedures that promote patient advocacy and address issues of gaslighting in hospital settings. This includes advocating for mandatory bias awareness training, empathy development programs, and creating patient advocacy teams. Hospitalists should also work with leadership to implement diagnostic protocols that ensure all patients receive comprehensive evaluations before attributing symptoms to psychological causes.

Hospitalists must also reject work conditions that lead to patient dissatisfaction with interactions.[5] After a negative workup, hospitalists should communicate with the patient tactfully. They must adopt an empathetic tone and collaborate with the patient as a partner or coach when introducing the possibility that some aspects of a patient's condition may stem from psychological or emotional health disturbances. Hospitals should implement mandatory bias awareness training to reduce gaslighting to help hospitalists recognize and address implicit biases.[6] Empathy development programs can improve communication by fostering active listening and patient-centered care.[7] Policies promoting diagnostic rigor should require thorough evaluations before symptoms are attributed to psychological causes. Establishing patient advocacy systems such as patient and family advisory councils, or PFACs, allows patients to voice concerns and seek second opinions, ensuring their voices are heard. Additionally, quality improvement initiatives that analyze cases of delayed diagnoses can identify trends, enabling targeted interventions to prevent future instances of dismissive care. These measures can enhance trust and improve patient outcomes. Table 1 summarizes additional interventions to address gaslighting.

Back to the Case

This case emphasizes the need for active listening and diagnostic vigilance. Rather than prematurely attributing symptoms to anxiety, the physician should have empathized with Emily, validating her concerns and asking follow-up questions to fully understand her symptoms. A comprehensive assessment of her symptoms could have prompted earlier diagnostic testing, like an MRI or a referral to a neurologist. This delay in diagnosis not only heightened her risk of complications but also undermined her trust in healthcare. It illustrates the necessity of ruling out life-threatening conditions before assigning psychological causes.

Bottom Line

Medical gaslighting can represent a significant risk to patient safety, contributing to diagnostic errors and disparities in care. It undermines patient safety and trust, and hospitalists have a unique opportunity to lead in reforming this aspect of care. By prioritizing patient-centered practices, addressing implicit biases, and advocating for comprehensive diagnostic assessments, hospitalists can significantly reduce instances of gaslighting and improve patient outcomes. As frontline providers, hospitalists are uniquely positioned to recognize and address this issue through improved communication, structured diagnostic processes, and advocacy for equity. By fostering a culture of trust and thoroughness, hospitalists can help mitigate the impact of medical gaslighting and ensure high-quality, patient-centered care. ■

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Simulating Success

Integrating simulation into education, clinical care, and career advancement

By Jilian R. Sansbury, MD, FACP, FHM, Arti Tewari, MD, Ethan Molitch-Hou, MD, MHP, SFHM

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Simulation in medical training is an evidence-based, cost-effective tool for doctors at every level to take part in patient care scenarios in a protected environment. From small group "megacode" practice to procedural mastery, using a hospital-based simulation center can add tremendous value. Hospitalists can use the simulation center to focus on quality initiatives, improve communication skills, practice team-based scenarios, and develop diagnostic ultrasound and procedural skills. Simulation can take the form of standardized patients, high-fidelity mannequins with realistic anatomy, simulated cardiac rhythms, and virtual and augmented reality.

Interested trainees and faculty have opportunities to pursue careers in simulation education and to help healthcare systems develop curricula and modules to enhance education, maintain skills, create a dynamic learner environment, and advance clinical practice.

Incorporating Simulation into Training

Historically, medical training has been an apprenticeship model with a mantra of "see one, do one, teach one." Simulation was developed to allow training in real-world scenarios where mistakes do not have significant consequences and has been integrated into medical education for decades. Major uses in training have included teaching learners how to have difficult conversations, place central lines, and participate in hands-on opportunities to practice high-stakes scenarios in the hospital setting.

Internal medicine and pediatric residency programs frequently incorporate simulation in education.[1-3] Finding opportunities to incorporate simulation beyond the common standards must address overall curricular gaps and have a deliberate purpose for students. One example is the University of Chicago's incorporation of rapid response and cross-cover simulation into the fourth-year medical student sub-internship (acting intern) curriculum. Sub-interns in the program have responded positively to the opportunity to practice these low-volume, high-stakes situations, and confidence in responding to decompensating patients and intense cross-cover has improved dramatically.

For residency programs, simulation periods should be structured to fit within the curriculum, whether through ambulatory blocks, half days protected for simulation, or direct electives. Senior and chief residents may serve as preceptors for interns to obtain exposure to procedures or challenging scenarios when faculty are less available. Surgical residencies have incorporated virtual reality and augmented reality environments to practice surgical techniques. Simulation serves to build both confidence and competence for trainees to build proficiency in a risk-free environment. Successful programs add some didactics to simulation and provide immediate feedback with post-simulation debriefing. They have direct learning objectives and a variety of clinical scenarios, and make the most of available technology.

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Ongoing Use of Simulation After Training

While simulation is widely used during training, it plays an increasing role in continuing medical education. Advanced cardiovascular life support remains the most common interaction with simulation after training; however, there is ample room for ongoing simulation, including learning new skills that weren't available during training, maintaining competence when there is less exposure, and accessing training in areas with fewer resources.

Point-of-care ultrasound (POCUS) training is a prime example of simulation use for ongoing training and learning advanced skills. As an increasingly utilized tool in hospital medicine, it has largely become integrated into residency training. However, clinicians who have been out of residency for five to 10 years likely have had limited exposure to POCUS. To address this gap, formal training programs through organizations like SHM and the American College of Chest Physicians offer comprehensive certification in POCUS. These programs offer in-person training sessions and require the participant to upload a portfolio of images that can be reviewed and verified, culminating in a formal certification exam. These programs can be intensive, often taking two to three years to complete.

While certification programs are ideal for practitioners who would like to become experts in ultrasound, there has also been a push to make introductory training more approachable. To this end, institutions have initiated smaller, workshop-based internal training and certification programs for POCUS. During the workshops, clinicians rotate through the simulation center, practicing cardiac, pulmonary, vascular, and abdominal ultrasound techniques on standardized patients, wherein the primary objective is to shorten learning curves and enhance competency in bedside ultrasound.

Smaller simulation centers in community hospital settings often do not have the faculty bandwidth to develop formal certification programs for hospitalists or simulation educators. There are some comprehensive but achievable curricula that programs can adopt to start building skills in the simulation and POCUS space. The Montefiore 10 curriculum is just one example of a user-friendly basic curriculum that is well-suited to cover the bedside ultrasound needs of a variety of learners.[4]

Simulation is key for more remote areas where practitioners must stretch their training despite a lack of frequent exposure to

events. Simulated codes may be necessary at smaller institutions for multidisciplinary teams to maintain critical skills that may be necessary at a moment's notice. Globally, simulation can help train providers where advanced training and fellowship options are limited.

The integration of simulation-based training offers a promising avenue for continuous professional development among hospitalists, ensuring they remain adept with the latest medical technologies and techniques and maintain the confidence to continue learning, champion ultrasound at the bedside, and ultimately begin to teach others these valuable skills.

Making a Career Out of Sim

With simulation now playing such a large role in hospital medicine and training, careers in medical education with a focus on simulation-based practice are a commodity at large academic institutions and community hospitals alike. Because simulation training has become increasingly integrated into medical school training and residency, many young hospitalists have had exposure to simulation training and bring novel ideas for its application in continuing medical education. Physicians with a strong background in simulation education can serve in medical directorship for simulation in centers of all sizes and can build both academic and community careers around its use.

The Society for Simulation in Healthcare (SSIH), in addition to SHM, is a national organization that can supplement a career in simulation and allow centers to pursue partial or full simulation-center accreditation pathways. Along with SHM Converge, SSIH also has a large international conference each year that draws experts and industry superstars from all over the world to share their scholarly work and innovations in the simulation realm.

Working with your hospital system to demonstrate the value of simulation can sometimes prove difficult. Depending on the levels of buy-in from leaders within your system, you may need to strategize the best way to show the alliance between the goals of the hospital and the role of a simulation center. Using the ample research available supporting simulation training, emphasis on the value of improving the patient experience, decreasing length of stay, improving patient care outcomes, or increasing revenue from physician billing may help to elicit buy-in from the institution.[1,5-7]

Conclusion

Simulation utilization can be varied and integrated into any hospital system. As a champion for simulation, your goals may be to educate and improve the learner experience at your institution or enhance patient care with procedural, POCUS-based, or low-volume, high-stakes scenario practice. Hospital system goals may be to start small or expand to build large-scale competency programs for hospitalists. Simulation is an efficient and cost-effective tool for trainees and continuing medical education. It can become a career niche in hospital medicine, no matter the location of practice. ■

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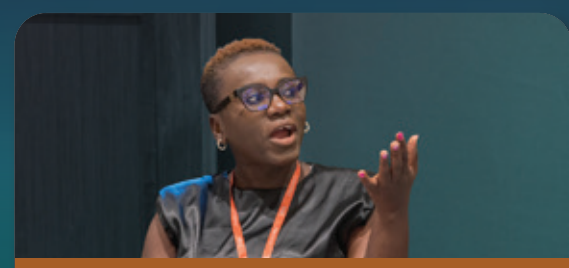

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