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IN THE NEXT ISSUE...
Are advanced degrees worth it?

SHM Converge 2026: Renew the Knowledge and Energy That Drives You Forward!

By Alfred Burger, MD, MS, SFHM

To my fellow hospitalists: It's the time we look forward to all year long—our annual reunion at SHM Converge! We are eager to welcome you to Nashville later this month. Each year, SHM Converge serves as a cornerstone for advancing our field, bringing together clinicians, educators, researchers, and leaders to exchange ideas, share breakthroughs, and strengthen the practice of hospital medicine.

Dr. Burger

Dr. Burger is a hospitalist and senior associate program director for the internal medicine residency at Mount Sinai Morningside/West and professor of medicine and medical education at the Icahn School of Medicine at Mount Sinai, both in New York.

A Thoughtfully Redesigned Conference Experience

Our Annual Conference Committee has worked diligently to create a dynamic, comprehensive program for 2026. This year's schedule includes clinical updates, evidence-based practice discussions, workshops, and keynote presentations. Each session is designed to deliver timely, high-value education to support your work and professional growth while giving you a chance to connect with peers and leaders from across the country. No matter your role or level of experience, you will find meaningful and applicable content to bring back to your institution.

Over the years, many of you have shared that difficult choices between concurrent sessions sometimes limit your ability to attend everything that interests you. We heard you. For 2026, we are pleased to introduce a redesigned schedule with more content types offered each day and tracks more evenly distributed throughout the conference. This approach reduces topic fatigue and allows you to move more freely between sessions without feeling conflicted.

New Tracks: AI & Technology and POCUS

Artificial intelligence (AI) and point-of-care ultrasound (POCUS) are at the forefront of many conversations in hospital medicine, and they play a key role in our conference schedule.

In our expanded AI & Technology track, you will hear from leaders in hospital medicine discussing novel AI techniques and extensions of informatics competencies that many hospitalists already own as part of their roles. You can explore how AI can help you in your daily practice, even in patient-facing areas that expand beyond diagnostics.

You may have seen Dr. Will Small on SHM's AI-related webinar in January, and he will be presenting two sessions in the AI track alongside respected colleagues: Review of Large Language Model (LLM) Summarization Tools for Clinical Care and Operations, and Byte-Sized Breakthroughs: Updates and Insights from Generative AI on the Wards. You will also find AI-related content woven throughout other tracks because of how commonplace it is becoming across hospitalist practice.

Our new POCUS track features sessions like The Ultrasound-Assisted Physical Exam, about an important subset of POCUS use in hospitalized patients, and To Stick or Not to Stick: A Guide to Ultrasound Guided Procedural Safety, where you can engage with real cases to identify complex findings on ultrasound and recognize how these findings affect the approach to bedside procedures.

Hot Topics: Things We Do for No Reason™ and Clinical Updates

It wouldn't be SHM Converge without the return of attendeefavorite sessions, including Best of Things We Do for No Reason™ with Drs. Tony Breu and Lenny Feldman. I'm

THE Hospitalist®

March 2026
Volume 30 | No. 3

also looking forward to hosting the Updates in Clinical Guidelines session on the second day of the main conference as a primer for the always-popular Update in Hospital Medicine later in the afternoon.

SHM Converge is your home for clinical updates, with a dedicated track led by experts across key areas of practice. Sessions include Updates in Heart Failure with Dr. Dustin Smith, Updates in Pneumonia with Drs. Claire Ciarkowski and Valerie Vaughn, and Update in Anticoagulation with Dr. Scott Kaatz—and that's just the beginning!

Featured Speakers: Dr. Robert Wachter and Rachel Tenenbaum

We are honored to welcome Dr. Robert Wachter, often called the Father of Hospital Medicine, who coined the term "hospitalist" in a 1996 *New England Journal of Medicine* article with Dr. Lee Goldman, back to the Main Stage on the first day of SHM Converge. During his keynote, A Giant Leap: Lessons from the Early Days of Generative AI-Meets-Healthcare, he will explore how healthcare is shifting from its initial, electronic health record era of digitization toward an AI-driven future that could fundamentally reshape medical practice.

NeuroTransformational coach

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and founder of The Reset Room, Rachel Tenenbaum, will deliver our closing keynote on the final day of the conference, When Your Team Is Running on Empty: Practical, Science-Based Strategies for the 7-on Reality. She will guide attendees through practical, science-backed strategies that strengthen clarity, connection, and resilience in the moments that matter most.

Connect With Your Community

Reconnecting with colleagues and friends is one of the most meaningful aspects of SHM Converge, and we are continuing to expand ways for you to spend time with your fellow hospitalists. From Chapter MeetUps and Special Interest Forums to the Scientific Abstract Competition Reception and the SHM Fellows Lounge, we have created countless opportunities for connection.

We are also proud to offer a Give Back Activity in Nashville. During breakfast on the first and second days, you can join the Strings for Hope Unwind Experience, a hands-on opportunity to sort and prepare recycled guitar strings. These strings are transformed into sustainable jewelry by survivors of substance use disorder, interpersonal violence, and human trafficking.

Join Us Early for Advanced Learning Courses

Looking to jumpstart your experience? Join us for a full day of advanced learning courses before the main conference begins. Whether it is Evolving Medicine—Getting Up to Speed with Cutting-Edge Care, or Leadership Essentials for Emerging Leaders in Hospital Medicine, we have something to prime you for our main conference experience.

New this year, in addition to our Point-of-Care Ultrasound: Fundamentals for Hospitalists advanced learning course, we are thrilled to introduce Point-of-Care Ultrasound: Beyond the Basics to immerse attendees in next-level ultrasound diagnostic skills. You can register for this course alone or combine it with the morning fundamentals session to further enhance your ultrasound learning experience.

Let's Make This the Best Converge Yet!

As course director, I am continuously inspired by the enthusiasm and commitment of our hospital medicine community. SHM Converge is not just a conference; it is a shared space for learning, reflection, innovation, and connection. Whether you are attending for the first time or are a long-time attendee, I invite you to immerse yourself fully: ask questions, engage with faculty, collaborate with peers, and explore new ways to elevate our patient care.

Thank you for choosing to spend time with us in Nashville. I look forward to an outstanding conference and to the conversations, insights, and relationships that will shape the future of our specialty and healthcare as a whole.

If you haven't registered, visit shmconverge.org to secure your spot!

See you in Nashville! ■

In the Literature

Columbia University Medical Center Med-Lit Reviews

By Abigail Ritter, MD, Jacob Spinner, MD, Lara Karaaslan, MD, Montgomry Burgoon, MD, Mitchell Gronowitz, MD, Mark Terng, MD, Rafael Vissepo, MD, and Sandra Goldlust, MD, MS

Columbia University Medical Center, New York

IN THIS ISSUE

By Abigail Ritter, MD

1 Educational Strategies for Clinical Supervision of AI Use

CLINICAL QUESTION: What are strategies that can equip medical educators and learners to engage critically with artificial intelligence (AI)?

Dr. Ritter

BACKGROUND: AI has the capacity to fundamentally alter medical learning and practice. As in other professions, the use of AI in medical training could result in professionals who are highly efficient, yet less capable of independent problem-solving and critical evaluation when compared to pre-AI counterparts. Off-loading complex tasks such as clinical reasoning can lead to "deskilling," "never-skilling," or "mis-skilling." Critical thinking is essential to clinical reasoning and for the safe use of AI during learning, both of which must be taught and modeled by educators.

STUDY DESIGN: Proposed stepwise approach to learner-AI interactions that educators can use to model and scaffold critical thinking for the concurrent development of effective clinical skills and engagement with AI.

SETTING: The setting to use this strategy is any "AI interaction" of the learner. It is up to the educator to recognize and name the interaction. The authors' definition for an AI interaction is from Bearman and Ajjawi's works. It is defined as any moment when "a computational artefact provides a judgement to inform an optimal course of action and... this judgement cannot be traced" or, in other words, requires the user to take a leap of faith to trust the AI output.

SYNOPSIS: The authors propose an adapted approach, termed DEFT-AI, based on the existing DEFT (diagnosis, evidence, feedback, and teaching) framework. This model emphasizes structured discussions of clinical reasoning, evidentiary support, and targeted feedback.

Diagnosis, Discussion, and Discourse—The educator begins by probing the learner's clinical reasoning process and their concomitant use of AI. This includes asking about the differential diagnosis, how the learner interacted with AI, what prompts were used, how the output was verified, and if the output affected the learner's diagnostic approach.

Evidence—The educator probes the learner for the use of supporting and opposing evidence to evaluate the learner's medical and AI knowledge and application of that knowledge. The educator then asks the learner to self-assess their AI literacy.

Feedback—The educator asks the learner to reflect on potential growth opportunities relevant to the case at hand. This can include missed diagnostic considerations, gaps in medical knowledge, or other AI applications perhaps better suited to the task.

Teaching—The educator provides feedback on the learner's reasoning, performance, and use of AI. This includes recommendations that concurrently promote foundational skills and AI literacy. With rare exceptions, the educator should encourage ongoing practice with AI, with appropriate guardrails. Universally, educators should caution learners against passively adopting AI output without interrogation and should encourage adaptive engagement.

BOTTOM LINE: AI is already embedded in medical learning and practice. The DEFT-AI framework can be used by educators to scaffold critical thinking for the concurrent development of effective clinical skills and engagement with AI during AI interactions.

CITATION: Abdulnour RE, et al. Educational strategies for clinical supervision of artificial intelligence use. *N Engl J Med*. 2025;393(8):786-797. doi: 10.1056/NEJMra2503232.

Dr. Ritter is an assistant professor of medicine at Columbia University Irving Medical Center, a hospitalist, and the co-director of the senior medicine rotation of the New York Presbyterian-Columbia University Irving Medical Center internal medicine residency program, both in New York.

By Jacob Spinner, MD

2 Influenza Vaccination Improves All-Cause Mortality and Rates of Readmission for Patients Admitted with Acute HF

CLINICAL QUESTION: Does influenza vaccination prior to hospital discharge improve all-cause mortality and rates of readmission for patients admitted with acute heart failure (HF)?

Dr. Spinner

BACKGROUND: Influenza vaccination is widely recommended for patients at risk of adverse outcomes, though data for specific at-risk groups are limited. Patients with advanced heart failure are at high risk for mortality and hospital readmission and interventions to prevent these outcomes are needed.

STUDY DESIGN: Cluster-randomized controlled trial

SETTING: Hospitals from geographically dispersed regions across China were recruited based on their capability to manage high volumes of patients with HF across three influenza seasons from September 2021 through May 2024.

SYNOPSIS: A total of 252 hospitals were identified for eligibility, of which 164 ultimately participated. Across three flu seasons, a total of 7,771 patients with New York Heart Association Class III or IV HF were recruited and randomized between the vaccination and usual care groups. Patients in the vaccination group were offered free influenza vaccination within 24 hours of their planned discharge from the hospital. For the primary analysis, 41.2% of patients in the vaccination group versus 47.0% of patients in the usual care group experienced the composite endpoint of all-cause mortality or any hospital readmission over 12 months (odds ratio [OR], 0.83; 95% confidence interval [CI], 0.72 to 0.97; *P*=0.019). Results were also statistically significant for the secondary endpoints of all-cause mortality within 12 months, which occurred in 10.0% of the vaccination group and 12.8% in the usual care group (OR, 0.76; 95% CI, 0.69 to 0.84; *P* <0.0001), and any hospital readmission, which occurred in 35.4% of patients in the vaccination group and 40.5% of the usual care group (OR, 0.83; 95% CI, 0.70 to 0.99; *P*=0.037). The number of patients with serious adverse events was also significantly lower in the vaccination group at 52.5% than the usual care group at 59.0% (OR, 0.82; 95% CI, 0.70 to 0.96; *P*=0.013).

This study has several limitations, including lower levels of influenza activity and higher levels of COVID-19-related mortality in 2021, which may have attenuated the observed effect size initially. The study was also necessarily unblinded, which could have introduced performance or detection bias. The study population, in semi-urban regions of China with historically low levels of community influenza vaccination, may affect generalizability.

BOTTOM LINE: Influenza vaccination prior to discharge lowers all-cause mortality and rates of hospital readmission in patients hospitalized with acute HF.

CITATION: Anderson CS, et al. Influenza vaccination to improve outcomes for patients with acute heart failure (PANDA II): a multi-regional, seasonal, hospital-based, cluster-ran-

domised, controlled trial in China. *Lancet*. 2025;406(10507):1020-1031. doi: 10.1016/S0140-6736(25)01485-0.

Dr. Spinner is a hospitalist and assistant professor of medicine and associate clerkship director in medicine at Columbia University Vagelos College of Physicians and Surgeons in New York.

By Lara Karaaslan, MD

3 Virtual Hybrid H@H Model Offers Comparable Safety, More Comfort

CLINICAL QUESTION: Is a hybrid hospital at home program as safe as traditional inpatient care?


Dr. Karaaslan

BACKGROUND: Hospital at home (H@H) programs are expanding in the U.S. in an effort to ease hospital overcrowding, reduce costs, and improve the patient experience. Early small studies have suggested H@H models are as safe as traditional inpatient care, however most of these studies relied on in-person physician visits. As telemedicine has advanced and expanded, hybrid models with exclusively virtual physician encounters combined with in-home clinical support have emerged, thus far with limited safety data.

STUDY DESIGN: A pragmatic, randomized, controlled, noninferiority trial

SETTING: Clinicians identified eligible patients admitted or in the emergency department being considered for admission at one of three Mayo Clinic hospitals in Arizona, Florida, and Wisconsin between July 10, 2023, and October 31, 2023.

SYNOPSIS: Investigators randomized 1,150 adults requiring acute hospital-level care to either a hybrid H@H model or standard brick-and-mortar inpatient care. In the H@H model, all physician encounters were virtual, supported by in-home nurses and paramedics using digital monitoring tools. The no-crossover cohort, after excluding patients who became ineligible or rejected randomization, had 686 patients (192 intervention, 494 control), while the no-crossover, propensity-score matched cohort included 374 matched pairs admitted to the intervention (187) or control (187) group.

The composite primary outcome of 30-day all-cause mortality or unplanned readmission occurred in 17.3% of H@H patients and 19.8% of brick-and-mortar patients in the randomized no-crossover cohort (OR, 0.85; 95% CI, 0.63 to 1.14; *P*=.28)and in 15.5% versus 18.7% in the propensity-score matched cohort (OR, 0.80; 95% CI, 0.46 to 1.37, *P*=0.41), meeting the noninferiority threshold. Thirty-day readmissions and mortality were similar, and no deaths occurred in the H@H group.

Patient-reported comfort was significantly higher in the H@H group (randomized 84% versus 61%, *P*=.001; propensity-score matched 90% versus 61%, *P*=.005). Patient satisfaction and perceived safety were high in both settings.

LIMITATIONS: The study was conducted within a single integrated health system, which may limit generalizability. A high rate of patient crossover and post-randomization exclusion reduced study power and introduced potential selection bias. Patient-reported outcomes are subject to selection bias, recall bias, and response bias. Additionally, the underrepresentation of Medicaid and minority patients highlights equity concerns that may affect access to home-based acute care models.

BOTTOM LINE: A hybrid hospital-at-home model using entirely virtual physician visits combined with in-home nursing support was as safe as traditional inpatient care with higher rates of patient comfort, supporting its use to expand hospital capacity safely and enhance patient-centered care.

CITATION: Maniaci MJ, et al. Safety in a hybrid hospital-at-home program versus traditional inpatient care: A pragmatic randomized controlled trial. *J Hosp Med*. 2025;20(11):1174-1184. doi: 10.1002/jhm.70076.

Dr. Karaaslan is a hospitalist and instructor in medicine at the Columbia University Medical Center in New York.

By Montgomry Burgoon, MD

4 Limited Access to Pre-dialysis Care Associated with Lower Rates of Usable AV Dialysis Access at Dialysis Initiation for Hispanic Patients

CLINICAL QUESTION: Is there a relationship between access to pre-dialysis nephrology care and the presence of usable arteriovenous (AV) access at dialysis initiation among Hispanic individuals?


Dr. Burgoon

BACKGROUND: Hemodialysis via AV vascular access is associated with reduced complications and costs compared to central venous catheter (CVC) access. However, rates of AV access remain low at dialysis initiation, particularly in the Hispanic population. Prior studies have demonstrated an association between pre-dialysis nephrology care and the presence of a mature AV fistula at dialysis initiation, but the magnitude of this association had not been previously quantified or explored in Hispanic patients.

STUDY DESIGN: Retrospective cohort study

SETTING: The U.S. Renal Data System, a nationwide database, was queried for adult Medicare recipients starting hemodialysis between 2010 and 2019, with primary analysis restricted to those who had at least six months of Medicare status prior to dialysis initiation, and excluding those who received prior transplants.

SYNOPSIS: Of 427,340 patients identified by the database search, 46,146 patients self-identified as Hispanic and 269,697 as white; the remainder were non-Hispanic Black or other races and ethnicities. Compared to white patients, Hispanic patients were less likely both to have received pre-dialysis nephrology care (adjusted odds ratio [aOR], 0.70; 95% CI, 0.68 to 0.72) and to have mature AV access (aOR, 0.77; 95% CI, 0.75 to 0.80) at dialysis initiation. Lack of pre-dialysis nephrology care was associated with 32.59% (*P* <0.001) of this disparity by statistical analysis. Additionally, Hispanic patients have significantly higher odds of conversion from CVC to AV access in the first year of dialysis (30% CVC only, 38% CVC with maturing AV access), when all patients are under nephrology care. Study limitations include separating self-reported ethnicity and race into only Hispanic, Black, white, and other; limited ability to explore residual associations driving disparities related to study design; and inability to assess other patient-specific factors like language or social determinants of health. Nonetheless, applications to hospital systems serving Hispanic patient populations are clear, and such systems should prioritize policy and practice measures aimed at enhancing access to pre-dialysis care for these patients.

BOTTOM LINE: Hispanic patients have lower rates of pre-dialysis nephrology care, and by association, lower rates of usable AV dialysis access at the time of dialysis initiation compared to white patients.

CITATION: Pramod S, et al. Predialysis nephrology care disparities and incident vascular access among Hispanic individuals. *JAMA Netw Open*. 2025;8(9):e2530972. doi: 10.1001/jamanetworkopen.2025.30972.

Dr. Burgoon is a hospitalist and instructor in medicine at Columbia University Irving Medical Center in New York

By Mitchell Gronowitz, MD

5 Early TAVR Improved Outcomes for Elderly Patients with Asymptomatic Severe AS

CLINICAL QUESTION: In patients with asymptomatic severe aortic stenosis (AS) and preserved ejection fraction (EF), will early-intervention transcatheter aortic-valve replacement (TAVR), compared to clinical surveillance, improve outcomes?


Dr. Gronowitz

BACKGROUND: Clinical guidelines currently recommend aortic valve replacement for patients with symptomatic severe AS or asymptomatic severe AS with an EF less than 50%. Routine surveillance every six to 12 months is recommended for patients with asymptomatic severe AS and preserved EF. Randomized data to support earlier intervention with TAVR in this population is limited.

STUDY DESIGN: Multicenter, open-label, randomized, controlled study

SETTING: 75 sites across the U.S. and Canada enrolled patients between March 2017 and December 2021. Eligible patients were 65 years old or older with asymptomatic severe AS and preserved EF. Patients with class I indications for valve replacement or high surgical risk were excluded.

SYNOPSIS: A total of 901 patients were randomized: 455 to early TAVR and 446 to routine clinical surveillance. The average age was 75.8 years, 94.9% were white, and 83.6% of patients were at low surgical risk. Over a median follow-up of 3.8 years, the primary composite endpoint of death, stroke, or unplanned hospitalization for cardiovascular (CV) causes occurred in 122 patients (26.8%) in the TAVR arm versus 202 patients (45.3%) in the surveillance arm (hazard ratio, 0.50, 95% confidence interval, 0.40 to 0.63; *P* <0.001). This difference was mostly driven by unplanned hospitalization for CV causes (20.9% versus 41.7%), and there was no significant difference in death between the two groups (8.4% versus 9.2%). Of note, 87% of patients in the surveillance arm eventually underwent valve replacement with no significant difference in procedural adverse events. The trial's main limitation is generalizability, as the trial specifically studied low-surgical-risk, elderly, and majority-white patients. Also, only balloon-expandable valves were used, so results may not apply to other valve types or surgical valve replacements.

BOTTOM LINE: In asymptomatic severe aortic stenosis, early TAVR significantly reduced the composite outcome of death, stroke, or unplanned cardiovascular hospitalization compared to guideline-recommended clinical surveillance.

CITATION: Généreux P, et al. Transcatheter aortic-valve replacement for asymptomatic severe aortic stenosis. *N Engl J Med*. 2025;392(3):217-227. doi: 10.1056/NEJMoa2405880.

Dr. Gronowitz is a hospitalist and instructor of medicine at Columbia University's Milstein Hospital in New York.

By Mark Terng, MD

6 Impact of Cardiopulmonary POCUS on Hospital LOS in Patients with Undifferentiated Dyspnea

CLINICAL QUESTION: Is cardiopulmonary point-of-care ultrasonography (POCUS) associated with reduced hospital lengths of stay (LOS) in patients with undifferentiated dyspnea?


Dr. Terng

BACKGROUND: POCUS has been shown to have high diagnostic specificity and sensitivity for a variety of cardiopulmonary conditions, in some studies directly outperforming traditional stethoscope and chest X-ray-based evaluation. However, the adoption of POCUS in clinical care has been inconsistent. One barrier may be the limited evidence regarding the impact of POCUS on management decisions and subsequent outcomes like hospital LOS.

STUDY DESIGN: Stepped-wedge-cluster-design randomized trial

SETTING: A tertiary care hospital in New Jersey

SYNOPSIS: Providers were divided into five clusters (the five medicine, teaching, hospitalist teams). At the start of the study, all five clusters were in the control group: none of the physicians routinely performed cardiopulmonary POCUS. Over the course of the study, clusters were moved over one at a time from the control to the intervention group, at which point cardiopulmonary POCUS would begin to be routinely implemented. At the conclusion of the study, all five clusters were in the intervention group. A total of 114 hospitalizations that occurred under the care of the control groups were included, and a total of 102 hospitalizations that occurred under the care of the intervention groups were included. Propensity score matching was then employed to obtain well-matched cohorts of 84 hospitalizations in each group for comparison.

Because the distribution of hospital LOS is typically right-skewed, a two-component gamma mixture model was used (essentially dividing hospitalizations into short stays and long stays in both groups). When comparing short-stay hospitalizations, POCUS use was associated with a 1.16-day reduction in LOS (90% credible interval of 0.03 to 2.31 days). When comparing long-stay hospitalizations, POCUS use was associated with a 14.30-day reduction in LOS (90% credible interval of 3.86 to 30.05 days).

One major limitation was the use of trained ultrasonographers and remote cardiologists to supplement hospitalist POCUS use, which may not be reproducible in other hospital settings. Additionally, this was a single-center study. Larger, multi-center trials are needed to validate these findings.

BOTTOM LINE: Cardiopulmonary POCUS has the potential to significantly reduce hospital LOS for patients with undifferentiated dyspnea. Practice patterns need to be tailored to individual hospital settings, but these results support wider adoption of cardiopulmonary POCUS.

CITATION: Maganti K, et al. Cardiopulmonary point-of-care ultrasonography for hospitalist management of undifferentiated dyspnea. *JAMA Netw Open*. 2025;8(9):e2530677. doi: 10.1001/jamanetworkopen.2025.30677. Erratum in: *JAMA Netw Open*. 2025;8(10):e2543834. doi: 10.1001/jamanetworkopen.2025.43834.

Dr. Terng is a hospitalist and instructor of medicine at Columbia University Medical Center in New York.

Rafael Vissepo, MD

7 Racial and Ethnic Disparities Limit Access to PCI for STEMI Patients

CLINICAL QUESTION: At which point(s) of the hospital care process are racial and ethnic disparities most pronounced for patients presenting with ST-segment myocardial infarction (STEMI), where percutaneous coronary intervention (PCI) would be indicated?


Dr. Vissepo

BACKGROUND: PCI has significantly reduced mortality in STEMI patients. However, prior research shows that non-Hispanic Black and Hispanic patients with STEMI are less likely to receive standard of care PCI and more likely to die compared to white patients. Research has been limited in detailing when and where along the hospital care pathway these disparities are most present to guide policy intervention.

STUDY DESIGN: Cross-sectional observational study

SETTING: Single state databases (Florida) were queried for all adult emergency department visits with a primary diagnosis of STEMI from January 1, 2011, to December 31, 2021

SYNOPSIS: Researchers evaluated four key care steps: (1) presentation to a PCI-capable hospital, (2) receipt of PCI at the presenting hospital, (3) transfer from a non–PCI-capable hospital, and (4) receipt of PCI after transfer to a PCI-capable hospital. A total of 139,629 patients with a diagnosis of STEMI were included in the evaluation. After adjustment for co-variants and statistical analysis, Black and Hispanic patients were found to be less likely than white patients to present to PCI-capable hospitals (–1.8 and –3.1 percentage points [pp], respectively) and be transferred when needed (–4.0 pp Black, –4.2 pp Hispanic). Additionally, Black patients received less PCI when eligible (–8.6 pp) and were less likely to receive PCI after transfer (–13.3 pp). Study limitations include the use of single-state data, which may limit generalizability, as well as the lack of clinical severity and symptomatic data due to limitations of the dataset.

BOTTOM LINE: Racial and ethnic disparities exist at every stage of STEMI care. Policy interventions are needed to target both hospital access and in-hospital decision-making processes to reduce inequity and mitigate such disparities.

CITATION: Hsuan C, et al. Disparities by race and ethnicity in percutaneous coronary intervention. *JAMA Netw Open*. 2025;8(9):e2532660. doi: 10.1001/jamanetworkopen.2025.32660.

Dr. Vissepo is an assistant professor of medicine and academic hospitalist at New York Presbyterian-Columbia University Irving Medical Center in New York.

By Sandra Goldlust, MD, MS

8 Dalbavancin Non-Inferior, But Not Superior, to Standard Therapy for Treatment of Complicated *Staphylococcus aureus* Bacteremia

CLINICAL QUESTION: Among patients with complicated *Staphylococcus aureus* bacteremia who achieve blood culture clearance with initial therapy, is completion of treatment with dalbavancin superior to standard therapy?


Dr. Goldlust

BACKGROUND: Standard therapy for complicated *S aureus* bacteremia typically includes at least four IV antibiotics, which can pose challenges to completion of treatment related to prolonged IV access and other factors. Dalbavancin is a long-acting, intravenous, anti-staphylococcal lipoglycopeptide antibiotic that has the potential to treat complicated *S aureus* bacteremia (including methicillin-resistant *S aureus*) via a two-dose regimen administered one week apart following initial blood culture clearance. Previously, robust data comparing the effectiveness of dalbavancin to standard therapy was lacking.

STUDY DESIGN: Open label, assessor masked, randomized, clinical trial

SETTING: Hospitalized adults at 23 medical centers across North America (United States and Canada) between April 2021 and December 2023 with complicated *S aureus* bacteremia who achieved blood culture clearance between days three and 10 of initial antibiotic therapy.

SYNOPSIS: Patients were randomized 1:1 to the control arm (n=100, standard therapy for four to eight weeks) or the treatment arm (n=100, dalbavancin in two 1,500-mg doses given one week apart) and evaluated for probability of a superior desirability for outcome ranking (DOOR) score at Day 70 (primary outcome) and non-inferiority by clinical efficacy (secondary outcome). DOOR includes assessment of five components: clinical efficacy, safety, complications, mortality, and quality of life. Dalbavancin treatment did not achieve the primary outcome (47.7%; 95% CI, 39.8 to 55.7%, threshold 50% for superiority) but did achieve the secondary outcome with a 1% difference (95% CI, -11.5 to 13.5%, threshold 20% for non-inferiority) in clinical efficacy between dalbavancin and standard therapy.

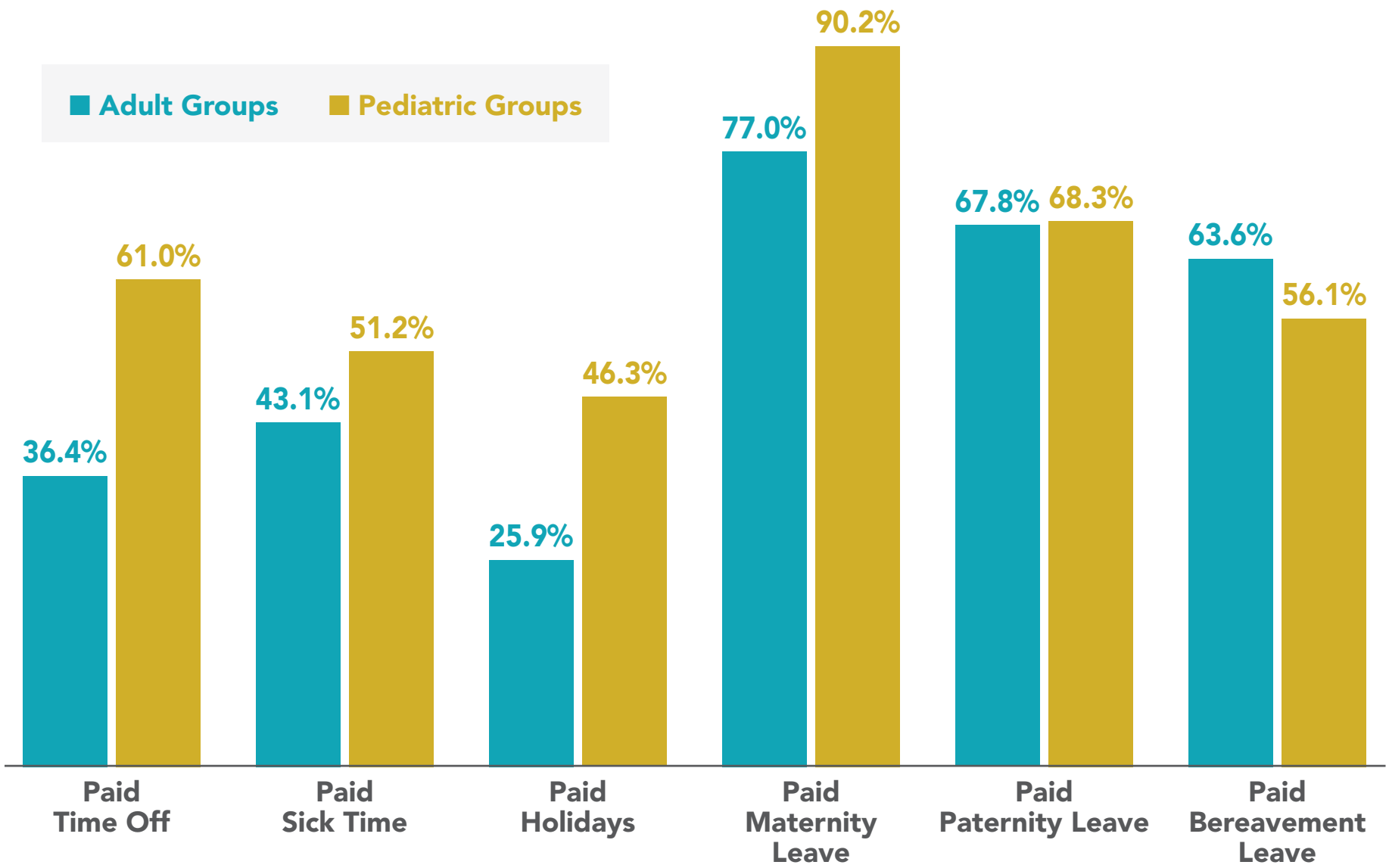
Study limitations include open-label design, selection of patients only after blood culture clearance (which may select for patients with less severe infections), numerically higher number of patients with four or more days of bacteremia prior to culture clearance in the control group, and the incorporation of treatment discontinuation in the composite endpoint, as dalbavancin—a long acting agent—cannot be discontinued after administration, unlike standard therapies.

BOTTOM LINE: For treatment of complicated *S aureus* bacteremia in adults who achieve blood culture clearance, dalbavancin is a non-inferior, but not superior, treatment option when compared to standard therapy in terms of safety and efficacy.

CITATION: Turner NA, et al. Dalbavancin for treatment of *Staphylococcus aureus* bacteremia: the DOTS randomized clinical trial. *JAMA*. 2025:e2512543. doi: 10.1001/jama.2025.12543.

Dr. Goldlust is a hospitalist and assistant professor of medicine at Columbia University Irving Medical Center in New York. ■

Figure 1: Groups Offering Paid Leave



Navigating PTO for Hospitalists

Highlights from SHM's Practice Management webinar

By Teresa Caponiti, Venkat P. Gundareddy, MBBS, MPH, FACP, SFHM, CHCQM-PHYADV, Sarah Shihadeh, MD, and TaRessa Wills, MD

SHM has heard anecdotes from hospitalists that, post-COVID-19 pandemic, the culture around paid time off (PTO) has been shifting—both in prevalence and in use. Some groups are exploring PTO policies due to local regulations, while others are using it to promote well-being among their teams.

In response, SHM has examined PTO from several perspectives to gain a deeper understanding of the current state in hospital medicine and to anticipate where the field may be headed.

The 2024 Hospital Medicine Workforce Experience Report (https://tinyurl.com/7563sakk) indicated that hospitalists with access to PTO were more likely to meet the criteria for professional fulfillment and less likely to meet the criteria for burnout. This highlighted the importance of time off as a tool to promote wellness in hospital medicine.

The 2025 State of Hospital Medicine (SoHM) Report, however, found that only about a third of adult hospitalists received PTO, which is only a slight increase from the 2023 SoHM. The 2025 SoHM Report additionally explored the various types of paid leave offered to adult and pediatric groups and found that adult groups are trailing pediatric groups in offering paid leave (see Figure 1 above).

On October 29, 2025, SHM's Practice Management Webinar Series hosted a panel discussion entitled "Just Give Me a Break! Navigating Time Off for Hospitalists." The webinar underscores that PTO and time-off policies are driven by the unique needs of institutions and cultures of groups, and explores the drivers, benefits, and value that time off can provide hospitalists. In this article, we share some of the highlights of the discussion.

Each of the panelists on the webinar shared that they have seen a cultural shift in the value hospitalists place on time off.

Dr. Gundareddy shared that, though his group has had PTO during his entire tenure at Johns Hopkins, in the last five years they have seen a shift toward increasing utilization and most hospitalists using their full bank of PTO. He surmised that this is due to hospitalists needing additional flexibility to care for children and/or aging parents, combating burnout, and promoting wellness. He also noted that since COVID-19, there has been more self-awareness about the need to use sick time rather than show up for a shift unwell.


Ms.Caponiti


Dr. Gundareddy


Dr. Shihadeh


Dr. Wills

Ms. Caponiti is SHM's practice management manager. Dr. Gundareddy is the associate division director for the division of hospital medicine at the Johns Hopkins Bayview Medical Center in Baltimore. Dr. Shihadeh is the section chief of the division of hospital medicine at the Overlook Medical Center in Northern New Jersey. Dr. Wills is an assistant professor in hospital medicine at Emory University's division of hospital medicine at Grady Memorial Hospital, both in Atlanta.

Dr. Shihadeh agreed and said that when her group switched from a Monday through Friday schedule to a seven-on, seven-off schedule, the importance of PTO increased. Additionally, she saw an increase in PTO utilization from about 40% pre-COVID-19 to now, with hospitalists using their entire PTO pool. Additionally, both Drs. Gundareddy and Shihadeh mentioned the role that PTO plays in allowing their foreign-born team members to visit or care for family.

Dr. Wills' group does not offer PTO outside of federal and state regulatory practices of offering paid time off for jury duty or family and medical leave (through the Family and Medical Leave Act). She reported that, when recruiting new hospitalists, recent conversations have been more focused on the group's efforts to promote wellness rather than to focus solely on compensation.

Academic Teaching Hospital with PTO

At Johns Hopkins Bayview Medical Center in Baltimore, hospitalist faculty receive a bank of paid time off at the beginning of the academic year. This bank includes sick days, leaves of absence, and paid time off.

The group used its scheduling model to determine which clinical shifts needed continuity and created a cap system for how many hospitalists can be on PTO per day and for the volume of total PTO in a clinical block.

Hospitalists in the group don't have to explain why they are using their PTO. "We realized internally [hospitalists] valued autonomy—autonomy in how they use their time and how their schedule looks. But then we also needed a functional schedule. So, we had to walk that fine line between flexibility and continuity. For a good PTO system to work, we had to understand how we can allow PTO to be used," Dr. Gundareddy said.

For unexpected absences, a backup system was created, with one person on call who can cover the shift. The person activated is paid back in time during subsequent blocks, while the person calling out can use their PTO to cover for call-outs.

Additionally, the group uses part-time hospitalists, moonlighters, and historical data to build an additional buffer of full-time equivalents for longer breaks, such as the Family and Medical Leave Act or extended family emergencies.

Additional Resources

SHM's 2025 State of Hospital Medicine Report is a comprehensive resource on hospital medicine group configuration and operation.

SHM's On-Demand Webinar "Just Give Me a Break! Navigating Time off for Hospitalists" is available to SHM members.

Large Community Hospital with PTO

Hospitalists at Overlook Medical Center in Summit, N.J., accrue PTO over time, beginning after a 90-day waiting period upon hire, for a maximum of 17 to 18 days per year.

Physicians work 195 shifts in 15-day blocks for day shifts or 184 shifts as a nocturnist. Holiday schedules are released a year in advance, and any long stretches of PTO are requested six months in advance. There are some "gray out" days. For example, group members cannot take all their PTO between Thanksgiving and Christmas. The group has invested in a large per diem pool to cover unexpected absences and has no formal backup system. They generally have no issues covering shifts Monday through Friday and sometimes offer non-financial incentives, such as lower patient volumes, to those who cover shifts.

Large Academic Hospital with PTO Plan in Development

At Emory University and Grady Memorial Hospital in Atlanta, they are currently in conversation about what paid time off looks like for the group. The group has two daytime models: Monday through Friday and seven-on, seven-off. Continuity teams work 10-hour shifts, and they have dedicated nocturnists as well. To build flexibility, hospitalists can request days off four months in advance, and the scheduler is innovative in allotting time-off requests. Sometimes this results in hospitalists working more undesirable shifts, but they can take off the time requested.

For unexpected absences, the group has a jeopardy system for absences related to illness. For other absences, directors and leaders find coverage in the per diem pool or with locums.

All three panelists reported that there seems to be less of a coverage burden when team members do take PTO or call out. As taking time off has become more normalized, there is less sense of resentment among hospitalists when their teammates use their time off. The panelists all referenced their strong group morale as helping to cut through negative perceptions.

The webinar concluded with the panelists sharing how else they offer flexibility to their group. Hospitalists in their groups can leave when their work is done.

Additionally, all of them reported that when hospitalists on their team had a family emergency, they worked with them to find solutions so that they were able to be with their families. As Dr. Shihadeh said, "sometimes you have to do that for the good doctors that you have, [those] that you really want to retain." ■

Get Published!

If you're an SHM member interested in contributing to *The Hospitalist*, there are lots of opportunities.

We publish articles about the topics, trends, and issues that affect hospital medicine and hospitalists. Topics include everything from clinical and practice management to quality, career, leadership, pediatrics, and more.

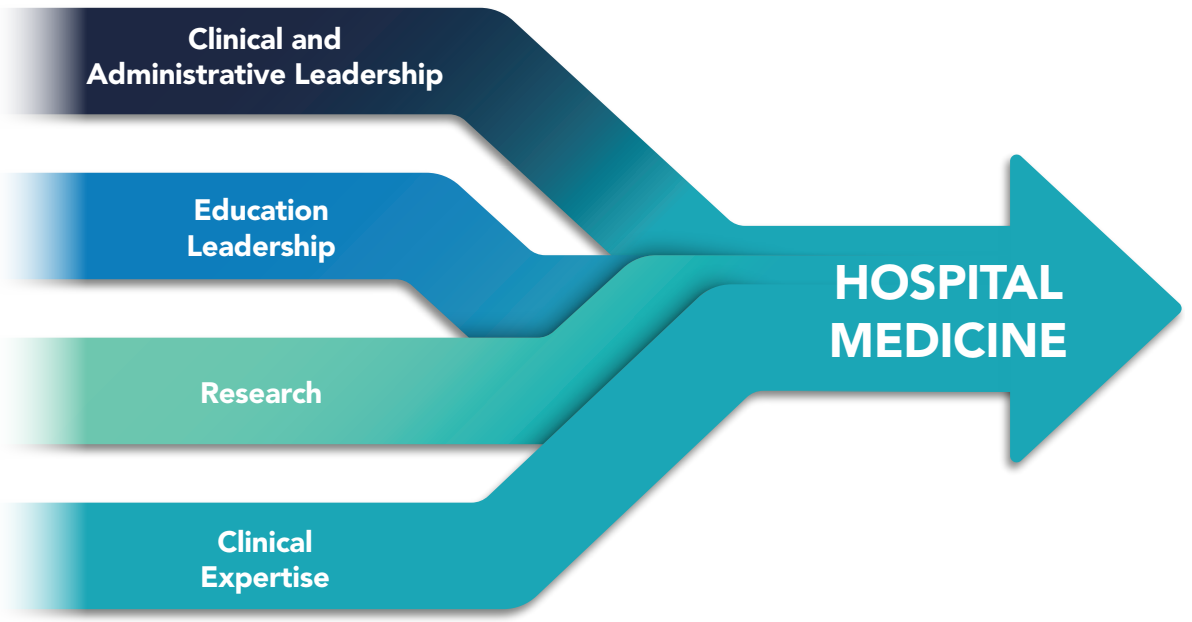
And, if you want to express yourself creatively, there's HM Voices, our online area showcasing poetry, creative writing, or creative visuals.

Scan the QR code for more information about publishing opportunities, writer's guidelines, and our policy on the use of artificial intelligence tools in writing and editing.

Celebrating National Hospitalist Day: Four Paths, One Purpose

How diverse careers and shared commitment shape hospital medicine

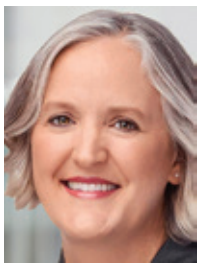
By Karen Appold



National Hospitalist Day celebrates hospitalists' contributions to health care on the first Thursday of March. Founded by SHM in 2018, the day will be commemorated on March 5 this year. In honor of the day, *The Hospitalist* is spotlighting four hospitalists who have varied career paths in hospital medicine.

Clinical and Administrative Leadership

When Tresa McNeal, MD, MBA, SFHM, associate professor at Baylor College of Medicine and associate chief medical officer at Baylor Scott & White Medical Center–Temple, a 670-bed hospital with 800 physician faculty, 500 graduate medical education trainees, and 120 medical students, joined her first hospital medicine group in 2007, the specialty was a fairly new field and staffing model in many areas of the country.


Dr. McNeal

"My colleagues were like-minded individuals interested in caring for patients with acute care needs that were often unanticipated," she said. She was also attracted to the group's collegiality and sharing of responsibilities and appreciated the option for different shift models.

At the same time, Dr. McNeal's mom was diagnosed with amyotrophic lateral sclerosis. "By working as a hospitalist, I could enjoy a rewarding career while also having dedicated time off to care for her because of my shift flexibility," she said.

Dr. McNeal earned her medical degree at Texas A&M College of Medicine and completed her internal medicine-pediatric residency at Scott & White Memorial Hospital in Temple, Texas.

As an early hospitalist, beyond everyday patient care, Dr. McNeal was mostly interested in medical education. She served for a few years as an associate program director for the internal medicine residency program at Scott & White Memorial.

This leadership experience provided the opportunity to lead the hospital medicine group there. "I learned so much in that role, and I loved how it resulted in partnerships with nursing staff, case management, other specialties, and the executive team," she said.

This experience led to leadership opportunities, serving as the interim chair of the department of medicine during the COVID-19 pandemic. "It's interesting how hospital medicine prepared me for a variety of leadership roles in healthcare that I never considered until there was a need at my institution," she said.

"I love serving our community through [my current] position, which has a variety of responsibilities including being a clinical leader as well as contributing to throughput initiatives, readmission reduction efforts, quality improvement, utilization review, and credentialing," she said.

Dr. McNeal is also currently serving a two-year term as the chair of the Baylor Scott & White Medical Group Board of Governors—a governance body representing the 4,000 employed physicians and advanced practice professionals across its 53-hospital, not-for-profit, health system in Texas.

Since 2019, she has served as a member of the practice management committee, which provides resources for optimizing hospital medicine operations, leadership structures, staffing, and processes. And, as of 2021, she has served on the State of Hospital Medicine Workgroup/Technical Advisory Panel, advising on the development and review of SHM's biennial survey. This survey is a comprehensive snapshot representing the practice of hospital medicine, including compensation, structure of shifts and work, administrative support, and benefits.

Dr. McNeal has also served on SHM's Workforce Experience Survey Workgroup since 2023, which explores factors in the hospital medicine workplace that contribute to professional fulfillment and burnout.

"SHM has helped me to grow professionally and take responsibility for serving in a professional organization to benefit both patients and the profession," she said.

Education Leadership

When Manpreet S. Malik, MD, FACP, SFHM, started his residency, he wanted to pursue cardiology, then rheumatology, and eventually fell in love with critical care and performing bedside procedures.


Dr. Malik

"It was a classic case of liking too many things," said Dr. Malik, who decided to pursue hospital medicine because it would expose him to every subspecialty while still being able to focus on patient care.

Dr. Malik grew up in India and graduated from medical school there, and completed his internal medicine residency at the University of Pittsburgh Medical Center in Pittsburgh. He worked at Virginia Commonwealth University in Richmond, Va., as an assistant professor and as an academic hospitalist for the first six years of his hospitalist career. There, he led the development of a procedure service and led faculty development for a growing hospitalist division.

Currently, Dr. Malik serves as an associate professor of medicine, the program director for the transitional year residency program, and the assistant division director for faculty development in the division of hospital medicine at Emory University School of Medicine in Atlanta. He works clinically at Grady Memorial Hospital, a large safety-net hospital and Level I trauma center in Atlanta. He is also the deputy editor of the *Journal of Hospital Medicine's* Visual Vignette column.

"International medical graduates often experience a wider range of healthcare systems and diverse patient populations," he said. "We're uniquely positioned to provide empathetic and culturally competent care to increasingly diverse and often vulnerable patient populations."

Over the past few years, Dr. Malik has led global health initiatives using point-of-care ultrasound (POCUS) in Ethiopia with Emory's internal medicine residency program. "Creating international programs and giving back whenever possible has been extremely gratifying," he said.

Dr. Malik co-leads many faculty-development initiatives for Emory's division of hospital medicine. Emory has the largest academic division in the country, with more than 350 hospitalists at more than 10 sites. "Developing creative programming and resources for my colleagues has been very rewarding," Dr. Malik said.

He also serves on his department's promotion and tenure committee. "I enjoy representing hospital medicine and advocating for my colleagues' great work," Dr. Malik said.

Regarding SHM, Dr. Malik initially contributed by teaching the bedside procedures pre-course and presented on topics including POCUS and immigrant hospitalists in equity-focused tracks.

Since 2018, Dr. Malik has served on SHM's Annual Conference Committee, where he has developed several tracks and innovative topics. He will serve as the assistant course director in March at SHM Converge 2026 in Nashville, and will be the course director for SHM Converge 2027 in Las Vegas. He is also a member of the Global Hospital Medicine and POCUS Special Interest Groups.

For Dr. Malik, SHM membership has many benefits. "SHM's in-person and online programming enables members to keep in touch and learn from one another," he said.

SHM's regional chapters—which have experienced tremendous growth—help hospitalists in various regions to stay connected.

Moreover, SHM provides opportunities for residents and future hospitalists to showcase their work at regional and national levels, setting them up for success.

SHM's advocacy at various levels of government—for patient care, hospitalists' compensation, and equity initiatives—is close to Dr. Malik's heart. "I owe a lot to SHM for supporting me and giving me a nurturing community where we can all thrive together," he said.

Research

Micah Prochaska, MD, MSc, SFHM, an assistant professor of medicine at the University of Chicago Medicine and a hospitalist at UChicago Medicine, an academic hospital with more than 400 beds in Chicago, gained hands-on experience as a research assistant and project coordinator for a large, multicenter trial studying the effects of hospitalists on patients and costs during his undergraduate years at the University of Chicago.


Dr. Prochaska

"At that time, collaborating with clinicians, statisticians, and research teams gave me foundational skills in data collection, project management, and multidisciplinary investigation," he said.

Dr. Prochaska earned his medical degree at Wright State Boonshoft School of Medicine in Dayton, Ohio, and completed his internal medicine residency at the University of Chicago. Post residency, he completed a master's degree in public health science, a research fellowship in health outcomes research, and a fellowship in clinical medical ethics.

"I chose hospital medicine because I liked caring for acutely ill patients and the pace of inpatient care allowed me to pursue my primary interest in training and becoming a clinician investigator, and health outcomes researcher," he said.

Throughout his medical training, Dr. Prochaska initiated independent research projects, designed studies, and published several manuscripts as a first author. They focused on patient-reported outcomes, such as fatigue as a symptom.

In his current role as a clinician-scientist, Dr. Prochaska's research continues to focus on how hospital-based interventions—such as red blood cell transfusion and iron for treating anemia—affect patient-reported outcomes.

He has also developed a research program studying "fatigability" as a key outcome measure in hospitalized patients and has published data demonstrating that it's more sensitive than traditional markers of fatigue or activity in capturing meaningful changes in patients' health status.[1,2] His work has been supported by National Institutes of Health-funded grants and national collaborations.

Dr. Prochaska is also an associate director of the MacLean Center for Clinical Ethics and the director of the inpatient Ethics Consult Service at the University of Chicago. He attends on the ethics consult service and manages clinical ethics consultations, and has developed and oversees a master's degree track in clinical ethics and a new online certificate program in clinical ethics consultation.

Dr. Prochaska maintains several national and international leadership roles that shape the field of transfusion medicine. He is a contributing author to two editions of the Association for the Advancement of Blood & Biotherapies' International Red Blood Cell Transfusion Guidelines—the gold standard for transfusion practices worldwide.

He is the incoming chair of Association for the Advancement of Blood & Biotherapies' patient blood management guidelines committee. He has previously contributed as an author on two patient blood management guidelines and plans to continue to develop high standards for safe, effective, and patient-centered use of blood products in hospitals worldwide.

He also chaired the annual meeting and research committees of the Society for the Advancement of Blood Management, helping define the organization's scientific direction and educational priorities.

Dr. Prochaska also serves on SHM's Research Committee and is a former winner of SHM's Junior Investigator Award. He has chaired the research portion of the Research, Innovations, & Clinical Vignettes competition at Converge for several years.

"Being an SHM member allows me to maintain strong connections with my research colleagues nationwide," he said. "Through this network, I stay informed and engaged with the latest work they're doing in our field."

Clinical Expertise

Nana Arthur, MD, FACP, CPE, SFHM, a hospitalist, associate medical director, and medical staff president at Wellstar Douglas Medical Center, a 108-bed community hospital in Douglasville, Ga., believes that she brings clarity and coordination to complex clinical situations while helping multidisciplinary teams stay aligned around safe, reliable, and high-value care.


Dr. Arthur

"Hospitalists meet patients at some of the most critical moments of their care," Dr. Arthur said. "When things feel uncertain, our role is to bring clarity, coordination, and calm. That work improves care for individual patients and strengthens how the entire hospital functions."

Dr. Arthur earned her medical degree in Ghana and completed her internal medicine residency at Yale New Haven Hospital–Saint Raphael Campus in New Haven, Conn.

Early in her training, she was influenced by mentors who modeled composed leadership under pressure and emphasized interdisciplinary collaboration. Those experiences shaped her belief that hospitalists are uniquely positioned to bridge clinical care, teamwork, and hospital operations.

In her daily practice, Dr. Arthur cares for a broad and diverse inpatient population, managing complex medical conditions across the adult age spectrum. She incorporates geriatric principles when appropriate—particularly for patients with frailty, delirium, or cognitive vulnerability—while maintaining a comprehensive hospital medicine practice. "Thoughtful medication review, collateral history, and attention to transitions of care matter for many hospitalized patients," she said.

Collaboration is central to Dr. Arthur's leadership approach. She adapts to a moment's need—whether stabilizing high-acuity clinical situations, aligning multidisciplinary teams, or supporting colleagues through operational change. She emphasizes shared accountability and role clarity as essential to reliable care delivery.

"Reliable care doesn't come from individual effort alone—it comes from teams sharing clarity, accountability, and trust," she said.

Her commitment to communication extends beyond the bedside. As a peer coach, Dr. Arthur works with physicians and advanced practice providers to strengthen communication behaviors that build trust, improve patient experience, and support team cohesion.

"Clear communication shapes patient understanding and team performance," she said. "It's foundational to safe, high-quality care."

Dr. Arthur has also served as interim chief medical officer within Wellstar. That experience broadened her understanding of quality, operations, and organizational culture, and it strengthened her ability to connect frontline realities with system-level priorities.

"I bring clinical credibility and operational insight to leadership work," she said. "My focus has always been on delivering high-value inpatient care while supporting the people and processes that make it possible."

As medical staff president, Dr. Arthur focuses on physician engagement, interdisciplinary partnership, and care reliability—particularly during transitions of care. She takes pride in work that improves coordination and consistency across teams, recognizing how small process improvements can meaningfully influence outcomes.

Dr. Arthur stays engaged with SHM through national meetings, educational programming opportunities, and ongoing professional development. She uses SHM resources to stay current on clinical care, leadership development, and quality improvement strategies. ■

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

Celebrate NHD by Entering the HM Voices 2026 Contest

The annual HM Voices National Hospitalist Day Contest is now accepting submissions.

HM Voices is *The Hospitalist's* online section where SHM members can unleash their creativity. We showcase creative writing—In Your Words (poetry, essays, etc.) and creative visuals—In Your Eyes (photos, art, digital creations).

This year's contest focuses on pathways. What path led you to becoming a doctor, hospitalist, researcher, leader, educator, clinician, administrator? What pathways are yet to be explored?

Share your creative thoughts about pathways through art, poetry, videos, essays, or photography, and email your submissions to communications@hospitalmedicine.org. The deadline is March 31. The top three winners will be published in an upcoming issue of *The Hospitalist*, and all submissions will be published online. ■

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What Is the 'Source of Truth' for Hospitalists?

Weighing the value of guidelines and other sources, hospitalists have much to consider

By Thomas R. Collins

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When he was a resident, Thejaswi Poonacha, MD, a hospitalist and assistant professor of medicine at Emory University in Atlanta, set out to look at the clinical practice guidelines of the National Cancer Care Network (NCCN), a collection of 30 National Cancer Institute (NCI)-designated comprehensive cancer centers in the U.S. that is considered perhaps the foremost authority on cancer care.


Dr. Poonacha

He found that only 61 of the NCCN's 1,023 recommendations on the 10 most common cancers — just 6% — were based on a "high level of evidence" with uniform consensus among the expert panelists. The rest were based on a "lower level of evidence" with varying degrees of consensus. Most were based on a lower level of evidence with uniform consensus, as was the case with 83% of the recommendations. Ten percent were based on a lower level of evidence without a uniform consensus, but no major disagreement, and 1% had some level of evidence but with major disagreement among the panelists.[1]

"The NCCN guidelines should be viewed, in general, as a representation of expert consensus on good clinical practice rather than the final word in patient care decision making," Dr. Poonacha and his co-author wrote.

Nine years later, Dr. Poonacha did the study again. While the number of NCCN recommendations in the guidelines on the 10 cancer types had expanded dramatically — jumping from 1,023 to 1,818, a 77% increase — the level of evidence did not change much. He and his colleagues found that 7% of the recommendations were based on a high level of evidence with uniform consensus, 87% were based on a lower level of evidence with uniform consensus, 6% on a lower level of evidence without a uniform consensus but no major disagreement, and 0% on some level of evidence but with major disagreement.[2]

Dr. Poonacha and his co-authors said that guidelines have to be regarded and used with care, and this is especially true, they said, when they are based mainly on expert opinion rather than strong evidence in the literature, as is the case with many guidelines throughout medicine, not just those from the NCCN.

"Our study underscores both the urgent need and available opportunities to expand the current evidence base in oncology, which forms the platform for clinical practice guidelines," they said.

Hospitalists and doctors in general often look for a "source of truth" in medicine, a kind of oracle that can be relied upon as a bedrock for decision making. Clinical practice guidelines are usually the main sources to which physicians refer. But in recent years, there has been a series of shifts in advice from government agencies, most prominently on vaccines, and statements from government officials intended to be viewed as authoritative, that have complicated this search for truth. And, for that matter, clinical practice guidelines themselves differ in how well they meet standards for being trustworthy.

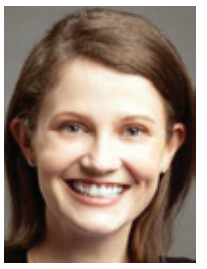
Experts and seasoned clinicians who have studied clinical guidelines, worked on developing them, and put them to use over many years say that it is important to understand the benefits and limitations of guidelines, and to separate government commentary from scientific evidence. Decision making often can rely on guidelines, but it also has to factor in clinical experience and the facts of the clinical situation that lie before a hospitalist at any given time, which might or might not be addressed in guidelines or consensus statements.

Understanding the Inherent Limitations

Dr. Poonacha said hospitalists have to be careful to acknowledge the limitations inherent in guidelines.

"These guideline members do a fantastic job in collecting evidence, but what is available out there? They can't go and create more evidence," he said. "They're experts in the field, and therefore they've been selected to be on the panel, but all they can do is to go and see what's available out there and then use that to the best of their knowledge and implement it into guidelines."

Blair Golden, MD, MS, assistant professor of medicine at the University of Wisconsin-Madison School of Medicine and Public Health in Madison, Wis., who has worked with the SHM research committee in identifying gaps in existing guidelines, said hospitalists need to understand that most guidelines are not a black-or-white proposition.


Dr. Golden

"One of the challenges, especially in the context of being a busy clinician, is that the emphasis of the guideline can be just the kind of one-line takeaway," she said. "But what is really critical to look at is what's the grading of evidence in terms of, are there actually robust clinical trials to support that recommendation?"

There will not always be clinical-trial-based recommendations, or possibly any guideline recommendations at all, for a particular situation in a hospital. For instance, she said, "We know that patients really care about how we talk to them, but it's not something where there are huge randomized controlled trials about it."

"Is there a guideline that's relevant to this clinical case?" Dr. Golden said. "What's the strength of the evidence? If there's not great evidence, does that matter for what I'm doing in my practice?"

She said guidelines are also limited by the pace at which they can be updated. New guidelines were recently issued about complicated urinary tract infections, she said, but she won't necessarily be relying on those guidelines for her patient care.

"Oftentimes, by the time those guidelines come out, we've already really incorporated the latest studies. We treat that condition so commonly that it's not really practice-changing for me."

Uses for Guidelines

But, Dr. Golden said, the guidelines can be a useful reminder, at times, for evidence that might have been missed. And she said they can also be helpful in her teaching.

"I use it as kind of a primer for educating myself, and also for educating residents and medical students where they may not always be on top of the most cutting-edge stuff," she said.

Guidelines can also help put into context some of the recommendations that can come from consultant specialists. They can act as "kind of a check" against what might have been considered common practice, and in cases where there is ambiguity, she said, "particularly if it's something I don't see commonly."

For instance, when there were changing views about the preferred modalities for cardiac work-up for heart failure, she checked a clinical practice statement from the *American Journal of Cardiology*. She saw, "to my surprise, that cardiac MRI was the next best

test for our patient, which is not something I would necessarily immediately go to." That spared a cardiology consultant.

"It kind of helped facilitate for something that was maybe a little bit outside my comfort zone," she said.

Consider Guidelines and Their Developers

The National Academy of Medicine, formerly the Institute of Medicine, in 2011 published a lengthy report on how to evaluate clinical practice guideline trustworthiness—a kind of guideline on guidelines.[3] The report identified eight factors for ensuring that guidelines can be trusted: transparency, management of conflict of interest, the composition of guideline committee members, how guideline committees and systematic review authors interact, methods for rating the strength of recommendations, how well the recommendations are articulated, external review of the recommendations, and updating.

Authors of the report underscored the growing importance of guidelines, given that the number of randomized controlled trials quintupled to 25,000 from the 1970s and 80s to the early 2000s.

"Clinicians can no longer stay abreast of the rapidly expanding knowledge bases related to health," the report authors said.

Therefore, they say, they rely on guidelines and need them to be trustworthy.

And, in addition to the evidence-based methods of developing the guidelines, decisions about who creates the guidelines can have important effects on what is recommended, the authors wrote.

For instance, a guideline committee member who performs a certain procedure is more likely to rate more indications for this procedure than someone who does not perform it.[4] On the importance of managing conflicts of interest appropriately, the authors of the report note that a study of Food and Drug Administration Advisory Committees found that members regularly disclosed financial conflicts but rarely recused themselves from voting as a result. But when they did, the drug in question received less favorable voting outcomes.[5]

In his 2020 study on the evidence base of the NCCN guidelines, Dr. Poonacha and his colleagues drew attention to the participation of pharmaceutical companies' involvement in research, and the complications that this introduces for providing the most robust evidence base for guidelines.

"While the collaboration between industry and clinical trial groups has been effective, the potential conflict between the goals of government-funded cooperative groups versus pharmaceutical industry sponsors cannot be ignored," they wrote. "The primary objective of the pharmaceutical companies is to provide data appropriate for a licensing application, while the objective of the cooperative groups is to evaluate the additive benefit of that new agent to standard treatment. A trial addressing a question of great importance to oncologists and patients may be of no interest to the pharmaceutical industry. The cooperative groups may also want to combine or compare agents from two different companies, which may not serve the interests of industry."

Hospitalists' Use of Guidelines

Hospitalists interviewed for this piece said that, rather than evaluate the wide array of guidelines that are available, they tended to simply rely on the guidelines put together by the most well-known organizations—for instance, the NCCN for cancer guidelines or the American College of Cardiology for guidelines on cardiac care.

But they emphasized that an overreliance on, or a misuse of, guidelines can pose problems.

Micah Prochaska, MD, a hospitalist and assistant professor of medicine at the University of Chicago, said that guidelines can potentially be misapplied as health systems oversimplify them as they try to standardize care.[6]


Dr. Prochaska

Dr. Prochaska, a member of the red blood cell transfusion international guidelines committee, said the recommendation that patients should not be given a transfusion until their hemoglobin drops below 7 g/dL has been implemented into electronic medical record systems, meaning that physicians are more likely to make their decisions based on an electronic health record prompt derived from this single metric, rather than making a decision based on the full clinical context.

The actual guidelines include nuance, but these complexities are often ignored in the pursuit of standardization and a well-intentioned interest in eliminating variability in care, he said.

"The role of doctors when we read guidelines is to recognize the certainty and uncertainty in the data, and then use clinical expertise and experience to try and decide, does this apply to my patient or not?" he said. "But when you have an electronic health record system that's prompting you to either 'Give blood or not give blood based on one clinical data point,' you're divorcing the clinical decision from the guidelines and supporting evidence, minimizing uncertainty and nuance, and I think you end up with quite dogmatic care. It is standardized, but it's not clear that it's the right care. It's not even clear that it represents what the guidelines support."

He said that much of the research on which guidelines are based may not directly apply to the setting in which hospitalists practice.

"As a hospitalist, we care for acute illness in the context of chronic comorbidities," Dr. Prochaska said. "And a lot of the studies that inform guidelines are not done in hospitalized patients. A lot of these are ambulatory studies."

On the international transfusion guidelines committee, he said, he is the only hospitalist, adding that he was not chosen to be on the committee because of his hospitalist experience, but because of his research on red blood cell transfusion.

Pankaj Agrawal, MD, chief medical officer at SGMC Health in Valdosta, Ga., said guidelines are full of "gray areas" and confounders—such as guidelines based on studies performed mostly in big cities and rarely in rural areas—and it boils down to the physician's assessment.


Dr. Agrawal

"At the end of the day, I become the decision maker to say, where's my patient, what works better for his situation?" he said. "It becomes an art."

He recalled a time as a physician when he faced a case on which there was hardly any foundation in literature at all, and he wished there was a guideline on which to rely. A patient came in with ciguatera fish poisoning. There was no robust evidence, nothing in UpToDate. When he did a Google search, he found only three case reports that offered some guidance.

As federal agencies make dramatic shifts in recommendations and national elected and appointed officials make statements about public health and medical care without clear scientific backing, even more confusion is being introduced into the search for clear guidance on medical care. In January, the Centers for Disease Control and Prevention (CDC) stopped routinely recommending six out of the 17 standard childhood vaccines. Even if physicians might look to rigorous evidence for guidance, patients can bring concerns and questions based on these pronouncements, hospitalists said.

Dr. Agrawal said that statements without evidence are not worth considering.

"Those are comments or statements, they're not evidence-based, they're not published in a study," he said. "That doesn't change my practice, knowing this is not driven by medical research."

Dr. Prochaska acknowledged that the CDC has made mistakes in the past in its recommendations, but the overhaul that is being undertaken now is concerning. He said he is no longer sure whether he could be comfortable referring a patient to the CDC's online information about vaccinations.

On statements such as the press conference in which the President suggested that pregnant women should not take acetaminophen because they would put their children at risk of autism, he said evidence should carry the day.

"In order to convince me that Tylenol causes autism, you would have to have a series of studies and data and experts that were laying it out in a transparent way to say, 'We really screwed this up. We misinterpreted the old data.' And instead, what happened was, the websites changed overnight."

In the end, Dr. Poonacha suggested, as hospitalists seeing complex patients search for guidance and truth in their care, little is more important than what they see with their own eyes in the moment. And common sense can go a long way, he said.

A guideline might say that the standard of treatment for atrial fibrillation is to put patients on a blood thinner.

"But if the patient has dementia and is a high risk for falls," he said, "then that guideline is tossed out."

Tom Collins is a medical writer based in South Florida.

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Rounding and Admitting Teams —Separate or Together?

Clean, Clear, and Consistent

By Elizabeth Herrle, MD, FACP, SFHM

FLIPSIDE

For years, I was strongly against splitting our hospital medicine team structure into admitting and rounding teams. In looking at the competing values associated with this structural choice, I placed patient continuity at the top of the list. Letting go of that continuity seemed anathema to high-quality, patient-centered care. So I consistently argued against the split at our hospital medicine team meetings. But I was outvoted by the group. Then our structure changed and I saw firsthand that there are many virtues of a split rounding and admitting teams, particularly on direct-care hospitalist teams.

I think all of us who work in hospital medicine recognize that there is a certain amount of unpredictable chaos in our work that can never be eliminated. It may even be something that many of us found appealing when choosing this specialty: It keeps it interesting. But at a certain point, that invigorating unpredictability can become a liability—particularly when our dose of chaos becomes too high and crosses over into poisonous territory.

Admissions are inherently unpredictable in number and complexity. On mixed rounding and admitting teams, admissions loom over each day, encouraging rushed rounding, and producing increased stress driven by anticipation of the admissions, regardless of what actually comes our way. Planning a day around the possibility of a workload that may contain anywhere from zero to six hours of admissions work is inefficient and untenable.

And when the admissions do come, the disruption to care of rounding patients can be significant. It is a well-established fact that humans cannot be in two places at once. Pulling a rounding clinician off the floor to head to the emergency department at random intervals throughout the day is a significant disruption. And when there is a demand on the floor that requires the practitioner's attention, the admission is interrupted, delaying and often degrading the care of that patient as well.

Contrast that with the relative serenity of a pure rounding team. At the start of the day, there is still that twinge of unpredictability: Will this patient discharge? Who might require additional medical attention? But in general, I have a sense of my day. I can develop a rounding order and commit to activities that contribute to rich, patient-centered care: complex multidisciplinary meetings, phone calls with family members, and time to linger at the bedside without the dread that I am spending time I will never get back if the admission fates decide to be cruel that day.

Continued on page 14

In Defense of the Messy Middle

By Chris Migliore, MD, MS, FACP, FHM

My colleague makes a clean and appealing case for pure teams. Let some physicians admit all day, living at the front door of the hospital, mastering triage, diagnosis, and early management. Let others round, cultivating continuity, efficiency, and discharge expertise. It's true, there would be fewer interruptions, clearer roles, and less cognitive switching. On paper, it's elegant, and on spreadsheets, even better.

It's a good argument, and I agree with much of it. Pure teams can be efficient; they can reduce burnout tied to constant task-switching, and they can standardize workflows while making staffing easier to model. In certain environments, such as high-volume emergency departments, surge conditions, or short-stay units, pure admitting or pure rounding teams may be exactly right.

But I fear that too much elegance can sacrifice excellence. Efficiency is not the same as responsibility. Hospital medicine is not a factory floor, even when it desperately wants to be one, and the work doesn't divide cleanly into "before" and "after." By having pure teams, we may end up quietly accepting losses that are harder to measure.

The strongest argument against pure teams, in my opinion, is accountability over time. When clinicians admit patients they will never see again, the incentives shift. Admission assessments can drift toward plausibility rather than precision, and diagnostic uncertainty will move forward. Plans are written in an environment where someone else will have to reconcile them later. To be clear, no one is acting in bad faith; the system is simply teaching that early decisions are provisional and disposable.

Rounding-only teams inherit those decisions without context and will spend time untangling assumptions made under pressure by people they may never meet. This is framed as continuity, but it is often archaeology. The rounding team becomes responsible for outcomes without having been responsible for the starting point. That is not continuity; it is custodianship.

Teams that both admit and round must live with their own thinking and remember what they were worried about on day one. As importantly, they can see which worries mattered. They recognize when an elegant admission narrative collapses by day three, a feedback loop that is not comfortable, but is instructive. It sharpens judgment in a way no protocol can.

Pure-team advocates often counter that feedback can be simulated through case review or handoff standards. In theory, this

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On the admitting side, practitioners focusing on admissions can do just that—triaging the patients with the highest need to more expedient attention and often completing the intake from start to finish without significant interruptions. Importantly, being fully focused on admissions allows for an enhanced ability to engage in conversations with the emergency department about patient disposition in those situations where an admission to the hospital may not be the best plan for a patient.

I have not abandoned my appreciation for the value of continuity in hospital medicine. But I have found that there are other values worth acknowledging. In addition to the benefits outlined above, there is a direct benefit of disrupting continuity—an automatic second opinion. Modern medicine is a team sport, and I appreciate that my stellar colleagues are reviewing the patients I have admitted and honing the plan of care that I set in motion. And I am privileged to do the same for them.

I'm glad I was wrong in my stubborn attachment to mixed admitting and rounding teams, and I encourage you all to join me on the flipside. ■

Dr. Herrle

Dr. Herrle is a hospitalist and physician leader with MaineHealth in Portland, Maine.

Migliore

Continued from page 13

is true, but in practice, nothing substitutes for seeing your own plan fail at 6:00 a.m. on hospital day four. That experience changes future decisions; a checklist, not so much.

There is also a cultural cost to pure teams. Segmentation encourages quiet moral outsourcing. "That's an admitting problem." "That's a rounding issue." Over time, clinicians can become very good at their slice of the process and less invested in the whole. The hospital runs, the patients get better, but no one quite owns the whole story. When things go poorly, responsibility (and therefore feedback, which can shape learning) diffuses.

Hybrid teams resist that diffusion. They understand throughput and trajectory at the same time and feel emergency department pressure while also negotiating discharge barriers. Speaking from experience, this is more friction, but I believe this understanding also imparts better judgment. Not every admission needs a maximal workup, and not every inpatient day needs maximal optimization. That sense of proportion comes from seeing both ends of the pipeline.

Education matters here as well. If there are trainees on pure teams, they are learning task lists and non-contextual fragments. Admitting teams learn to start stories while rounding teams learn to finish them. Hybrid teams learn narrative medicine and see how an initial framing shapes days of care, and how small early choices echo downstream.

The pure-team model promises sanity through separation. The hybrid model offers something less tidy. Yes, the days are busier, and the interruptions are real. But medicine has always been interruptive, and the solution to that reality should not be to narrow professional responsibility until it fits in a rectangle on a scheduling app.

In sum, pure rounding risks turning physicians into very competent custodians of other people's decisions, while pure admitting risks turning them into talented note-writers who never meet the consequences. The hybrid model is messier, but it keeps clinicians honest.

Hospitalists need efficiency, but they also need memory. Teams that both admit and round provide both, not because they are faster, but because they remain answerable to time. That, more than elegance, is what patients deserve. ■

Dr. Migliore

Dr. Migliore is an assistant professor of medicine at Columbia University College of Physicians and Surgeons, and director of general medicine consult and perioperative services as well as a medicine attending physician at Columbia University Medical Center, both in New York..

SHM Converge 2026 Session Recommendations

What's on your must-see list?

SHM Converge 2026 in Nashville is packed with 20 educational tracks and more than 100 sessions. Members of *The Hospitalist's* editorial board share a few of the sessions they're excited to attend.

Jennifer Caputo-Seidler, MD, *hospitalist and assistant professor of medicine at the University of South Florida Morsani College of Medicine in Tampa, Fla.*

Dr. Caputo-Seidler

I always enjoy watching my colleagues succeed at Converge. This year, I'm especially looking forward to "Updates in Clinical Guidelines" from Dr. Michael Roberts. For the last few years, Dr. Roberts has given this talk to the SHM Tampa Bay chapter, and it is always a huge hit with the audience. It's also been a practice-changing experience for me. After last year's talk, I've adopted a more aggressive approach to initiating all four pillars of goal-directed medical therapy for my heart failure patients before discharge. I'm excited to leave Nashville with more evidence-based, actionable improvements for my practice.

As the hospital medicine liaison to my institution's trauma program, I'm also excited to see "Achy Breaky Hips: A Hospitalist's Guide to Hip Fractures" on the schedule. The perioperative and co-management content at Converge is always superb. Historically, these sessions have provided evidence-based strategies and best practices that are immediately translatable to clinical practice. I'm expecting to leave this session with ideas to improve the quality of care for our patients with hip fractures and to strengthen our geriatric hip fracture co-management program.

Jensa Morris, MD, *director of the Smilow hospitalist service and chief of inpatient medical services at Smilow Cancer Hospital at Yale New Haven Health, and associate clinical professor of medicine at the Yale School of Medicine, both in New Haven, Conn.*

Dr. Morris

If you're an oncology hospitalist, SHM Converge 2026 is shaping up to be absolutely unmissable. The conference keeps getting better each year, and this time around, I'm thrilled to see more cancer-focused content reflecting our field's rapid growth. Here are my three must-attend sessions.

First up on Monday, March 30, at 2:45 pm, don't miss Dr. Bianca McLean of Yale Health in New Haven, Conn. at The Third Annual MedTed Competition. She'll be breaking down cellular therapy—covering clinical applications, potential complications, and evidence-based management strategies. As chimeric antigen receptor T cell, or CAR-T, and other cellular therapies become increasingly common on our services, this knowledge is now essential.

Later that afternoon at 4:15 pm, Dr. Patricia Litkowski and her team from Washington University's Barnes-Jewish Hospital in St. Louis deliver "Sweet Tea, Grits and Diagnostic Hits," tackling one of our most common clinical conditions: fever in the cancer patient. I've heard Dr. Litkowski present before, and she is brilliant and engaging. I'm expecting practical pearls I can use immediately.

On Tuesday, I will co-present "Honky tONC Blues No More" with Dr. Naomi Hodde. We'll walk through the complete inpatient cancer journey, from the initial diagnosis to end-of-life care. It's the kind of comprehensive, real-world discussion that captures what we do every day.

I couldn't be more excited about the increasing oncology hospital medicine content: more evidence that the field of hospital medicine continues to grow, expand, and specialize.

Goutham Talari, MD, FACP, SFHM, *hospitalist and vice chair, department of medicine at AdventHealth in DeLand, Fla., and assistant professor at Florida State University College of Medicine in Daytona Beach, Fla.*

Dr. Talari

Attending the SHM conference is one of the most energizing times of the year for hospitalists. While conference agendas can feel overwhelming, intentional session selection can transform a meeting from a passive experience into a meaningful investment in clinical practice and career development. As I reviewed the Converge agenda, I focused on sessions that advance three priorities central to hospital medicine today: updating clinical knowledge, improving quality and outcomes, and supporting long-term career sustainability.

First, "Update in Anticoagulation: Don't Chicken Out, Learn About the Hottest Recent Studies" remains essential for every practicing hospitalist. It will cover rapidly evolving evidence surrounding direct oral anticoagulant use in complex populations, including patients with advanced chronic kidney disease, obesity, and malignancy, and those in periprocedural settings. This session offers practical clarity for decisions we make daily that carry significant risk if misapplied. Similarly, "Updates in Clinical Guidelines" provides a high-yield synthesis of new recommendations that directly influence inpatient management, helping clinicians distinguish truly practice-changing updates from background noise.

I am particularly drawn to sessions focused on Things We Do for No Reason™. These sessions challenge deeply ingrained habits and promote thoughtful de-implementation of low-value care. Importantly, the insights gained from these sessions extend beyond individual practice, as hospitalists carry this knowledge back to their teams and institutions to drive broader improvements in hospital outcomes.

The session, "After Hours: Optimizing Night Float and Cross Cover in Hospital Medicine" speaks directly to patient safety, communication breakdowns, handoff quality, and clinician burnout.

Looking ahead, artificial intelligence in hospital medicine represents both opportunity and responsibility. Understanding how AI can augment clinical decision making, risk stratification, and documentation, while remaining mindful of its limitations and ethical implications, is essential for thoughtful adoption.

Finally, addiction medicine and career-focused sessions round out a balanced agenda. Substance use disorders account for a growing share of hospitalizations, placing hospitalists at the center of evidence-based treatment initiation. Career-focused sessions, meanwhile, provide space for reflection on leadership development, role diversification, and sustaining a meaningful career in hospital medicine.

Together, these topics sharpen clinical skills, improve systems of care, and invest in a durable, meaningful, professional trajectory in hospital medicine.

Arnold Facklam, NP, FHM, *adult hospital medicine nurse practitioner and nocturnist with First Physicians Group at Sarasota Memorial Health System in Sarasota and Venice, Fla., and a member of SHM's NP/PA advisory council*

Mr. Facklam

As a hospital medicine nurse practitioner and nocturnist, I am looking forward to Converge 2026. It gives me the chance to come out into the light and spend time with fellow hospitalists to discuss and learn about both current and emerging topics.

Cognitive overload is not just an abstract concept for hospitalists—it is the lived reality of daily practice, especially for those of us working nights. I will not miss the session "Cognitive (Over)load in Hospital Medicine: Impacts on Diagnosis and Approaches to Mitigating." This session promises to delve into cognitive load theory and its relationship to hospitalist practice. The presenters use real cases and recent research to show how overloaded clinicians think when faced with constant interruptions and patients requiring complex care. These demands add to our mental burdens and can impair diagnostic accuracy. The speakers identify the problems and offer strategies that are practical and evidence-based to help reduce cognitive overload.

Another session I plan to attend is "Generative AI for the Hospitalist: A Practical Approach in a Rapidly Changing World." Gone are the days when our lab coat pockets were filled with notes and pocket-sized clinical reference books (like "The Harriet Lane Handbook") just to quickly look up something like a porcelain level (my pediatric colleagues will get that reference). This session begins with an overview of how generative AI works, where it is useful, and where it still needs improvement. The presenters discuss current applications, ongoing initiatives, hospital course generation (creating a summary of an entire inpatient stay), patient-friendly discharge instructions, and more. The time-saving tools described in this session, I believe, will give us more time with our patients and ultimately enhance patient care.

SHOW YOUR BADGE DISCOUNTS AT CONVERGE 2026

Explore Nashville and save during your stay as an SHM Converge 2026 attendee! Be sure to check out the Show Your Badge (https://tinyurl.com/mr2rfu4u) discount opportunities, along with other special offers (https://tinyurl.com/3cwstty8) available for you to enjoy while you're in town. ■

Christopher Migliore, MD, MS, FACP, FHM, *an assistant professor of medicine at Columbia University College of Physicians and Surgeons and director of general perioperative medicine and consult services and medical director of surgery and surgical step-down at Columbia University Medical Center, both in New York*

Dr. Migliore

Academic Summit!

Neha Garg, MD, FACP, *chair of the department of medicine, physician lead of hospitalist group, secretary-treasurer of the medical executive committee, and glycemic excellence physician lead at Providence Medford Medical Center in Medford, Ore., and vice president of SHM's Oregon/SW Washington chapter*

Dr. Garg

I'm absolutely thrilled to attend SHM Converge 2026, especially with Nashville as the backdrop. SHM meetings consistently do a great job of bringing hospitalists from across the country together to learn, reflect, and walk away with ideas we can actually apply on our very next shift.

There are many sessions I'm looking forward to, but a few immediately caught my attention. One is "My Bad! (Please Don't) Just Sue Me!—Common Reasons Why Hospital Medicine Physicians Get Sued and How to Mitigate Risk." I'm eager to learn how communication and documentation can increase or reduce medicolegal risk, and it will be especially helpful to learn from real-world scenarios.

I'm also excited for "Top 5 AI Applications Transforming Medicine and What You Need to Know." AI is no longer a distant concept; it's already shaping our workflows. I'm looking forward to learning how hospitalists can use AI tools thoughtfully and responsibly while keeping patient care front and center.

SHM Converge 2026 promises to be an energizing, forward-thinking meeting that captures everything I love about hospital medicine.

Ethan Molitch-Hou, MD, MPH, SFHM, *assistant professor, director of hospital medicine sub-internship, core faculty for the internal medicine residency program, and co-director of the Care Transition Clinic at the University of Chicago Medical Center in Chicago*

Dr. Molitch-Hou

SHM Converge is a time to reconnect with my medical home, where I visit with colleagues from afar and get to learn where the field is changing and growing. Nothing captures how the field is advancing more than the "Top 5 AI Applications Transforming Medicine and What You Need to Know" talk. Medicine is going through a rapid period of change, and this talk covers the areas where it is most active, from helping me write my notes to helping my diagnostic skills.

We need to be able to adapt to a world where AI becomes a tool in our arsenal. We need to learn to use it well and know the strengths and weaknesses, so we can better care for our patients and train the next generation who will be using it at even higher rates. Beyond this emerging technology, staying up to date with the "Updates in Hospital Medicine" and "Things We Do For No Reason™" remain my standard go-tos for the fun and engaging approach to my day-to-day clinical care. ■

More Must-Attend Quick Takes

A Giant Leap: Lessons from the Early Days of Generative AI-Meets-Healthcare

Dr. Robert Wachter, chair of the UCSF department of medicine and a pioneer in hospital medicine, authored "A Giant Leap: How AI is Transforming Healthcare and What That Means for Our Future" (2026). Following the launch of ChatGPT, Dr. Wachter evaluates whether AI is finally achieving its potential in healthcare and what role hospitalists will play.

Finding Your Rhythm: Exploring the Phenotypes of Hospital Medicine

Learners and early-career physicians often feel overwhelmed by various career paths in hospital medicine. This session explores professional phenotypes—Clinical Excellence, Clinical Leadership and Administration, Education Leader, and Researcher—highlighting each role's unique responsibilities and potential career trajectories.

Updates in Pneumonia

Dive into the latest breakthroughs reshaping how hospitalists diagnose and treat pneumonia. This fast-paced, clinically focused session tackles real-world dilemmas—from early IV-to-oral transitions and shorter antibiotic courses to the evolving role of procalcitonin, diagnostic stewardship, and steroids.

From Grand Ole Scan to Grand Ole Plan: A Clinical Point of Care Ultrasound Image Trivia Challenge

This session is a highly interactive, small-team-based, friendly competition where the teams review POCUS video and image clips and clinical cases that will help illustrate how to integrate POCUS into clinical care.

Life-Threatening Inpatient Endocrine Emergencies

This session will review complex presentations of endocrine emergencies that are commonly overlooked and describe diagnostically challenging cases encountered in critically ill inpatients.

Delirium Superimposed on Dementia—Best Practices for Hospitalists

Delirium superimposed on dementia is associated with poorer clinical outcomes, including accelerated cognitive decline, functional impairment, and increased mortality. This session describes pharmacological and non-pharmacological management and lists key care transitions to optimize care following hospitalization.

When Your Team Is Running on Empty: Practical, Science-Backed Strategies for the 7-On Reality

In this keynote, Rachel Tenenbaum, MCC, certified neurotransformational coach and founder of The Reset Room in Leesburg, Fla., guides healthcare practitioners through practical, science-backed strategies that strengthen clarity, connection, and resilience in the moments that matter most.

Change Management for Hospitalist Leaders: Best Practices for 2026

Hospitalist leaders and aspiring leaders will be guided through the key aspects of change management, starting with a 30,000-foot view of the value proposition, then transitioning to the specifics of initiating and executing change management at the organizational level, including tailored strategies and negotiation skills to help close the deal.

Byte-Sized Breakthroughs: Updates and Insights from Generative AI on the Wards

Session presenters start with a brief overview of generative artificial intelligence, then discuss its current applications in the field of hospital medicine, underscored by ongoing initiatives at NYU Langone Health in New York. They'll highlight the ongoing pilot of automatic hospital course generation, clinical trial for patient-friendly discharge narratives, enhancement of patient safety by identifying discordance between clinical notes and orders, and screening of secure messages for those with high clinical urgency.

Optimizing Transitions of Care: Lessons from a Hospital Medicine Transitions Clinic

Transitions of care are a critical inflection point for reducing readmissions and improving value-based outcomes. This session showcases a hospitalist-led transitions clinic model that evolved from a virtual chronic-obstructive-pulmonary-disease pilot to a multi-disease, hybrid clinic supporting patients across the care continuum.

Changing Your Tune: A Trauma-Informed Approach to Challenging Encounters in the Hospital

Challenging patient encounters in hospital medicine, such as those involving misaligned goals, system issues, or verbal or physical violence, frequently contribute to provider burnout. This interactive session introduces trauma-informed care as a novel framework for understanding and managing these difficult situations. ■

Expanding Pediatric Care: Inplementing a Peds H@H Unit in a Large U.S. Children's Hospital

By Tonya Obita, MD, MPH, Stefanie Reed, DO, SFHM, Sara Horstmann, MD, Douglas Dodds, MD, SFHM, David Marseille, MD, Dustin Long, PhD, Gang Liu, PhD, and Christine B. Turley, MD

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Children's hospitals across the U.S. are increasingly experiencing capacity shortages, particularly at times of seasonal surges in acute illness.[1] In addition, increasing closures of smaller and rural pediatric units have further consolidated pediatric beds to regional children's hospitals, increasing bed demand.[2] Our Pediatric Hospital Medicine service at Atrium Health Levine Children's Hospital (AHLCH) in Charlotte, N.C., experiences ongoing capacity constraints. AHLCH spent more than 300 days (91%) at or near capacity during 2024, limiting access to care. Thus, the system searched for creative ways to expand capacity rapidly and control costs.

Solution Overview

At the height of the COVID-19 pandemic, hospital beds were in high demand. Many adult medicine services successfully adopted the hospital at home model, expanding acute care capacity by providing equivalent care in the comfort of the patient's home. The model includes virtual monitoring by nurses and physicians, daily in-home paramedic or nurse visits, and the provision of services such as oxygen therapy, intravenous medication administration, and lab testing.[3] Acute Hospital at Home (AH@H) has increased bed capacity, mitigated unintended consequences of hospital care such as traumatic experiences and increased family burden, and, in many cases, has decreased hospitalization costs.[4-7]

Our health system, Advocate-Atrium Health, has a large adult AH@H program operating successfully since the pandemic. This provided a framework to build upon. Through partnership with the adult AH@H leadership, we leveraged support for adaptation to a pediatric model with senior Atrium leadership. While pediatric AH@H is used in Europe and Australia for a variety of acute care issues, U.S. health systems have not integrated this model of care into pediatric medicine.[8,9] Thus, with the international evidence of success in pediatrics and the success of our local adult AH@H program, our team saw pediatric AH@H as a viable solution for our pediatric bed capacity shortage.

In May 2024, we began the process of development and implementation of a full-service pediatric AH@H program that would allow us to demonstrate that this model can be adapted and successfully used in U.S. pediatric acute-care settings. Our goal was to demonstrate successful expansion of bed capacity while providing safe hospital care that is acceptable to patients, families, and practitioners.

Implementation Process

Beginning in May 2024, Atrium Health leadership brought together leaders from pediatric hospital medicine, nursing, paramedicine, pharmacy, ancillary services, and adult AH@H to begin pediatric AH@H implementation planning, background data collection, and evaluation design for the program. As the clinical program was designed, our evaluation team considered what data were needed to demonstrate that the program is safe and acceptable to both practitioners and families, as well as to evaluate the program rapidly throughout the implementation period and beyond. Together, these teams identified the initial patient populations served by this care model and how the program needed to be adapted for a pediatric population.

As program concepts developed, we recognized that the pediatric AH@H program would establish entry criteria that focused on patient stability instead of diagnosis, a distinction from the adult program. To meet the state-mandated regulatory requirements for our AH@H program, only patients in North Carolina and those within 30 minutes of our emergency department could be considered eligible.

We leveraged our adult paramedic service,


Dr. Obita


Dr. Reed

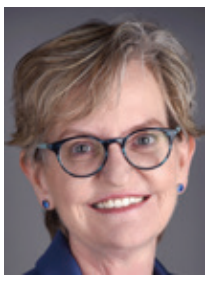

Dr. Horstmann


Dr. Dodds


Dr. Marseille


Dr. Long


Dr. Liu

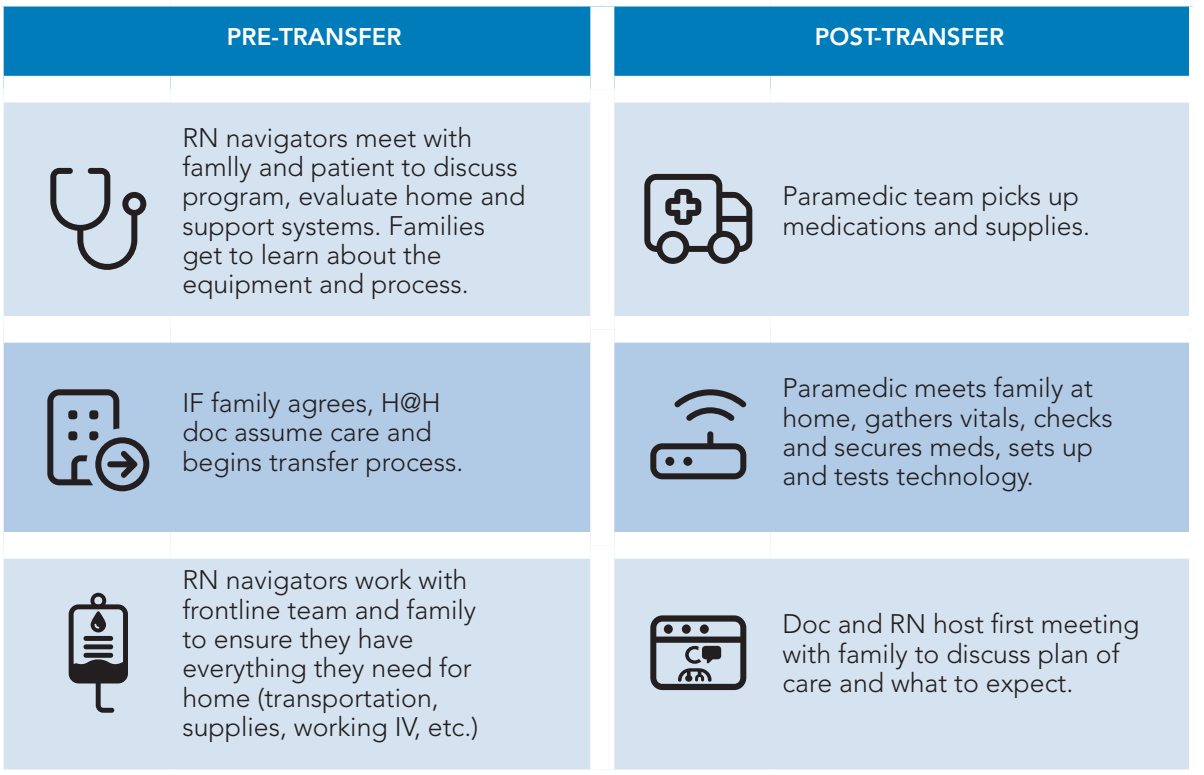

Dr. Turley

Dr. Obita is a pediatric hospitalist at Atrium Health Levine Children's Hospital and associate professor of pediatrics at Wake Forest University School of Medicine, both in Charlotte, N.C. Dr. Reed is a pediatric hospital medicine faculty member, site director for pediatric hospital medicine, and medical director of the first U.S., comprehensive, acute-care, pediatric, hospital-at-home program at Atrium Health Levine Children's Hospital, and assistant professor of pediatrics at Wake Forest University School of Medicine, both in Charlotte, N.C. Dr. Horstmann is a pediatric hospitalist at Atrium Health Levine Children's Hospital, an associate professor of pediatrics at Wake Forest School of Medicine, and the division director of pediatric hospital medicine at Atrium Health, all in Charlotte, N.C. Dr. Dodds is a pediatric hospitalist at Atrium Health Levine Children's Hospital and assistant professor of pediatrics at Wake Forest University School of Medicine, both in Charlotte, N.C. Dr. Marseille is a pediatric hospitalist at Atrium Health Levine Children's Hospital, and assistant professor of pediatrics at Wake Forest University School of Medicine, both in Charlotte, N.C. Dr. Long is an associate professor of biostatistics and data science at Wake Forest School of Medicine in Winston-Salem, N.C. Dr. Liu is a data scientist with the Research and Excellence in Advancing Children's Health program at Atrium Health Levine Children's Hospital in Charlotte, N.C., and an adjunct assistant professor of biostatistics and data science at Wake Forest University School of Medicine in Winston-Salem, N.C. Dr. Turley is the vice chair for research at Atrium Health Levine Children's Hospital and professor of pediatrics at Wake Forest University School of Medicine, both in Charlotte, N.C.

Table 1: Screening Questions

LCH PEDIATRIC AH@H ADMISSION/ TRANSFER REQUIREMENTS
Location Screen
Live in North Carolina
Live within 30 minutes of Levine Children's Hospital-affiliated ED
EHR Stability Screen
Hemodynamically stable with age-appropriate vitals for at least 4 hours
Requiring less than 2 L of oxygen for at least 6 hours
Not requiring continuous infusions or new controlled substances, and no more than twice-a-day dosing of IV medications
Evaluated with history and physical by the inpatient pediatric team, who agree they are stable and suitable for pediatric AH@H
Stable to have vital signs taken no more often than every 6 hours
PEDIATRIC AH@H PROGRAM CLINICAL EXCLUSION CRITERIA
Traumatic injury
New or increasing oxygen requirement
Airway impingement diagnosis or concern
Altered mental status
Requiring total parenteral nutrition
Mental health condition requiring continuous attendant surveillance
ELEMENTS CAPTURED DURING CAREGIVER/PARENT INTERVIEW
Ability of the parent/caregiver (or a consistent designee) to be available 24/7 for the expected hospital period (e.g., able to be released from work or school without penalty)
INTERVIEW SCREEN
Working home/cell phone for caregivers
Parent/caregiver over age 18 in the house available to care for the child continuously, and available to obtain vitals/speak with nursing/paramedics over the expected hospital stay course
Other caregiving responsibilities of the parent/caregiver or designee during the planned hospitalization period (e.g., other children in the home younger than 5 years old, elderly or disabled family member caregiving responsibilities)
Any concerns with the availability of electricity, water, and utilities during the planned hospital period (screen with hospital-required social determinants of health screen)
Access to a phone 24/7 (as a back-up/ emergency method of contact)
Suitability of the home setting, as judged by the parent/caregiver, to the expectations of the pediatric AH@H caregiving (e.g., available crib or bed for the patient, quiet setting to facilitate healing, appropriate heating or cooling available)

Figure 1: Transfer Process



known as Mobile Integrated Health, to identify a self-selected paramedic team that received additional training in pediatric care, including assessments, IV placements, and lab draws. We partnered with the adult AH@H and Levine Children's Hospital (LCH) pediatric pharmacy teams to develop processes for medication verification, delivery, and subsequent in-home safety measures. Additionally, the Child Life department was brought on board early to design unique virtual care assistance and provide therapeutic and medical play items to the mobile units and families. Systems and flows for transferring to home, escalating care in home, and transferring back to the brick-and-mortar (BaM) hospital were all adapted from the adult program to fit the flow of our pediatric hospital service.

The program launched on February 3, 2025. For this novel program, patients are screened for medical stability (see Table 1). Those deemed stable, with permission from the BaM attending, are approached by a nurse navigator for a standardized interview to ensure the home environment and caregiver capacity are appropriate. Once the patient is screened in these two steps, they are offered care in pediatric AH@H.

Once enrolled, the patient transfers to the LCH-AH@H unit in the electronic health record (EHR), and transfer orders are placed by the pediatric AH@H clinician (see Figure 1). The paramedic team meets the family in the home after they travel there by private vehicle and sets up remote two-way monitoring systems, and the patient has the first virtual visit. Patients are seen in person by the paramedic, virtually by the hospitalist, and by the pediatric nurse twice daily until discharge from the program. Families have virtual access to their nurse and physician 24 hours a day.

Table 2: Reasons Families Declined the Program

REASON	N (%)
Prefers in-person	7
Lacks social support network	5
Other	3
Uncomfortable with strangers in home	2
No reason given	2
Virtual program	2

Key Points

- Pediatric AH@H can be implemented in a U.S. children's hospital.
- Careful planning to determine suitable populations is important, and focusing on patient characteristics over diagnoses allows for more potential access to the service.
- For growth in this model, key aspects of sustainability and appropriate equipment will be needed.

Equipment can be a challenge in the pediatric AH@H setting, as the market for this type of equipment has been adult-focused up until recently, and many companies are just moving into the pediatric-population market. The equipment for remote patient monitoring and communication used by our adult program is approved by the U.S. Food and Drug Administration for patients 14 and older. Thus, we had to develop a research protocol with the vendor to use communication equipment for patients younger than 14 years, and we have had delays in sourcing remote monitoring equipment approved for use in children of all ages. This has led to delays in enrolling younger children who require continuous vital sign monitoring.

Obtaining the buy-in of our hospitalists required continuous ongoing engagement, with frequent updates on program development in 2024 and on enrollments and metrics once launched in 2025. The AH@H team actively screens patients and reaches out to the BaM teams with potential candidates. This allowed gradual growth in the understanding of potential candidates for the program. In addition, care was taken not to increase the BaM teams' workload in that all transfer orders and arrangements are made by the AH@H team.

An additional obstacle we considered when building out the program was the ability to communicate with non-English-speaking families. The virtual platform we use provides auto-translation from English to Spanish and vice versa in the chat function. This is critical for nurse-family communication when not on a video call. We have access to video virtual interpreters but

have not yet enrolled patients who do not speak English or Spanish due to the limitations.

Outcomes

Since the start of the program, we have screened 1,942 patients admitted to the hospitalist service. Figure 2 illustrates the flow of patients through the screening to the point of qualifying for an eligibility interview. We interviewed 78 families. All were deemed eligible after the interview. Of these, 57 consented to enter the program. Table 2 lists the reasons families declined entry into the program, Table 3 summarizes the age ranges of patients in the program, and Table 4 shows enrollments by month.

The three most common reasons for hospitalization in pediatric AH@H were dehydration, feeding difficulty, and treatment of infection. Overall, patients have been satisfied with the service to date, exceeding our patient satisfaction scores for our BaM units. Given the limited number of clinicians involved in the program, surveys have not yet been distributed to staff. Over the five months, we have seen increases in referrals to the unit by members of our BaM hospitalist team. Given that the program has not reached a steady state, the calculation of bed days saved per patient in pediatric AH@H has not yet been reported. If these BaM beds are backfilled with traditional pediatric hospital patients, a projected return on investment will be calculated.

Lessons Learned

This novel approach to pediatric care, born out of a bed capacity shortage, embraced innovation and focused on the unique needs of pediatric patients while leveraging in-house resources from a robust adult AH@H program. We demonstrated that through careful process planning, thoughtful design of inclusion and exclusion criteria, and partnership, pediatric AH@H is implementable. As technology is optimized for remote patient monitoring, designing and obtaining Food and Drug Administration approval for such technology must include children of all ages.

While we are the largest quaternary children's hospital in our state, we are not strictly a standalone children's hospital. Thus, we were able to take advantage of the larger system's hospital-at-home waiver for reimbursement of services, functionally helping us launch within an expedited timeline and with a template for reimbursement. For sustainability, there is a need to demonstrate clear value from the perspectives of patients and families, the health system, and staff. This will require well-designed evaluations of these program aspects. Creating a compelling argument for both waivered and non-waivered viability of this care model is essential for pediatric hospitals across the U.S. that face capacity constraints.

Future Directions

Pediatric AH@H represents a real step forward in patient-centered pediatric acute care. We are actively planning the expansion of the service across all the pediatric centers served by our hospitalist team, and then across other children's centers in our healthcare system.

As we consider the declining pediatric subspecialty practitioner numbers, we are planning to work in collaboration with subspecialists to develop pathways for specific patient populations that may be well-served by this model. Pediatric AH@H has immense potential as a viable care model for special populations, including late preterm infants and postoperative and complex-care patients. Evaluating the efficiency of program entry, hours for entry, and the timing and frequency of patient visits is necessary to allow more patients access to this model. For example, we can only deliver twice-daily IV medication in our current model. Having the ability to do IV medication three times a day will allow many more children to qualify. We are also planning to compare patient outcomes for those cared for in this new model with BaM standards, as a crucial component in ensuring that high-quality inpatient care can be delivered reliably in this new way. ■

Figure 2:

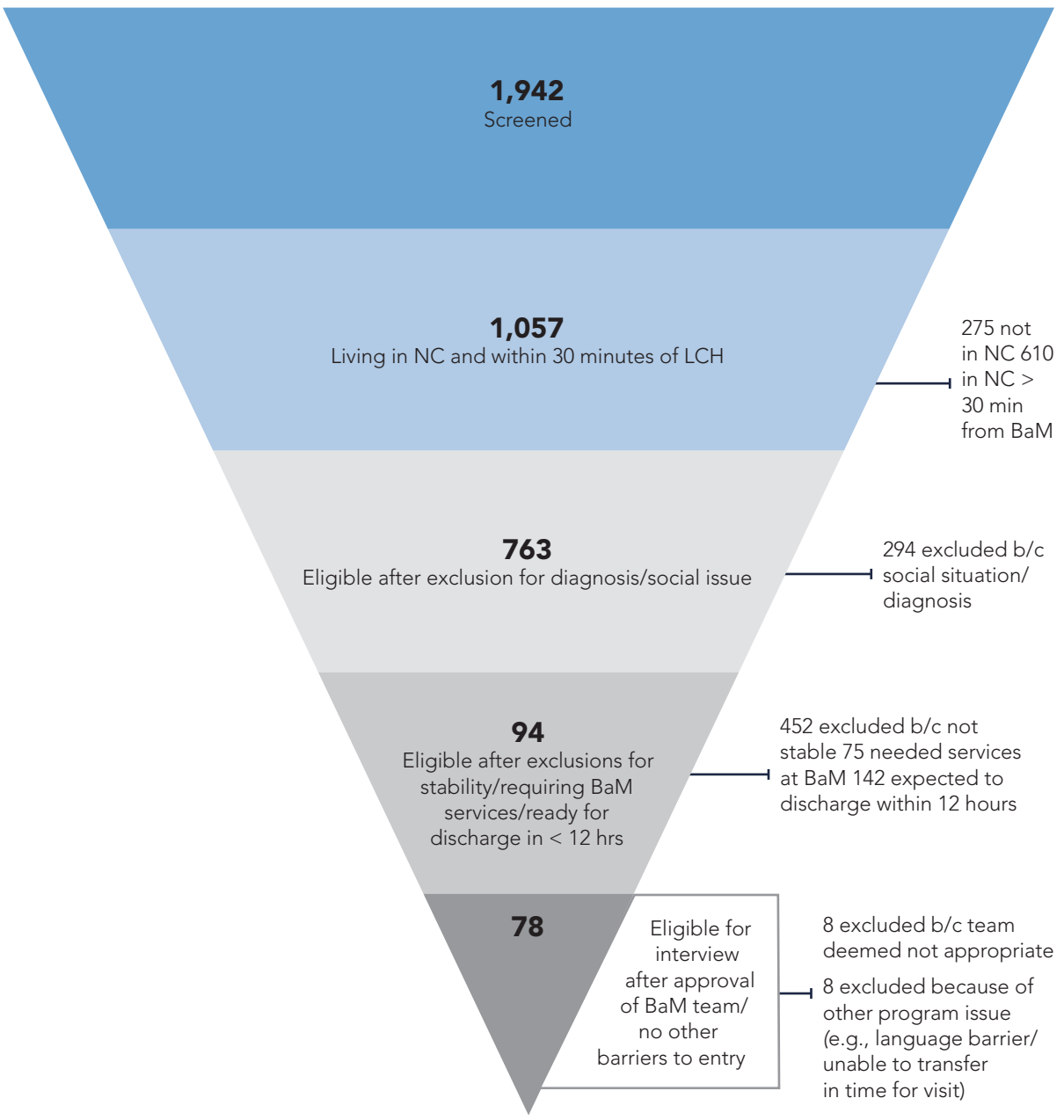


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Table 3: Ages of Enrolled Patients

AGE GROUP	N (%)
Neonate	7 (11.7%)
<1 year	18 (30.0%)
>/=1 and <5 yrs	18 (30.0%)
>/=5 and <13 yrs	12 (20.0%)
13+ yrs	5 (8.3%)

Table 4: First Four Months' Enrollment

MONTH	N	AVERAGE LENGTH OF STAY (STANDARD DEVIATION)	NUMBER OF TRANSFERS BACK TO BRICK-AND-MORTAR	30 DAY READMISSION
February	13	9.15 (9.55)	2	1
March	14	4.00 (2.48)	1	0
April	14	8.93 (8.64)	0	1
May	19	10.95 (15.44)	1	1

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Chapter Spotlight: Central Ohio

Striving for diverse topics, roles, and experiences to meet members where they are

By Richard Quinn

For Rashmi Ganith, MD, FACP, SFHM, president of SHM's Central Ohio chapter, involvement started as a wellness campaign.

See, Dr. Ganith is the assistant director of wellness of hospital medicine at The Ohio State University in Columbus, Ohio. When she first got involved in the chapter a few years back, it was about improving patient care and developing a sense of community within central Ohio—not with an automatic eye on rising through the ranks and assuming the top job.

Dr. Ganith

"Then, I found out it is so much more," she said. "You gain leadership skills, then integrate with other chapters across the nation to expand your professional network and eventually collaborate on projects nationally."

Dr. Ganith, an associate professor of hospital medicine and double board-certified in lifestyle medicine and internal medicine, said that rising through a chapter starts small.

"Expanding medical knowledge, professional development, communicating national guidelines, and advocacy are natural pathways to increasing the value of a chapter to its members," she said.

"Starting as a member, I found value in being recognized for my contributions in hospital medicine by becoming a Senior SHM Fellow, and engaging with national leaders of SHM," Dr. Ganith said. "Also, other attendees motivated me to gain a yellow belt in [quality improvement] and realize that educating faculty on wellness practices prevents burnout and thereby improves patient care.

"Additionally, I gave a lecture on 'Maintaining Physician Wellness During the Pandemic.'"

Dr. Ganith said that she tries to engage all healthcare professionals across the hospital medicine spectrum, be they physicians, support staff, or learners.

"I like that our chapter can be a place where we can mentor learners and collaborate on research with colleagues," she said. "For example, a resident won our chapter's poster competition, thereby gaining entrance into the SHM national poster competition."

Again, she sees the group starting small with the potential to expand its reach to help all medical professionals grow.

"As a chapter leader, you promote your members' goals, advocate for hospitalist wellbeing, and serve as a bridge to leadership. For example, I created a network of chapter leads to write letters of support for those in our region going up for promotion.

"My president elect, Dr. Melanie Prestige, and I selected popular restaurants and topics to attract the foodies and intellectuals to attend talks on opiate use disorder, updates in medicine, infectious disease 'Jeopardy,' updates in cancer medicine emergencies, and updates in consult and perioperative medicine, to name a few. We are lucky to have had speakers from all institutions in central Ohio and even from Stanford University."

The importance of varied topics can't be overstated.

They are "essential to SHM Central Ohio regional meetings because hospital medicine is a broad, evolving field that serves physicians across different practice settings and career stages," Dr. Ganith said. "A diverse agenda allows meetings to address not only clinical excellence, but also leadership development, wellness, quality improvement, and system-based challenges that hospitalists face daily. This variety keeps meetings engaging and inclusive, encourages cross-institution learning, and fosters innovation by exposing members to new perspectives and ideas."

Dr. Ganith said the chapter is working to have more attendees at chapter meetings from different institutions in central Ohio, so they, too, can benefit as she has.

"We aim to expand our reach by emailing other chapter leads and encouraging attendance at our meetings," she said. "Our goal is to share a meal and actively collaborate on patient care principles and share operational ideas."

Diversity for the chapter also extends to its offerings. Clinical topics are obviously important, but sessions and social gatherings that address a more "holistic" approach to wellness are also part of Dr. Ganith's agenda.

"Maybe members want to improve their financial wellness, so they come to our financial wellness talk. Or maybe they want to gain insight into the impact of infertility on men and women. I want to make sure our topics are relevant."

A future goal is the creation of tracks, which Dr. Ganith sees as a method to broaden the chapter's appeal for its individual members.

"I'd like to create tracks for learners versus faculty in the next few years," she said. "I think it will diversify our options and engage more members." Common tracks relevant to hospitalists would be practice management, updates in clinical medicine, workshops and lectures in education topics, wellness, and more.

Another goal Dr. Ganith has is to win a chapter excellence award.

"I think it would provide us validation that we're helping our faculty, learners, and staff to grow professionally within central Ohio." ■

Richard Quinn is a freelance writer in New Jersey.

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SIG Spotlight: Environmental Health

Amplifying the dialogue of climate and environmental factors

By Karen Appold

Hospitals generate large amounts of waste, pollution, and greenhouse gas emissions through energy use, material waste generation, pharmaceutical use, testing, and temperature control. In fact, hospital care represents the largest share of U.S. health care emissions.[1]

By being in the center of hospital care, hospitalists are uniquely positioned to lead environmental health and sustainability efforts in their everyday work—clinically, operationally, educationally, and academically, said Katherine T. Liu, MD, who chairs a newer SHM Special Interest Group (SIG)—Environmental Health.


Dr. Liu

"We wanted to create a community of hospitalists who share our passion for understanding and mitigating the health impacts of climate and environmental factors," said Catherine Chen, MD, who is vice chair of the SIG and also an associate professor of medicine and vice chair of quality and safety for the department of medicine at Robert Wood Johnson Medical School, a 650-bed academic hospital in New Brunswick, N.J. "Hospitalists have a lot of opportunities to decrease the carbon footprint of hospital care and promote health."


Dr. Chen

"My goal in creating this SIG was to signal to other hospitalists that this is not only work that we can or should be doing, but it's work we're already doing through our roles as clinicians, educators, researchers, and leaders," said Dr. Liu, a clinical assistant professor in the department of medicine, division of hospital medicine, at MaineHealth, a 700-bed academic hospital in Portland, Maine. "We need to amplify the dialogue and fill our toolkits so that this work can be effective and recognized."

Founded in 2024, the Environmental Health SIG is intended to be a community for all facets of environmental health in hospital medicine. Dr. Chen's work in this space currently focuses on healthcare sustainability, quality improvement, and medical education. Other members focus on a broad range of topics, including leadership, health care access, environmental justice, and advocacy.

Ultimately, the SIG's core goals are these:

- Reduce the environmental impact of patient care delivery
- Promote clinical practices that support both healthy patients and a healthy planet
- Disseminate climate-smart practices (including tools and resources) through collaboration and education
- Build a national community of hospitalists engaged in environmental health, research, quality improvement, and leadership

When people don't have a stable climate, clean air, safe water, and resilient infrastructure, Dr. Liu believes that their health suffers. Hospitals experience this routinely through heat and air quality-triggered exacerbations of chronic illness, infectious outbreaks, supply chain disruptions, and widening health inequities.

The Environmental Health SIG also emphasizes resilience, i.e., prevention at the healthcare systems level, and being prepared for climate-driven hazards such as heat waves, hurricanes, flooding, wildfire smoke, power outages, and optimizing resource use in anticipation of supply shortages, Dr. Chen said. All of this directly affects inpatient care.

Much of this work already includes what hospitalists do well, such as reducing unnecessary testing, early transitions from intravenous to oral medications, preventing readmissions, and improving resource stewardship.

"We're building this SIG to amplify all of these good works," Dr. Chen said. "The environmental health field is very much about accelerating change by sharing ideas and breaking out of silos."

During the SIG's kickoff event in January 2025, participants came with a shared desire to integrate environmental health into practice. They cited a diverse range of motivations, including the negative human health impacts of microplastics, emerging infectious diseases, environmental justice, high-value care, quality improvement, research, and administrative leadership. "We will strive to incorporate these topics into events as we move forward," Dr. Liu said.

Early achievements include launching regular programming, building a presence on SHM's online forum platform, HMX, and hosting a Special Interest Forum at SHM Converge Las Vegas 2025.

The SIG's largest ongoing effort is the "Sustainability Works in Progress," or WiP, series on the HMX forum. These sessions allow hospitalists to present ongoing projects, get feedback, and learn from peers. A Special Interest Forum will be held at SHM Converge in Nashville in 2026.

Already 210 members strong, the Environmental Health SIG aims to increase educational offerings for hospitalists on environmental health and related topics, both through online continuing education and at venues such as SHM Converge, Dr. Chen said.

Recently created SHM learning modules on climate health have topics that range from quality improvement and high-value care to practical guidance on carbon footprints so that hospitalists can quantify the environmental impact of current or future projects.

"Professional development and mentorship are important to our members," Dr. Chen said. "We plan to continue to grow our offerings around these topics and hope that our current events serve as a platform for early career hospitalists and future hospitalists to learn from others doing this kind of work."

"We're looking forward to more members joining us," Dr. Chen added. "Many hospitalists have been engaged in this work for years; others are interested in hearing more and want to figure out where to get started. Finding this like-minded group in SHM will hopefully spur more discussions and exchanges of ideas." ■

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

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Journal of Hospital Medicine®

JHM's Leadership and Professional Development Series Offers Pearls on Professional Growth

By Thomas R. Collins

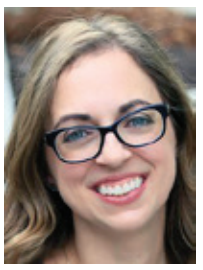
> *"When I started, the field was relatively new, and it would have been great to have a column like this to turn to for advice and ideas. It also serves as a place where less research-focused hospitalists can publish to advance their own career."*
>
> —Dr. Karen Jerardi

The tough transition from trainee to hospitalist can be a crucial time in the professional life of the hospital-medicine physician. But creating a "team" of collaborators and mentors, developing one-year goals, and identifying the resources you have available can boost the chances of success, according to a column in the Leadership and Professional Development series in the *Journal of Hospital Medicine*.

"Making the transition to unsupervised practice can be difficult clinically, academically, psychologically, and personally," the authors wrote. "No amount of training can prepare you for everything the new role has to offer, so give yourself grace as you adjust."[1]

The Leadership and Professional Development series, published in the journal since 2019, gives right-to-the-point, condensed advice to hospitalists in areas that might be overlooked in much of the career-oriented literature.

The career paths and professional development of hospitalists are, of course, shaped in part by big-splash promotions and publication of major quality-improvement achievements. But the journal series—edited by Karen Jerardi, MD, MEd, professor of pediatrics at the University of Cincinnati College of Medicine in Cincinnati, Ohio, and Kimberly Manning, MD, professor of medicine at the Emory University School of Medicine in Atlanta—recognizes that, just as often, hospitalists' professional paths are determined by the smaller, day-to-day challenges that can call for diligence and finesse. The column is an attempt to help hospitalists work through these challenges.



Dr. Jerardi

Dr. Manning

Dr. Jerardi, who has edited the series since it began and is co-director of the division of hospital medicine at the Cincinnati Children's Hospital Medical Center, said the column is meant to cover topics that are less likely to be explored elsewhere.

She said the series allows for a "more holistic view of hospitalists and the work we do" and is meant to "discuss topics that are less often covered in research or editorials."

"This is for hospitalists by hospitalists, so that take-away action items feel relevant, or that is our hope," she said. "Initially, we saw that hospitalists were asked to take on many leadership roles across health systems, and yet there was a lack of formal training in this area, and what did exist was limited to only those at higher levels of leadership."

Dr. Jerardi has researched innovative ways to improve clinician conflict communication skills, how best to support residents interested in pediatric hospital medicine fellowships, and other professional development topics.

Dr. Manning's work has included enhancing diversity in hospital medicine and studying system structures for improving healthcare.

The topics covered in the series reflect this interest. In the piece on the transition from trainee to hospitalist, the authors—Whitney Cameron, DO, MSc, and Daniel Herchline, MD, MSEd—suggest considering during the interviewing process who might make a good mentor and scheduling one-on-one meetings to find the best fit. They also suggest exploring what the institution can offer in the way of career coaching. Beyond that, a yearly timeline can help frame short- and long-term career goals.

The authors also suggest taking advantage of the institution's resources for onboarding and orientation, in order to get to know a center's culture and history. They also emphasize the importance of getting feedback on performance and actively seeking it out if there is no formal process.

In another recent Leadership and Professional Development piece, authors Josue Zapata, MD, MBA, and Katie Raffel, MD, discuss a strategy to disagree with colleagues productively—a method they call DISNT, for determine value, illustrate commitment and show logic, negotiate partnerships, and transform your success into future impact.[2]

When deciding whether to voice dissent, they say, the positives and negatives have to be carefully weighed, including whether an outcome can really be changed, the magnitude of the impact, the hit you might get to your social capital, and disruption to the group's decision-making process.

"Only if the positive outcomes outweigh the costs should you proceed," the authors write.

Disagreement, when voiced, is best when you also show your commitment to the organization and when you line up allies in advance who might support your view when you bring it up, the authors write. Physicians also need to understand that if this dissent is successful, they might not get credit and need to avoid saying "I told you so," and instead leverage the goodwill and social capital that they've gained by bringing about positive change.

In another recent piece—by Lauren Spaeth, DO, and Bruno Concejo, MD — the authors give tips for using the five senses to avoid excessive self-judgement throughout a workday, such as questioning what you could have done differently during an unpleasant patient encounter and allowing it to affect subsequent patient encounters.[3] Paying attention to a sensory detail, such as the feel of a patient's hand, or the smell of coffee in the hallway, can help bring you back into the moment.

When rushing from one meeting to the next, the authors write, it can be a helpful boost to stop and look out the window and take note of five things you see outside.

"This is simple but not easy, and the Buddhist proverb 'short moments, many times' can help us implement it," the authors write. "We can gradually develop a habit by creating momentum throughout the day with short bursts of attention."

Dr. Jerardi said that, when she was a fellowship director in pediatric hospital medicine, she saw that the fellows needed to learn these skills without a curriculum or other clear way to do so.

"When I started, the field was relatively new, and it would have been great to have a column like this to turn to for advice and ideas," she said. "It also serves as a place where less research-focused hospitalists can publish to advance their own career."

Drs. Jerardi and Manning strive for authors with a variety of backgrounds and professional experiences.

"Hospitalists do so many things, and each person can bring a unique perspective," Dr. Jerardi said. "We like to have pediatric and adult hospitalists, folks who have done additional training and those that haven't, those that practice in community settings and larger tertiary centers—no hospitalist job is the same, and no hospitalist is the same. We also like to see a more senior author pair with a junior author to provide mentorship and sponsorship for the junior author."

She said she hopes readers find meaning in the series.

"I hope," she said, "that our readers can find ways to grow, learn, and reflect on their practice when they read our column." ■

Tom Collins is a medical writer based in South Florida.

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