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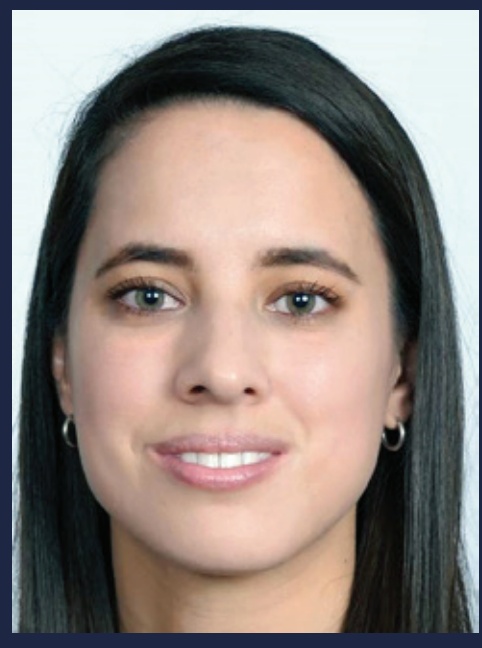

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THE Hospitalist

Common Ground: Notes from PHM 2026

By Patricia Tran, MD, MS, FAAP

As I reflected on this year's Pediatric Hospital Medicine Conference, I found myself contemplating two words: connection and communication. And as a bit of a language nerd (after all, I do have a degree in linguistics), I asked, where do these words come from and are they related?

Words have origins, and sometimes those origins tell us more than what the words themselves have come to mean. Take connection, which traces to the Latin *connectere*; *com-*, meaning together, and *nectere-*, meaning to bind, coming together to create "to bind or tie together." At its root, connection is a literal act of fastening, two things bound so they no longer stand apart.

Communication comes from a different Latin root, *communicare*, "to share or to make common," which builds on *communis-*, meaning common, public, or shared. If this looks familiar, it's because we can break this down even further into *com-* and *munis-*, meaning obliging or performing a service. Communication is built on performing a service together for the common good.

I couldn't stop thinking about these two words once I started noticing them everywhere I turned at this year's conference. Connection and communication weren't themes printed on a program; they were the texture of the conference experienced plainly by all who attended.

Take the sheer amount of networking. One thing that struck me about PHM was the active investment in connecting people, *nectere* in its plainest form: not connection as something that happens to you, but connection as something people do, on purpose, on each other's behalf.

And once people were connected, the communication started—idea after idea moved from one person's practice into someone else's hands and came out a usable idea to be improved and iterated on together. This is what *communicare* describes: a service rendered, person to person, toward something held in common. We weren't just sharing what we knew; we were performing a kind of obligation to each other and to the field, the *munis* underneath it all, in service of patients that none of us can fully help alone.

Dr. Tran

Dr. Tran is an assistant professor of clinical pediatrics at the University of Illinois College of Medicine and a pediatric hospitalist at the Children's Hospital of Illinois, both in Peoria, Ill. She is also the pediatric editor for The Hospitalist and a deputy editor of digital media for the Journal of Hospital Medicine.

I keep coming back to the fact that both words, at their roots, describe something done rather than something that simply exists. *Connectere* is an act of tying; *communicare* is an act of sharing, of serving. Neither happens on its own. Our field's ongoing work—improving care for hospitalized children and translating good research into everyday practice—depends on people continuing to choose these verbs again and again.

PHM 2026 was, in the end, a few days of people coming together and choosing to connect and communicate, over and over, in ways large and small. We bound ourselves to each other and put that relationship immediately to use. That, etymology aside, felt like exactly the right way to spend a conference. ■

PHM 2026 Recaps

If you weren't able to attend PHM 2026, check out Beyond Expertise: Influence, Trust, and the Future of Pediatric Advocacy on page 17, Top 10 Articles in Pediatric Hospital Medicine on page 19, and scan the QR code for more PHM session recaps published online. ■

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In the Literature

NYU Langone Hospital Medical Literature Reviews

By Cyril George Cheriyan, MD, John I. Hwang, MD, Lauren Heery, MD, Knox Kelly, MD, MS, Ian Larson, MD, Pooja Patel, MD, Nadine Vidor, MD, and Emily Zhou, MD

NYU Langone Hospital, New York

IN THIS ISSUE

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By Cyril George Cheriyan, MD

1 Hospital at Home As a Safe and Cost Effective Alternative for Older Adult Patients

CLINICAL QUESTION: How do clinical outcomes and costs of hospital at home (H@H) compare with traditional inpatient care among Medicare beneficiaries?

Dr. Cheriyan

BACKGROUND: Inpatient hospital medicine faces mounting pressure from rising costs, staff shortages, and limited hospital beds. H@H is an alternative model that can deliver acute care to support increasing demands. Existing studies are limited to single-center designs and small sample sizes. Larger, national-scale evidence is needed to guide adoption decisions for healthcare institutions, payers, and regulatory agencies.

STUDY DESIGN: Propensity-score–matched, retrospective, comparative effectiveness study

SETTING: 68 H@H-waivered hospitals in the U.S.

SYNOPSIS: This study compared 4,174 Medicare beneficiaries (ages 65 and up) admitted to H@H against 11,697 patients in a traditional brick-and-mortar inpatient setting. The H@H cohort had significantly lower in-hospital mortality (0.4% versus 3.6%; adjusted odds ratio, 0.09, 95% confidence interval [CI], 0.06 to 0.16) and reduced emergency department utilization within 30 days of discharge (8.8% versus 10.0%; adjusted odds ratio, 0.86, 95% CI, 0.76 to 0.97). There was no difference in 30-day readmissions between the two groups. The H@H cohort also had lower intensive care unit escalation (3.5% versus 7.9%) and hospital-associated complications (3.6% versus 5.1%). Despite higher index hospitalization costs in the H@H group, there was a decrease in total discharge costs within 30 days. Perhaps the largest limitation of this observational study was that it relied on codes from Medicare fee-for-service claims, which are designed for billing and do not specify the patient's severity of illness, functional status, or geographic eligibility criteria. Thus, the results extrapolated in this study should be seen as associations in patients using H@H rather than cause and effect. It's also important to note that the study period was in the throes of the COVID-19 pandemic, which may have played a role in who was chosen to participate or who did not qualify for H@H.

BOTTOM LINE: H@H is associated with significantly reduced mortality and decreased emergency department use, in addition to a reduction in total 30-day post-discharge costs, solidifying its utilization as a safe and economically viable alternative for appropriately selected older patients.

CITATION: Vakkalanka JP, et al. Outcomes associated with hospital at home vs traditional inpatient stay. *JAMA Netw Open*. 2026;9(5):e2610810. doi: 10.1001/jamanetworkopen.2026.10810.

Dr. Cheriyan is a unit medical director and hospitalist for the division of hospital medicine at NYU Langone Hospital in New York.

By John I. Hwang, MD

2 Bone Biopsy Not Superior to Ulcer Bed Biopsy-Guided Antibacterial Therapy on Remission of DFO

CLINICAL QUESTION: In patients with diabetic foot osteomyelitis (DFO), is percutaneous bone biopsy superior to ulcer bed biopsy for guiding antimicrobial therapy?

Dr. Hwang

BACKGROUND: Bone biopsy is considered the gold standard for guiding antimicrobial therapy in DFO because superficial cultures correlate poorly with causative organisms. Yet surprisingly little evidence demonstrates that routine bone biopsy improves clinical outcomes. This trial tested that assumption by comparing antibiotic therapy guided by percutaneous bone biopsy with ulcer bed biopsy.

STUDY DESIGN: Multicenter, double-blinded, randomized, controlled trial

SETTING: University hospitals in Amsterdam, the Netherlands, and Sydney, Australia

SYNOPSIS: 84 adults with diabetic foot ulcers and clinically diagnosed osteomyelitis managed nonoperatively underwent both a percutaneous bone biopsy and an ulcer bed biopsy. They were randomized one to one to receive six weeks of targeted antibiotic therapy based on either biopsy culture. The primary outcome was remission at 12 months, defined as healing without recurrent infection requiring additional antibiotics or surgery after the initial six-week treatment course. Remission occurred in 31% of patients assigned to bone–biopsy-guided therapy and 39% assigned to ulcer-bed–biopsy-guided therapy, a difference that was not statistically significant. Notably, these remission rates were substantially lower than what the authors had anticipated when designing the trial (80% versus 50% in the bone and ulcer groups, respectively). Several descriptive findings were arguably more clinically informative than the primary outcome: Bone biopsy cultures were frequently negative (40%), necessitating unblinding of the ulcer bed biopsy to guide treatment. Microbiologic discordance frequently did not translate to therapeutic discordance. In 86% of patients, the prescribed antibiotic regimen provided adequate coverage for organisms recovered from both biopsies. Among the patients whose prescribed antibiotics did not cover every organism recovered from both biopsies, nearly half nevertheless achieved remission.

BOTTOM LINE: Routine percutaneous bone biopsy was not shown to be dramatically superior to ulcer bed biopsy, although unexpectedly low remission rates limit the ability to exclude smaller yet potentially meaningful differences. Bone biopsy appears to change microbiologic diagnosis more often than it changes antibiotic

selection, suggesting that its routine clinical impact may be smaller than often assumed.

CITATION: Lagrand RS, et al. Bone biopsy not superior to ulcer bed biopsy-guided antibacterial therapy on remission of diabetic foot osteomyelitis: a randomized controlled trial. *Clin Infect Dis*. 2026;82(3):436-442. doi: 10.1093/cid/ciaf684.

Dr. Hwang is a clinical associate professor at NYU Grossman School of Medicine and a hospitalist at NYC Health + Hospitals/Bellevue, both in New York.

By Lauren Heery, MD

3 Reduction in Clinical Reasoning Accuracy in AI-Trained Physicians Provided with Erroneous LLM-Generated Recommendations

CLINICAL QUESTION: In physicians with training on AI literacy, is clinical reasoning impaired by reliance on large language model (LLM)-generated content?

Dr. Heery

BACKGROUND: While some studies have shown improvement in clinical reasoning with use of accurate LLM content, the impact on physicians' clinical reasoning when provided erroneous LLM-generated content is unknown.

STUDY DESIGN: Single-blinded, randomized, controlled trial

SETTING: University-based research setting in Lahore, Pakistan

SYNOPSIS: 44 physicians who completed a 20-hour course on AI literacy were randomized to two groups that reviewed six case vignettes. Both groups received the option to review ChatGPT-4$_o$ generated recommendations, with the control group receiving error-free diagnostic recommendations and the study group receiving standardized, flawed recommendations in three of six cases. Participants were graded by three blinded raters on their top three differential diagnoses, top diagnosis, and recommended next steps in diagnosis, using a standardized rubric. The primary outcome measured mean diagnostic reasoning, for which the control group achieved 84.9%, and the study group achieved 73.3% (95% CI, −18.9 to −9.1; P <0.0001). Subgroup analysis was notable for greater drops in reasoning accuracy in physicians with more clinical experience. These findings were attributed to physicians' susceptibility to automation bias when interacting with LLM outputs. Limitations included evaluation of a single LLM, unknown applicability of intentional errors compared with real-world LLM errors, lack of assessment of the AI literacy course, and unclear impact on clinical care, particularly with the limited complexity provided by case vignettes.

BOTTOM LINE: Physicians are susceptible to automation bias in diagnostic reasoning when using AI-generated outputs, even when trained to be critical of AI outputs.

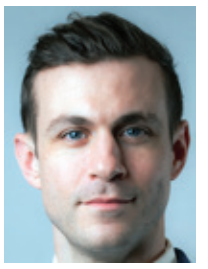
CITATION: Qazi IA, et al. Automation bias in large language model–assisted diagnostic reasoning among physicians trained in AI literacy — a randomized clinical trial. *NEJM AI*. 2026;3(5). doi:10.1056/AIoa2501001.

Dr. Heery is a hospitalist at NYU Langone's Tisch Hospital and a clinical assistant professor at NYU Grossman School of Medicine, both in New York.

By Knox Kelly, MD, MS

4 Faster Sodium Correction Associated with Lower 90-Day Mortality and Delayed Neurologic Events in a Large Community-Based Cohort, Challenging Current Guideline Targets

CLINICAL QUESTION: Among adults hospitalized with severe hyponatremia (serum sodium ≤120 mEq/L), does the rate of 24-hour sodium correction affect the composite risk of 90-day death or delayed neurologic events?


Dr. Kelly

BACKGROUND: Guidelines recommend correcting severe hyponatremia no faster than 4 to 6 mEq/L per 24 hours to prevent osmotic demyelination syndrome (ODS)—a recommendation built on case reports and animal data rather than randomized trials. ODS occurs in fewer than 0.5% of patients, yet slower correction has been independently linked to higher mortality in several retrospective studies, including a 3,274-patient analysis at two academic centers and a 2025 meta-analysis. Whether this mortality signal reflects a true causal harm from slow correction—or confounding by illness severity, since sicker patients correct more slowly—has remained unanswered. Equally unresolved is whether faster correction increases broader neurologic harm beyond ODS itself.

STUDY DESIGN: Retrospective cohort study

SETTING: Twenty-one community hospitals within Kaiser Permanente Northern California

SYNOPSIS: Over 16 years, 13,988 adults admitted with serum sodium ≤120 mEq/L were categorized by maximum 24-hour correction: slow (under 8 mEq/L, 43%), medium (8 to 12 mEq/L, 26%), or fast (over 12 mEq/L, 18%). Median age was 74 years (63% female); comorbidities included congestive heart failure (24%), liver disease (18%), and alcohol dependence (14%). The primary outcome of 90-day death or delayed neurologic event occurred in 21%, driven predominantly by mortality (18%). Compared to slow correction, both medium (risk difference, −5.6 percentage points; 95% CI, −7.1 to −4.0) and fast (risk difference, −9.0 percentage points; CI, −11.1 to −6.9) correction were associated with lower risk, with no significant attenuation of benefit observed even among patients with classic ODS risk factors, including liver disease, malnutrition, hypokalemia, and alcohol use disorder. Coded demyelinating disease was rare (19 cases), though ODS is likely underdiagnosed given its variable presentation. An exploratory analysis suggested the lowest predicted risk at correction rates of 15–20 mEq/L per 24 hours. Limitations include residual confounding and outcomes identified by billing codes rather than chart review.

BOTTOM LINE: In this large retrospective cohort, both medium and fast 24-hour sodium correction were associated with lower 90-day mortality and fewer delayed neurologic events compared to slow correction, with no subgroup showing benefit from slower rates—findings that challenge the basis for current guideline targets and support reconsideration of recommended correction thresholds.

CITATION: Mark DG, et al. Sodium correction rates and associated outcomes among patients with severe hyponatremia: a retrospective cohort study. *Ann Intern Med*. 2026;179(3):330-339. doi: 10.7326/ANNALS-25-03676.

Dr. Kelly is a hospitalist and unit medical director at NYU Langone Hospital-Brooklyn in New York.

By Ian Larson, MD

5 Lower Bleeding Risk with Apixaban Versus Rivaroxaban for Acute VTE Treatment

CLINICAL QUESTION: Is there any significant difference in bleeding risk between apixaban and rivaroxaban when used to treat acute venous thromboembolism (VTE)?

Dr. Larson

BACKGROUND: Acute VTE is a highly prevalent condition. Nearly all patients with new VTE will require a minimum of 90 days of anticoagulation. There have been no previous trials that compare apixaban and rivaroxaban head-to-head concerning bleeding risk when used to treat acute VTE.

STUDY DESIGN: International, prospective, randomized, open-label, blind endpoint study

SETTING: 32 medical centers in Canada, Australia, and Ireland

SYNOPSIS: 2,760 patients 18 years or older with symptomatic acute VTE were randomized to receive either apixaban or rivaroxaban for three months. Over the course of the three-month trial period, 44 of 1,345 patients (3.3%) in the apixaban arm and 96 of 1,355 patients (7.1%) in the rivaroxaban arm experienced the primary outcome of clinically relevant bleeding, represented by a composite of major bleeding or clinically significant nonmajor bleeding as defined by the International Society on Thrombosis and Haemostasis. There were no significant differences in non-bleeding-related adverse events between the apixaban arm (2.7%) and the rivaroxaban arm (2.2%). Limitations include the possibility of ascertainment bias given the open-label nature of the study, and the lack of data regarding bleeding beyond the initial 90-day treatment period for those requiring longer treatment durations. Outcomes from this study cannot be applied to patients with other indications for direct oral anticoagulant use. A similar trial for patients with atrial fibrillation is ongoing at the time of publication.

BOTTOM LINE: For patients with acute VTE, apixaban is associated with decreased risk of clinically relevant bleeding in the first 90 days of treatment.

CITATION: Castellucci LA, et al. Bleeding risk with apixaban vs. rivaroxaban in acute venous thromboembolism. *N Engl J Med*. 2026;394(11):1051-1060. doi: 10.1056/NEJMoa2510703.

Dr. Larson is a hospitalist in the division of hospital medicine at NYU Langone's Tisch Hospital and Kimmel Pavilion and medical director for Unit 14 West at Tisch Hospital, all in New York.

By Pooja Patel, MD

6 Initial Vancomycin Taper for the Prevention of Recurrent *Clostridioides Difficile* Infection

CLINICAL QUESTION: Is a four-week vancomycin pulse-and-taper regimen superior to the standard two-week vancomycin pulse regimen

in terms of preventing recurrent *Clostridioides difficile* infection (rCDI)?

Dr. Patel

BACKGROUND: *Clostridioides difficile* infection (CDI) is seen in more than 450,000 cases in the U.S. and more than 37,000 cases in Canada annually. This accounts for an annual combined cost of $5 billion, with an additional $2.8 billion in the U.S. alone from the morbidity and mortality of recurrent CDI (rCDI). This study was proposed with recognition that fidaxomicin is not universally available and is more expensive than vancomycin. Despite the availability of fidaxomicin in the last 10 to 15 years, a recent international survey found that more than 66% of clinicians still use vancomycin for the initial treatment of CDI. This study sought to compare a four-week vancomycin pulse-and-taper regimen with the standard two-week vancomycin pulse regimen for prevention of rCDI.

STUDY DESIGN: Parallel-design, double-blinded, clinical trial

SETTING: 12 Canadian hospitals

SYNOPSIS: This trial followed 265 patients between 2020 and 2024 who were 18 years or older with a first episode or first recurrence of CDI. CDI was defined as three or more episodes of diarrhea in 24 hours with a positive test (nucleic acid amplification test, toxin immunoassay, or cell cytotoxin assay) or a positive test with ileus, pseudomembranous colitis, or toxic megacolon. All patients were given vancomycin pulse treatment for 14 days. On day 15, they were randomized to 125 mg vancomycin or placebo twice daily for seven days, then daily for seven days. The primary outcome was rCDI on days 15 and 56. In the study group, 14.8% had recurrence, versus 17.7% in the placebo group (adjusted risk ratio, 0.84; 95% CI, 0.48 to 1.45). On the Kaplan-Meier curve, there was an observed reduction in the probability of superiority from 99.0% on day 38 to 73.4% on day 56, which suggests that some recurrences were delayed as opposed to prevented. A major limitation is that the trial was stopped early due to the infeasibility of recruitment once the CDI guidelines in Quebec repositioned fidaxomicin as first-line therapy for high-risk patients.

BOTTOM LINE: A four-week vancomycin pulse-and-taper regimen had a 73.8% probability of being superior to the standard two-week pulse regimen. This may provide safe and accessible treatment options to delay or prevent early rCDI where fidaxomicin is not available or adopted as first-line therapy.

CITATION: McDonald EG, et al. Initial vancomycin taper for the prevention of recurrent *Clostridioides difficile* infection: a randomized clinical trial. *JAMA Netw Open*. 2026;9(2):e2560495. doi: 10.1001/jamanetworkopen.2025.60495.

Dr. Patel is a hospitalist at NYU Langone's Tisch Hospital and a clinical assistant professor at NYU Grossman School of Medicine, both in New York.

By Nadine Vidor, MD

7 Empirical Antifungal Therapy Improves Survival in Patients with ACLF at High Risk for Invasive Fungal Infections

CLINICAL QUESTION: Does early empirical antifungal therapy improve survival compared with diagnostic- or biomarker-driven pre-emptive therapy in hospitalized patients with acute-on-chronic liver failure (ACLF) at high risk for invasive fungal infections (IFIs)?

Dr. Vidor

BACKGROUND: IFIs are a major cause of morbidity, mortality, and liver transplant delisting in patients with ACLF. Early diagnosis is challenging because clinical manifestations are nonspecific and conventional fungal cultures have limited sensitivity and prolonged turnaround times. Although current international guidelines recommend empirical antifungal therapy for selected high-risk patients, these recommendations are based largely on expert opinion and observational data, and the optimal timing of antifungal therapy has remained uncertain.

STUDY DESIGN: Pragmatic, prospective, parallel-group, randomized, controlled trial with blinded endpoint adjudication

SETTING: Departments of hepatology of the Postgraduate Institute of Medical Education and Research (PGIMER) in Chandigarh, and Amrita Institute of Medical Sciences in Kochi, both in India

SYNOPSIS: This randomized clinical trial enrolled 216 hospitalized adults with ACLF and predefined host and clinical risk factors for IFIs. Patients were randomized one to one to receive either empirical antifungal therapy at enrollment or diagnostic- or biomarker-driven pre-emptive therapy, initiated only after laboratory, radiologic, or mycologic confirmation. Both groups followed structured biomarker- and culture-guided antifungal stewardship protocols. The primary endpoint was 28-day overall survival. Empirical therapy significantly improved 28-day survival compared with the pre-emptive strategy (35% versus 13%; HR [hazard ratio], 0.64; 95% CI, 0.47 to 0.88; *P*=0.005), corresponding to an approximate number needed to treat of five. Patients receiving empirical therapy also demonstrated higher treatment success (37.4% versus 16.9%), greater IFI resolution (45.8% versus 22.5%), lower in-hospital and IFI-attributable mortality, fewer serious adverse events, reduced ventilator dependence, greater quality-adjusted life-year gains, and favorable cost-effectiveness. Exploratory causal-tree analysis suggested the greatest survival benefit occurred among patients more than 40 years old with cardiovascular failure but without respiratory failure. Limitations include the single-center, open-label design and the study being conducted in a high-IFI-burden population, which may limit generalizability to lower-prevalence settings despite blinded outcome assessment.

BOTTOM LINE: In hospitalized patients with ACLF at high risk for invasive fungal infections, early empirical antifungal therapy within a structured stewardship framework significantly improves survival and other clinically meaningful outcomes compared with a diagnostic- or biomarker-driven pre-emptive strategy.

CITATION: Verma N, et al. Empirical antifungal therapy improves survival in patients with acute-on-chronic liver failure with suspected invasive fungal infections: a pragmatic randomized trial. *Am J Gastroenterol*. 2026;121(9):2198-2210. doi: 10.14309/ajg.0000000000003832.

Dr. Vidor is an attending physician in the department of medicine at Bellevue Hospital and a clinical assistant professor of medicine at NYU Grossman School of Medicine, both in New York.

By Emily Zhou, MD

8 Invasive Versus Conservative Strategy for Frail Older Patients with Myocardial Infarction: A Secondary Analysis of the SENIOR-RITA Randomized Clinical Trial

CLINICAL QUESTION: Among frail older adults with non-ST-elevation myocardial infarction (NSTEMI), is there a reduction in risk of cardiovascular death or nonfatal myocardial infarction when choosing an invasive strategy over a conservative strategy?

Dr. Zhou

BACKGROUND: Frailty is a geriatric syndrome characterized by a state of diminished physiologic reserve and increased vulnerability to poor health outcomes from various stressors, such as acute coronary syndrome (ACS). In frail older adults with ACS, frailty can be associated with more complex coronary disease, negative prognosis, longer hospital stays, decreased utilization of standard therapies, increased all-cause mortality, and other neurological or cardiovascular comorbidities. As the global population is aging, frailty has increasing significance in clinical work.

STUDY DESIGN: Subgroup analysis of a randomized clinical trial, utilizing Fried frailty criteria

SETTING: 48 National Health Service trusts in England and Scotland

SYNOPSIS: Frailty data were available for 1,446 of the 1,518 randomized patients. The 469 frail patients, all 75 years and older, were randomized in the study to compare invasive management with coronary angiography (231 patients) versus medical management with goal-directed medical therapies (238 patients), and the study examined the primary outcomes of time to cardiovascular death or nonfatal myocardial infarction. Among frail older adults with NSTEMI, an invasive approach was not associated with a statistically significant reduction in the primary outcomes and was more likely associated with increased adverse events with angiography, especially when compared to prefrail and robust patients.

BOTTOM LINE: Frailty assessments should be considered in clinical decision making for older adults with NSTEMI. In frail older adults with NSTEMI, an invasive intervention provided no benefit over conservative management and may be linked to worse outcomes at high levels of frailty. It is important to apply personalized approaches and utilize shared decision making in discussions with older adult patients and the care team.

CITATION: Rubino F, et al. Invasive vs conservative strategy for frail older patients with myocardial infarction: a secondary analysis of the SENIOR-RITA randomized clinical trial. *JAMA Netw Open*. 2026;9(4):e267316. doi: 10.1001/jamanetworkopen.2026.7316.

Dr. Zhou is a hospitalist in the division of hospital medicine and an inpatient geriatrics consultant in the division of geriatrics at NYU Langone Medical Center, and a clinical assistant professor of medicine at NYU Grossman School of Medicine, both in New York. ■

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Are Technology-Generated Notes Good for Patient Care?

By Ethan Molitch-Hou, MD, MPH, SFHM, Leah Reid, MD, MSHI, FACP, FHM, and Christopher Migliore, MD, MS, FHM, FACP

FLIPSIDE

Flipside, we examine the arguments for and against AI-assisted medical documentation.

Dr. Molitch-Hou

Dr. Reid

Dr. Migliore

Dr. Molitch-Hou is an 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. Reid is a hospitalist at the Medical University of South Carolina in Charleston, S.C. 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 and a medicine attending physician at Columbia University Medical Center, both in New York.

The primary purpose of medical documentation is to improve clinical outcomes by facilitating effective communication between healthcare practitioners, patients, and care teams. Over time, clinical documentation has taken on important roles in billing and reimbursement, clinical research, quality improvement, population health, and healthcare data analytics.[1] The adoption of electronic health records (EHRs) has transformed note writing beyond the traditional hardware of a computer and keyboard to laptops, smartphones, and tablets equipped with software and mobile applications that support documentation across diverse clinical settings.[2] More recently, advances in artificial intelligence (AI) have introduced a new generation of technology-assisted documentation, including AI scribes, AI-generated chart summaries, and automated hospital course narratives.[3] In this

20 Minutes I Used to Spend Typing, I Now Spend at the Bedside

I'm on my admitting shift for the hospital, and I was recently trained on my system's new ambient AI scribe tool. The last discharge summary for a patient I'm admitting contained an AI-summarized hospital course, which let me reconstruct the prior admission in two minutes instead of clicking through a dozen notes. After obtaining the patient's consent to use the AI scribe, I can sit face-to-face, make eye contact, and focus on listening. Those moments were often lost when EHRs were first introduced, as I spent more time clicking and typing than truly listening while my patient spoke. The ambient scribe takes our conversation and distills it into a note. Knowing that the AI scribe can document my plan, lab work, and physical exam if it hears me discuss it, I communicate more about these items to my patient in a direct and explicit manner to ensure it is captured accurately in the AI-generated note. This has made me more thorough in my communication with my patient as I'm not scrambling to begin documenting the encounter. The AI scribe even identifies recommended orders for my review and signature. This time saved on busy work lets me spend more time on direct patient care.

EHR templates have become routine and help guide documentation for billing purposes. Our institution has automated documentation functionality that reduces coding queries, which saves time on the back end. If someone

is treated for hypokalemia, a dietician diagnoses someone with severe malnutrition, or a patient has acute anemia, an embedded smart phrase will document that for us.[4] Billing and coding queries were not the reason I chose to go to medical school, and now I don't worry about capturing some of the more minor diagnoses in clinical care. AI-powered clinical-decision-support tools help ensure I don't overlook an important diagnosis. While reviewing the laboratory results, I initially overlooked how much lower the platelet count was compared with the previous admission. Although it had not yet reached clinical significance, the embedded clinical decision support tools highlighted the trend and prompted me to investigate further. An AI-generated summary also identified a remote episode of thrombocytopenia after a recently prescribed outpatient antibiotic—information I might otherwise have overlooked.

Used thoughtfully, AI has reduced my documentation burden and given me more time to focus on what drew me to medicine in the first place: caring for patients.

It's Not Just Copy and Paste That's Making Our Notes Unreadable

I'm on my admitting shift for the hospital, and I'm reviewing my patient's last history and physical (H&P), progress notes, and discharge to get a sense of why the patient was re-presenting so quickly after discharge. The discharge summary had an AI-generated hospital course, and the last H&P was generated with our ambient AI scribe tool. The history of presenting illness feels much longer than usual. The AI scribe transformed my colleague's conversation into a history of present illness (HPI), but it also added unnecessary—and apparently unedited—information. There is conflicting information about the patient's heart failure regimen. In reviewing the free text of the assessment and plan that my colleague wrote themselves, it discusses missing medications; however, this conversation must have been misinterpreted by the AI, as it created a line that states "the patient is managing his heart failure very well" in the same sentence as the "missed torsemide doses."

The H&P has further errors as I scroll. Many H&P templates were initially designed to capture the elements of billing requirements with an extended HPI, a 10-point review of systems, and a completed past medical, family, and social history. A good, detailed H&P remains a key ingredient to ensure great patient care. However, the output is only as good as what goes into it. History elements that change infrequently often remain incomplete because they fall outside the clinical workflow, leaving templated fields that simply state, "no history noted."

The EHR captures so much information that when the elements are not curated, poorly performed medication reconciliation leaves outdated medications in the chart while omitting current therapies. The AI-generated hospital course pulled in an incorrect diagnosis of lymphoma that, upon further review, had been ruled out at the last admission, creating additional "chart lore."

While our templates and AI-generated notes do represent significant innovation, their improper use has hampered documentation, bloating the chart and individual notes to a degree I think we all recognize as unwieldy at best and dangerous at worst. At present, these technologies have not matured to the point where they can be used safely without diligent clinician oversight. While I acknowledge the benefits (they can be helpful), they are not ready for prime time and may be treated as such when clinicians get busy.

Table 1. Benefits and Challenges of AI-Assisted Clinical Documentation

BENEFITS	CHALLENGES	KEY QUESTION
Documentation efficiency	Accuracy and hallucinations	Can AI improve efficiency without sacrificing quality?
Reduced burnout	Clinician oversight	Who is responsible for AI-generated notes?
Improved workflow	Loss of clinical reasoning	Does AI augment or replace physician thinking?
Better patient interaction	Note bloat	Will notes become more or less useful?
Coding support	Medicolegal liability	Can documentation remain compliant?
Improved interoperability	Bias and governance	How should AI be implemented responsibly?

Discussion

Rapid technological innovation has transformed nearly every aspect of healthcare, and medical documentation is no exception. The EHR facilitates multidisciplinary care by allowing simultaneous access to the patient's medical record, enhancing communication among clinicians, and improving clinical outcomes. As patients increasingly receive care across multiple healthcare systems, the accurate, timely, and secure exchange of health information has become essential to maintaining continuity of care.[1] Yet differences in EHR platforms, documentation practices, and data standards continue to challenge seamless interoperability (note sharing) across the healthcare ecosystem.

Hospitalists are caring for increasingly complex patients while simultaneously meeting expanding documentation, quality, and regulatory requirements. These competing demands have fueled interest in technologies that can reduce documentation burden and improve workflow efficiency. AI represents the next stage in the evolution of clinical documentation. Unlike earlier advances that primarily digitized or standardized documentation, AI has the potential to actively assist in note creation. Ambient AI scribes, automated chart summarization, intelligent hospital course generation, and other EHR-integrated tools promise to streamline documentation while allowing clinicians to devote more attention to patient care. At the same time, these technologies raise important questions regarding accuracy, clinician oversight, accountability, bias, and the preservation of clinical reasoning within the medical record. As AI becomes increasingly embedded in documentation workflows, the conversation has shifted beyond note templates and note bloat toward how these tools can be implemented safely while preserving the integrity of the patient's record.

Physicians now devote more time to the EHR than to face-to-face patient care, and documentation burden has become a significant contributor to burnout, diminished job satisfaction, and clinician turnover. Early evidence suggests that AI-assisted documentation may help address these challenges. In a quality-improvement study of 263 clinicians across six health systems, 30 days of ambient AI scribe use was associated with a reduction in ambulatory burnout from 51.9% to 38.8%, along with improvements in cognitive workload, after-hours documentation time, and clinicians' ability to focus on patients.[5] Similarly, a study of more than 1,400 clinicians at Mass General Brigham and Emory, published in *JAMA Network Open*, demonstrated a 21.2% absolute reduction in burnout prevalence at Mass General Brigham and a 30.7% absolute increase in documentation-related well-being at Emory.[6] In addition, The Permanente Medical Group reported more than 2.5 million ambient AI scribe encounters in a single year, estimating that thousands of physician-hours were redirected from documentation to patient care.

While these findings highlight the promise of AI-assisted documentation, they represent only one side of the debate. Table 1 summarizes the principal benefits and challenges associated with AI-assisted clinical documentation and frames the issues explored in this Flipside article.

Perhaps the greatest concern surrounding AI-assisted documentation is not whether it saves time, but whether it produces notes that clinicians can trust. Documentation quality is not solely determined by who—or what—writes the note. Long before the emergence of AI-assisted documentation, handwritten notes, transcription errors, copy-forward practices, and incomplete medication reconciliation contributed to inaccuracies in the medical record. AI introduces new opportunities for error, including hallucinations and the propagation of outdated information, but it also has the potential to identify inconsistencies, synthesize complex hospitalizations, and improve the organization of clinical information. The question is not whether AI makes mistakes; rather, it is whether AI-assisted workflows can produce documentation that is ultimately more accurate and clinically useful than current practice.

The shared perspective earlier about torsemide dosing error is real, but a misremembered medication in a handwritten or traditionally dictated note was never inherently less likely; it was simply less legible. Neither problem originated with the technology, and both are more visible and more readily corrected than they were in the era of hand-typed, copy-forwarded notes that buried the same errors under far more text.

Critics of AI-assisted documentation argue that automation may perpetuate existing documentation problems rather than solve them. Studies have reported medication discrepancies in a substantial proportion of discharge summaries for older adults, as well as frequent inclusion of missing, inaccurate, or clinically irrelevant information—the very "chart lore" and note bloat that clinicians have long sought to eliminate. However, emerging evidence suggests that AI-generated documentation may perform at least as well as traditional approaches when used with appropriate clinician oversight. In a cross-sectional study pub-

lished in *JAMA Internal Medicine*, investigators at the University of California, San Francisco found that large language model-generated discharge summaries were of comparable overall quality to physician-authored summaries and were suitable as drafts for clinician review.[7] More recently, a pragmatic, randomized trial published in *NEJM AI* involving 238 outpatient physicians found that use of an ambient AI scribe reduced documentation time by 9.5% compared with usual care, while both ambient documentation tools evaluated produced modest improvements in burnout and work exhaustion.[8] These findings suggest that AI-assisted documentation can improve efficiency without compromising documentation quality, provided physicians remain actively engaged in reviewing and validating the final note.

Ultimately, the role of AI is to augment—not replace—physician judgment. Although AI can efficiently summarize clinical data and assist with documentation, it cannot replace the physician's clinical reasoning. The value of a hospital note lies not only in documenting what happened, but in communicating why clinical decisions were made. Preserving the physician's assessment, diagnostic reasoning, and medical decision-making therefore remains essential, particularly for handoffs, consultant communication, quality review, and trainee education.[2]

As AI becomes increasingly integrated into hospital medicine, the focus should shift from whether these tools will be adopted to how they can be implemented responsibly. Although AI-assisted documentation offers tremendous promise, clinicians must resist the temptation to become overly reliant on these technologies. Today, AI is primarily being used to assist with documentation, but its role is rapidly expanding to include diagnostic support, clinical decision-making, and treatment recommendations. As trainees enter practice in AI-enabled environments, developing the skills to critically evaluate AI-generated output will become as important as learning to write a high-quality clinical note.

The growing adoption of AI should not prompt a retreat from innovation, but rather a commitment to responsible implementation. Healthcare organizations, informatics leaders, and clinicians should establish governance frameworks that include routine auditing of AI-generated documentation, physician review and attestation, and ongoing monitoring for accuracy, bias, and unintended consequences. Without thoughtful oversight, we risk creating the "Godzilla version" of today's documentation challenges—amplifying note bloat, inaccuracies, and automation bias on a larger scale. With appropriate governance, however, AI has the potential to reduce these problems rather than magnify them.

AI should be judged not against an unrealistic standard of perfection, but against the documentation practices it seeks to improve. While AI-generated notes are not immune to inaccuracies or hallucinations, accumulating evidence suggests that, when paired with thoughtful physician oversight, these tools can improve efficiency, reduce clinician burden, and preserve more meaningful patient interactions without compromising documentation quality. AI should not be held to a standard of perfection that human documentation has never achieved—it should be expected to make documentation safer, more efficient, and more useful than the systems it replaces. The challenge for hospitalists is therefore not whether to embrace AI-assisted documentation, but how to integrate it responsibly while preserving the clinical reasoning, accountability, and trust that remain at the heart of the medical record. ■

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What Do IMGs Need to Know About Being a Hospitalist in the U.S.?

Culture adjustments balance with the needs of a complex healthcare system

By Vanessa Caceres

International medical graduates (IMGs) play a prominent role in hospital medicine and the U.S. healthcare system as a whole, yet they often encounter culture shocks as they adjust.

That includes getting used to more direct communication with patients and their families, taking part in multidisciplinary decision making with colleagues, and navigating a healthcare system that is often different from the one in their home country.

Yet despite these adjustments, many see the value in having more IMGs within the U.S. health system.

"We all bring different cultures, perspectives, experiences, and ways of contributing to medicine. I believe the U.S. healthcare system is richer because of that diversity," said Agostina Velo, MD, a hospitalist at Beth Israel Deaconess Hospital and an instructor in medicine at Harvard Medical School, both in Boston.

Dr. Velo

"As the U.S. anticipates a growing physician shortage in the coming years, I believe it is increasingly important to understand and address the unique needs of IMGs and provide them with the support they need to successfully transition into practice and fully contribute to the healthcare workforce," said M. Carolina Musri, MD, an assistant professor of medicine at Johns Hopkins School of Medicine, a hospitalist with the Johns Hopkins collaborative internal medicine service, assistant director of the faculty development program at Johns Hopkins Bayview Medical Center, all in Baltimore, and a digital media editorial fellow at the *Journal of Hospital Medicine*.

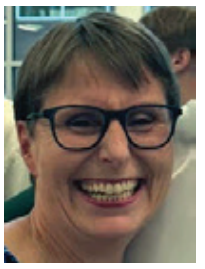
Dr. Musri

That enrichment is balanced with the challenges—and hope—that come from working abroad.

"International medical graduates decide to leave their home countries with the hope of building a good life, developing a fulfilling career, and growing personally and professionally," Dr. Velo said. "Starting over in another country can sometimes be incredibly challenging. We love our home countries, and often the decision to leave is not about what we are leaving behind, but rather about what we hope to build for our future."

Adapting to a Different Model of Hospital Medicine

Angelika Koch-Leibmann, MD, FACP, ACPA-C, FHM, adult internal medicine hospitalist and medical director for care management at EvergreenHealth in Kirkland, Wash., came from Germany to the U.S. in 2001 and began her residency in 2005 at the University of Washington Medical Center in Seattle.


Dr. Koch-Leibmann

One major surprise for Dr. Koch-Leibmann was the fact that hospital medicine was a newer specialty at the time.

"In Germany, the distinction between inpatient and outpatient care was well-established, but there was no equivalent to the U.S. hospitalist model as a distinct specialty," she said.

She said it also was interesting to see how quickly the specialty evolved and continues to evolve.

Dr. Koch-Leibmann observed many other differences compared to Germany, one of which is the stronger, more integrated role that case managers and discharge planners have in the U.S. For instance, patients in the U.S. can be discharged directly to a skilled nursing facility.

"In Germany, patients sometimes had to go home first before they could start rehabilitation, which could make the transition more difficult," she said.

Dr. Koch-Leibmann also has observed more emphasis and value placed on medical education in the U.S., perhaps because of the higher cost of that education in the U.S. versus Germany.

During her intern year, it took some time to get used to a different attending and senior resident about every two weeks.

"In Germany, I was accustomed to working within a much more stable team structure and developing longer-term relationships with the physicians supervising me," she explained. "The frequent changes in the U.S. system required me to adapt to different personalities, expectations, and teaching styles."

Today, Dr. Koch-Leibmann's current roles as a medical director and physician advisor have led her to observe a much more complicated payer system in the U.S. that creates more administrative work and ultimately adds to healthcare costs with the need for nurse case managers, denial management teams, and other resources.

She also observes more patient and family autonomy in the U.S.

"In Germany, we rarely asked about code status, and we generally only had extensive goals-of-care discussions in very complicated cases," she said. "Since practicing in the U.S., I spend much more time talking with patients and their families. I also spend significantly more time documenting these discussions and the medical decision making involved."

Although detailed documentation is important, Dr. Koch-Leibmann believes some of it is driven

by defensive medicine and the fear of potential legal consequences.

Dr. Koch-Leibmann would like to see more attention given to the immigration status issue in the U.S., which adds much stress and cost on top of an already demanding job.

Dr. Velo is originally from Argentina and has worked in the U.S. since 2023, first in New York City and now in Boston.

In her home country, hospital medicine is not as clearly separated from primary care or outpatient internal medicine. In Argentina, most internists work in the hospital and have outpatient clinics in the afternoon or evening.

Physicians in her native country tend to have a more direct role in discharge planning and disposition compared with the U.S., and case management is not usually a separate, formal entity the way it is in many U.S. hospitals.

"In my home country, shared decision making is also part of clinical practice, although there may be greater reliance on physician guidance in some settings. I think these differences reflect, in part, varying cultural expectations around the physician-patient relationship. Adapting to those expectations and learning how to communicate in a way that feels natural and appropriate to each patient was an important part of my transition," Dr. Velo said.

Another aspect Dr. Velo noticed was the language used around routine physical examinations, with permission often communicated more implicitly within the clinical encounter in Argentina. "It's a subtle difference, but one that helped me appreciate how cultural expectations can shape even routine aspects of the physician-patient interaction," she explained.

Some of the differences in work dynamics pleasantly surprised her during her clinical internship, about a year before starting her residency application. That included when a senior attending complimented a sub-intern on a presentation during morning rounds. "It was a small interaction, but it gave me an early sense of the teaching culture at that institution," she said.

Dr. Yu

Amy Yu, MD, MS, creator of SHM's IMG Special Interest Group and IMG observership program and assistant professor of medicine at Johns Hopkins University School of Medicine in Baltimore, is originally from China and completed medical school in the Caribbean. She has worked as a physician in the U.S. since 2020.

One major surprise for Dr. Yu was how much hospital medicine occurs beyond making a diagnosis and choosing a treatment.

"As an IMG, medical school prepares you extensively for the clinical aspects of medicine, but the U.S. hospitalist is also at the center of a very complex healthcare system … For many IMGs, the medical knowledge transfers relatively well. Learning the healthcare system around the medicine can be the more significant transition," she observed.

This is why IMGs must develop systems awareness that captures not only the medical decision but also how the decision moves through the larger healthcare system and affects what happens next for the patient.

Patient and family communication was another big adjustment for Dr. Yu, just as other IMGs have expressed.

"There's a strong emphasis on shared decision making, explaining uncertainty, discussing alternatives, and making sure patients understand and participate in the plan," she said.

That ties back into communication—not just speaking the language well but understanding culture.

"It is learning how patients, families, nurses, consultants, and other team members expect information to be communicated, how disagreement is handled, and how decisions are shared. These norms often become much clearer through observation and experience than through formal instruction," she said.

Because of these adjustments, Dr. Yu sees many benefits from exposing IMGs early on to the clinical experience, ideally in both patient and outpatient settings. This should be more than passive shadowing and should include patient communication and seeing how nurses and physicians collaborate and how multidisciplinary rounds are done, among other steps of the hospital medicine process.

"This perspective has shaped my own work in IMG education and our efforts to develop a more structured, competency-based approach to hospital medicine observerships," she said.

Navigating Multidisciplinary Approach

Mikaela Kcomt Lam, MD, an internal medicine PGY-3 resident at Eastern Virginia Medical School at Old Dominion University in Norfolk, Va., is originally from Peru and has been in the U.S. more than two years.

The multidisciplinary approach of care in the U.S. and the comprehensive approach to discharge planning were both surprising for Dr. Kcomt.

Dr. Kcomt

"A significant part of our responsibility is coordinating safe and appropriate discharge planning, ensuring that patients have the necessary medications, follow-up appointments, and support in place before they leave the hospital," she said.

In the U.S., clinicians consider a patient's functional status, decision-making capacity, social support, medication needs, and their ability to safely manage care outside of the hospital and then determine which setting may best suit the patient, such as home health or a skilled nursing facility.

In the system where Dr. Kcomt originally trained, most patients were discharged directly home, and there was much less involvement from a multidisciplinary team.

Another adjustment within the U.S. has been speaking directly with families and patients during goals-of-care discussions.

"As IMGs, we spend years focusing on developing our medical knowledge and clinical skills, but we don't always receive the same formal training in communication. I've learned that being able to communicate clearly and compassionately is just as important as having the medical knowledge to guide the discussion," Dr. Kcomt explained.

Despite many qualified IMGs available who can practice hospital medicine, Dr. Kcomt observes that immigration requirements restrict some of them from working at certain hospitals. This may lead them to consider positions in more rural or underserved areas or positions with heavier workloads because those institutions are more likely to offer visa sponsorship.

Bridges to Practice

Dr. Musri came to the U.S. from Argentina six years ago. One surprise for her was that working as a hospitalist was an actual career choice that you make, as that is not an option in many other countries.

She was also surprised by the structure of the schedule, which typically involves one or two weeks of clinical service followed by a week or two of non-clinical work, such as scholarly activities, leadership, and administrative responsibilities.

Taking part in a clinical observership gave Dr. Musri valuable

Advice for IMGs from IMGs

Learning the ins and outs of a new job can be challenging, but add on learning a new country, culture, and possibly language, and you could get overwhelmed. Drs. Koch-Leibmann, Kcomt, Musri, Singh, Velo, and Yu offer advice for fellow international medical graduates, but their words of wisdom could apply to all.

- Consider joining the Society of Hospital Medicine and the American College of Physicians. Attend their national or chapter meetings to network and discover new opportunities.
- Be respectful and communicate well with colleagues, consultants, nurses, and ancillary staff. Show them your enthusiasm for hospital medicine and medicine in general.
- Find ways to integrate yourself into the system that feel natural to you. This could include things like contributing to a journal club, signing up for committees, participating in group activities, or occasionally picking up an extra shift or trading shifts with a colleague. "These may seem like small things, but they go a long way toward building relationships, becoming part of the team, and establishing yourself within the group," Dr. Koch-Leibmann said.
- Start searching early for your first position. This allows you to give yourself time to research institutions, understand different visa pathways, and find a position that's the best fit for you.
- Network as much as you can to open doors to new opportunities.
- Look beyond salary to focus on a position that provides you with a supportive environment. "I would look closely at the patient volume, team structure, staffing, schedule, and level of physician autonomy, as well as the availability of support from specialists," Dr. Kcomt said. Ask about visa sponsorship as well.
- Reach out to current hospitalists in your desired location to ask about their experiences.
- Visit the location in person before you decide. "Your gut feeling is real," Dr. Musri said.
- Define negotiables and non-negotiables when choosing where you will practice.
- Seek out mentors and sponsors.
- Speak with hospitalists in many different niches before deciding what your first job should look like. "Hospital medicine is a multifaceted specialty with far more possibilities than the traditional 'seven-on, seven-off' model, and understanding these options early can profoundly shape a career," Dr. Singh said.
- Reflect on what matters most to you and what type of career you want to build. This may be in academic medicine, community practice, medical education, quality improvement, or administration.
- Also consider personal preferences, such as family needs, financial considerations, climate, or how easy it would be in a certain area to travel to your home country. Of course, consider visa sponsorship requirements as well. "Based on all these factors, you can identify the geographic regions that best fit your needs and, depending on how flexible or restrictive your criteria are, expand your search accordingly," Dr. Velo advised.
- Lean on fellow physicians for help. This advice may be better geared toward physicians working with IMGs, but it's good for everyone to hear. "I would encourage every physician reading this to remember the additional layers of complexity that their IMG colleagues may have had to navigate in order to work alongside them. Sometimes, simply recognizing those challenges and offering support when a colleague is navigating a difficult situation or could use a hand can make a meaningful difference," Dr. Velo said.
- Get a better understanding of the U.S. hospital system. "You cannot fully understand how U.S. medicine works by studying medicine alone. You also have to understand the system in which that medicine is delivered," Dr. Yu explained.
- Ask about the hospital's onboarding process. Inquire about mentorships, clinical support, how admissions are distributed, and whether senior colleagues are accessible when questions arise.
- Pay close attention to the culture, including the prospect of continuing to learn in your job. "A supportive environment where people are comfortable asking questions and discussing difficult cases can make a tremendous difference early in your career," Dr. Yu said. ■

insights into the U.S. healthcare system.

On the plus side, she gained a better understanding of the healthcare system, improved her clinical English communication skills, became familiar with the electronic health record (EHR), and built her professional network, all through the observership.

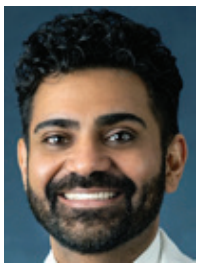
Although Dr. Musri was able to shadow the medical team as they interacted with patients and participated in discussions regarding diagnostic workups and patient management, she was not allowed to be alone in the room with a patient or perform a physical exam during the observership.

Plus, "many of these opportunities are very expensive and restrictive in terms of the level of involvement allowed," Dr. Musri said.

Dr. Musri would like IMGs to have more opportunities to network with medicine leaders, sponsors, and mentors to help build their understanding of the U.S. healthcare system and develop professionally.

"In my opinion, the U.S. is one of the best, if not the best, places in the world for medical residency training, given the quality of education, opportunities for research, and strong regulations and standards surrounding programs," she said.

Amteshwar Singh, MD, MEd, FACP, SFHM, assistant professor of medicine and director of education in the division of hospital medicine at Johns Hopkins University School of Medicine, program director for Johns Hopkins Bayview Medical Center's hospitalist fellowship program and associate program director of the Johns Hopkins Bayview Medical Center's internal medicine residency program, all in Baltimore, is originally from India and came to Baltimore for a U.S. internal medicine residency in in 2013.


Dr. Singh

One major change for Dr. Singh was the breadth of hospital medicine, which did not exist in the same way in India.

In the U.S., hospitalists may work as clinicians, educators, researchers, quality-improvement leaders, and many other roles.

"Hospitalists have expanded far beyond the traditional image of the inpatient physician and continue to push the boundaries of what the specialty can contribute to patients, health systems, and communities," he said.

Hospitalists also play an important role in working with a multidisciplinary team to plan and coordinate care.

A clinical observership helped Dr. Singh get to know the U.S. healthcare system and hospital medicine.

"Observers generally cannot independently provide clinical care, but a thoughtfully designed experience can still provide meaningful learning in clinical reasoning, communication, professionalism, health-system navigation, and interprofessional teamwork," he said.

Dr. Singh and co-authors (including Dr. Yu) recently published a proposed framework for international medical observerships, with the idea of using them as competency-based medical education so they move beyond just passive shadowing.[1]

One major adjustment within the U.S. healthcare system for Dr. Singh was recognizing that nurses, patients, families, and other members of the multidisciplinary team are equal partners who help shape care. That prompts the need to communicate across all of those partnerships.

Another area that took some getting used to was the EHR. Despite its initial challenges, Dr. Singh hopes that AI tools incorporated into EHRs can ultimately lower clinical burdens and allow for more face-to-face time with patients.

IMG hospitalists are an important part of the U.S. healthcare workforce, and their perspectives and experiences strengthen hospital medicine and patient care. Succeeding in their roles requires more than having strong clinical knowledge; it requires understanding complex healthcare systems, learning to effectively communicate with colleagues and patients, and adapting to expectations around teamwork and patient care. ■

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Can I Discontinue Anticoagulation After Atrial Fibrillation Ablation?

By Santana Sanchez, MD, Fima Macheret, MD, MS, and Amiran Baduashvili, MD

A 70-year-old woman with a history of hypertension and paroxysmal atrial fibrillation (AF), who had a successful catheter ablation one year prior, is admitted with acute gastrointestinal bleeding. She is found to have a bleeding peptic ulcer, requiring an epinephrine injection and a clip placement to achieve hemostasis. She takes apixaban 5 mg twice daily for stroke prevention. Since she has had a successful ablation, do the benefits of discontinuing anticoagulation outweigh the risks?

Brief Overview

AF is estimated to affect more than 10 million individuals in the U.S.[1] AF is associated with a marked increase in ischemic stroke and thromboembolism risk. Individualized risk stratification—usually using CHA_2DS_2-VASc score—currently guides decision making regarding oral anticoagulation for stroke prevention. Catheter ablation of AF is now the first-line treatment, with more than 50,000 procedures performed annually in the U.S. Despite its widespread use, optimal long-term anticoagulation management after successful ablation remains uncertain.[2]

The current 2023 American Heart Association/American College of Cardiology/Heart Rhythm Society (AHA/ACC/HRS) guidelines on the management of AF provide the following recommendations for anticoagulation therapy before and after catheter ablation: "In patients who have undergone catheter ablation of AF, oral anticoagulation should be continued for at least three months after the procedure with a longer duration determined by underlying risk" and "continuation of longer-term oral anticoagulation should be dictated according to the patients' stroke risk (e.g. CHA_2DS_2-VASc ≥2)."[2] These recommendations are given a Level of Evidence of B-NR, meaning that they are supported by moderate quality evidence from non-randomized, observational, or registry studies. The guidelines cite several studies, including the CABANA trial, as evidence. The CABANA trial, published in 2019, randomized patients with AF to catheter ablation or antiarrhythmic therapy. This study found no significant difference in stroke or bleeding rates between the arms, with the caveat that there was a crossover of up to a third of the patients from medication to ablation arms. Notably, patients in this trial were continued on anticoagulation if CHA_2DS_2-VASc was 2 or higher.[3]

Following the publication of the 2023 guidelines, a large retrospective observational study using data from the Japanese nationwide claims database found an association between post-ablation anticoagulation continuation and reduced risk of stroke for patients with a CHA_2DS_2-VASc of at least 3, but those with a score of 1 or less had an increased risk of bleeding without evidence for clinically meaningful protection from stroke.[4] With limited evidence and a guideline recommendation to use scores for risk stratification post-ablation, most patients with CHA_2DS_2-VASc of at least 2 remain on lifelong anticoagulation regardless of ablation outcome. High-quality data on stroke risk post-ablation in the absence of anticoagulation has previously been lacking.

Overview of Data

In 2025, two randomized controlled trials investigating the safety of anticoagulation discontinuation after AF ablation were published—the ALONE-AF Trial by Kim et al. and the OCEAN Trial by Verma et al.[5,6]

In the ALONE-AF trial, investigators from South Korea examined whether the discontinuation of anticoagulation—12 months after successful catheter ablation for AF—was associated with superior clinical outcomes compared with continuing anticoagulation. ALONE-AF was a multicenter, open-label trial that enrolled 840 participants and randomized them to either continue or discontinue oral anticoagulant therapy. The inclusion criteria for this study were: age 18 to 80; CHA_2DS_2-VASc at least 1 for men, or at least 2 for women, and no documented recurrence of atrial arrhythmia for at least 12 months after catheter ablation. Before enrollment, participants had to undergo two 24- to 72-hour Holter monitoring sessions to document absence of arrhythmia. Exclusion criteria included requiring anticoagulation for another indication, significant structural heart disease, significant hepatic or renal disease, and active malignancy. The follow-up period was two years, with clinic visits occurring every six months. ECGs were obtained at each follow-up, and 24- to 72-hour Holter monitoring was planned to be obtained at least every six months (although only about 30% of patients had repeat Holter monitoring). If participants had recurrence of AF during the study duration, they were censored at the time of the event, and their anticoagulation was resumed if they had been assigned to the discontinuation arm.

The primary outcome in the study was a composite of stroke, systemic embolism, and major bleeding. The authors found no significant difference in the primary outcome at two years, with one event (ischemic stroke) occurring in the discontinuation group of 417 participants and eight events occurring in the anticoagulation group of 423, for an absolute difference of –1.9 percentage points (95% confidence interval, –3.5% to –0.3%). In the anticoagulation group, five patients experienced stroke (three ischemic, two hemorrhagic) and three had extracranial major bleeding episodes. The secondary endpoints were largely similar, although major bleeding events were numerically higher by 1.4 percentage points in the anticoagulation group.

The OCEAN trial was a multicenter, multinational, open-label trial that randomized 1,284 participants to either rivaroxaban 15 mg daily or low-dose aspirin. The inclusion criteria were similar to the ALONE-AF trial and included remaining AF-free for at least one year post-ablation and CHA_2DS_2-VASc at least 1 for men, or at least 2 for women. Exclusion criteria for this study were: contraindication to anticoagulation or antiplatelet agents; contraindication

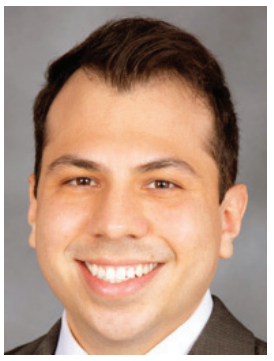

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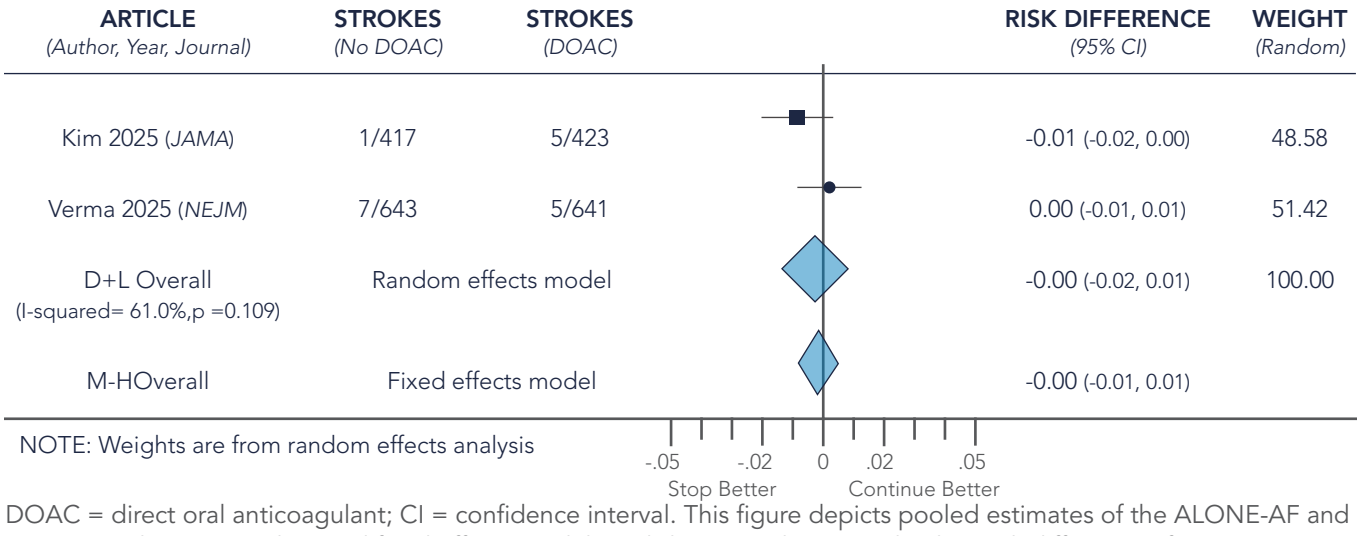
Figure 1: Meta-Analysis of Strokes-Only Outcomes From the ALONE-AF and OCEAN Trials



DOAC = direct oral anticoagulant; CI = confidence interval. This figure depicts pooled estimates of the ALONE-AF and OCEAN trials using random and fixed effects models and shows results using absolute risk difference of symptomatic stroke rates between the stop and continue DOAC arms of the trials.

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to magnetic resonance imaging; creatinine clearance under 30 ml/min; known hypercoagulability disorder; or stroke within 14 days before enrollment. Participants were followed for three years with appointments (initially in-person, but that changed to telephone during the COVID-19 pandemic) at six months, and then at yearly intervals. Participants had a brain MRI at the beginning of the study and a repeat MRI at year three to evaluate for subclinical strokes. In contrast with ALONE-AF, there were no mandates for cardiac testing; therefore, ECGs and Holter monitors were performed as clinically indicated, with the authors providing the rationale that such an approach reflected clinical practice worldwide. The primary outcome was a composite of stroke, systemic embolism, and new covert stroke measuring over 15 mm on MRI at three years.

Similar to the ALONE-AF trial, ischemic strokes and systemic thromboembolism were rare in both trial arms. The authors found no statistically significant difference in the primary outcome between the two groups, with five participants in the rivaroxaban group and nine in the aspirin group having an event, with an absolute risk difference of –0.6 percentage points. Of note, two of the nine primary outcome events in the aspirin group were new covert strokes noted on MRI, while the remaining seven patients experienced symptomatic ischemic strokes. Safety outcomes demonstrated numerically higher major bleeding events (10 versus four events) and higher minor bleeding episodes (11.5% versus 3.1%) in the rivaroxaban group. There were no fatal bleeding events in this trial.

Although the primary composite outcomes were not identical across these trials, we extracted and pooled all symptomatic stroke events from both trials (see Figure 1). The pooled estimate and 95% confidence intervals are similar for both random- and fixed-effects models and suggest that the two approaches are likely equivalent concerning stroke prevention, and the probability that stopping anticoagulation increases the stroke risk by at least one percentage point is very low. Taken together, the results of the ALONE-AF and OCEAN trials indicate that, for patients who remain arrhythmia-free at least one year after AF ablation, discontinuation of anticoagulation does not confer excess risk of ischemic stroke or systemic embolism and likely reduces bleeding complications. Furthermore, these results point to AF ablation being an excellent form of stroke prevention, as there were only 18 strokes identified out of more than 2,000 participants in the studies, and the rates of stroke were similar between both groups of patients.

Table 1: Summary of Key Features of ALONE-AF and OCEAN Trials

CHARACTERISTIC	ALONE-AF TRIAL	OCEAN TRIAL
First author, journal, year	Kim, *JAMA*, 2025	Verma, *NEJM*, 2025
Country	South Korea	Multi-national
Design	Randomized, open-label trial	Randomized, open-label trial
Intervention	Discontinue anticoagulation	Low-dose aspirin
Control	Continue anticoagulation	Rivaroxaban 15 mg daily
Number of patients	840	1,284
BASELINE CHARACTERISTICS		
Age (median)	64	66
Female sex (%)	25	29
Hypertension (%)	69	68
Diabetes (%)	19	14
Stroke or TIA (%)	6	6
CHA_2DS_2-VASc (%) 0 or 1 2 3 4 or higher	 29 40 20 11	 30 38 21 11

OUTCOMES	DISCONTINUE	CONTINUE	DISCONTINUE	CONTINUE
Primary composite outcome (%)	0.3	2.2	1.4	0.8
Symptomatic stroke (%)	0.3	1.4	1.1	0.8
Major bleeding (%)	0	1.4	1.6	0.6

Closer examination of these two trials reveals several key caveats to consider. First, not every patient who undergoes AF ablation is eligible for anticoagulation discontinuation after successful ablation, partially because of a variable definition of success. Both trials required absence of symptomatic or documented atrial arrhythmia for at least one year after ablation. The AF ablation success rates may vary with different patient-specific factors, with prior randomized trials documenting success rates to be between 50% and 75% for paroxysmal AF.[7-9] In fact, EARLY-AF and CIRCA-DOSA are the two largest AF trials that used implantable loop recorders to track AF recurrence, and unsurprisingly more AF recurrence was found in those than in other studies. Additional real-world data on the success of ablation comes from studies suggesting success rates bordering 80% for paroxysmal AF and 60% for persistent AF.[10-12] Therefore, there is increasingly strong evidence that early ablation will reduce stroke occurrence due to decreased progression from paroxysmal to persistent disease, which has lower ablation success.

Second, the distribution of the participant baseline CHA_2DS_2-VASc scores indicates that the trial results may not be generalizable to higher-risk patients. In ALONE-AF, 70% of participants had a CHA_2DS_2-VASc of 2 or less, and 90% had a score of 3 or less. Similarly, in OCEAN, nearly 90% of participants had a CHA_2DS_2-VASc of 3 or less. Consequently, it is unclear if the trial results can be extrapolated to patients who have a CHA_2DS_2-VASc greater than 3, and whether well-modified risk factors like recovered-ejection-fraction heart failure or diabetes that has returned to normal A1C should be treated the same as unmodified risk factors or unmodifiable risk factors like age. Additionally, some patients with AF will likely require lifelong anticoagulation due to high recurrence risk, such as patients with prior embolic stroke, hypertrophic cardiomyopathy, and amyloidosis, who may receive anticoagulation regardless of CHA_2DS_2-VASc score.

Finally, the rate of AF recurrence in these trials is also worth considering. In ALONE-AF, approximately 9% of participants had a recurrence of AF at some point during the two-year follow-up period, with the majority of cases being detected by routine (asymptomatic) ECG. The authors of OCEAN do not report the rate of atrial arrhythmia recurrences, and as they write in the manuscript, "the precise incidence of recurrence of asymptomatic AF is unknown." The significant rate of AF recurrence in ALONE-AF highlights the importance of ongoing cardiac monitoring following ablation, and likely resumption of anticoagulation—if otherwise indicated—with AF recurrence.

Data Application to Original Case

The patient has a CHA_2DS_2-VASc score of 3 and HAS-BLED of 2. She wore a prolonged ambulatory monitor after her ablation, which confirmed normal sinus rhythm, and she has been in normal sinus rhythm on all ECGs since her ablation. She has not reported recurrence of AF symptoms. Based on these studies, her anticoagulation can be discontinued without increasing her risk of stroke. She should be counseled to seek care if she develops any symptoms of atrial arrhythmia. Going forward, she should have active surveillance for recurrence of AF. Wearing a Holter monitor every six months would be a reasonable strategy to verify that she remains in sinus rhythm.

Bottom Line

For patients who remain AF-free for a year after catheter ablation and have a CHA_2DS_2-VASc score of 3 or less, stopping anticoagulation reduces risk of bleeding without increasing stroke risk. ■

Quiz:

To anticoagulate or not? A 65-year-old man with past medical history of AF, hypertension, and type 2 diabetes undergoes catheter ablation for AF. Normal sinus rhythm is confirmed via Holter monitor. Three months later, he is seen in clinic and asks if he can discontinue apixaban. How do you reply?

a. He should continue a DOAC indefinitely due to his elevated stroke risk.

b. He should discontinue apixaban immediately as his stroke risk has decreased, since he is no longer in AF.

c. He should continue DOAC for at least 12 months post-ablation. If he has no recurrence of AF at that time, he can discontinue DOAC.

d. He should switch from full-dose to prophylactic-dose anticoagulation

Correct Answer: C. The ALONE-AF and OCEAN trials demonstrate that discontinuing DOAC following successful AF ablation does not increase the risk of stroke. In these trials, patients were maintained on DOAC for at least 12 months post-ablation. In these trials, most patients had a CHA_2DS_2-VASc score of 3 or less. The patient in this question has a CHA_2DS_2-VASc score of 3. Therefore, he can discontinue his apixaban 12 months after his ablation if he has no recurrence of AF.

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When Detection Doesn't Always Mean Infection

Interpreting Plasma Microbial Cell-Free DNA Next-Generation Sequencing (Karius Testing)

By J. Cale Cummings, MD, MS, and Keri T. Holmes-Maybank, MD, MSCR, SFHM

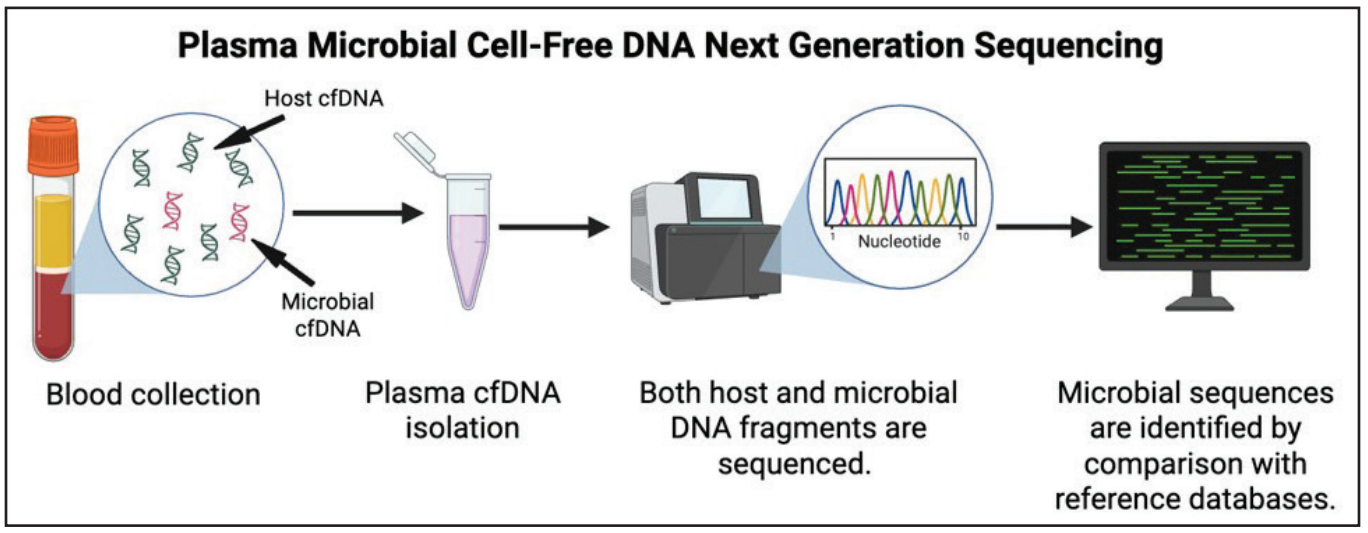
A 54-year-old man with a history of bicuspid aortic valve presents with three weeks of low-grade fevers and fatigue. On examination, he appears fatigued, flushed, and in mild distress with a temperature of 38.1˚C. Tender nodules are noted on the pads of his fingers. Three sets of blood cultures obtained prior to antibiotics show no growth after five days. Transthoracic echocardiography demonstrates a mobile echodensity on the aortic valve. Given concern for culture-negative infective endocarditis, plasma microbial cell-free DNA next-generation sequencing (Karius test) is ordered.

Brief Overview

Plasma microbial cell-free DNA next-generation sequencing (mcfDNA NGS) is a diagnostic assay that identifies microbial DNA fragments circulating in the bloodstream (Figure 1). Although mcfDNA NGS is done at varying degrees at various medical centers, most clinicians are familiar with the "Karius test" as it is the most comprehensive and established commercial mcfDNA NGS. The assay performs next-generation sequencing on all cell-free DNA present in the plasma sample; detected microbial sequences are quantified and reported as molecules per microliter (MPM).[1] By sequencing cell-free DNA in plasma and comparing detected fragments to a reference database of approximately 1,250 pathogens, the test can detect bacteria, fungi, DNA viruses (but not RNA viruses), and parasites without the need for culture.[1,2]

Hospitalists may consider plasma mcfDNA NGS when standard microbiologic evaluation is unrevealing and infection remains strongly suspected, or in cases of suspected deep-seated infection when invasive diagnostic procedures are contraindicated.[2]

Figure 1. Plasma mcfDNA NGS



Key Points

- mcfDNA NGS can detect bacteria, fungi, DNA viruses (but not RNA viruses), and parasites without the need for culture by sequencing cell-free DNA in plasma and comparing detected fragments to a reference database of approximately 1,250 pathogens.
- mcfDNA NGS is best used when pretest probability of infection is high, and traditional workup has been unrevealing and results should complement rather than replace conventional microbiologic evaluation.
- Significant limitations exist regarding plasma microbial cell-free DNA sequencing (Karius testing), including inability to distinguish colonization from true infection, variable sensitivity, incomplete or absent antimicrobial susceptibility data, and substantial cost.

Overview of the Data

Across published studies, the reported positive clinical impact of plasma mcfDNA NGS ranges from approximately 7.3% to 43%.[3-7] Much of this variability likely reflects differences in how "positive impact" is defined, with studies that include diagnostic confirmation as a positive outcome reporting higher rates.[3-7] (see Tables 1 and 2). However, in all cohorts there is a substantial gap between plasma mcfDNA NGS positivity and measurable impact on clinical care. In other words, even when the test detects a microorganism, only a minority of cases ultimately appear to benefit clinically from the result.[3-7] Importantly, this pattern persists even though most institutions restrict ordering of the test to highly selected patients, often requiring infectious-disease consultation or clinical microbiology approval prior to testing.[3-7]

Plasma mcfDNA NGS results are typically available within two to four business days after sample receipt. Unfortunately, plasma mcfDNA NGS is relatively expensive compared with conventional microbiologic testing and frequently is not covered by insurance, with estimated direct costs to patients exceeding $2,000.[1,2]

Plasma microbial cell-free DNA sequencing can be challenging to interpret. Microbial DNA may originate from colonization, transient translocation, or non-pathogenic organisms; therefore, plasma mcfDNA NGS reports may include multiple organisms detected above an internal reporting threshold.[2,8] Additionally, test sensitivity is not fully defined, varying by organism and clinical syndrome; therefore, a negative result does not exclude infection. While some markers of antimicrobial resistance may be reported, susceptibility data are incomplete or absent, and traditional microbiological analysis may be required.

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Dr. Holmes-Maybank

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Quiz:

A 62-year-old man with cirrhosis is admitted to the hospital with fever and abdominal pain. Blood cultures are negative after 48 hours. The patient underwent a dental extraction three days prior to admission. Plasma microbial cell-free DNA sequencing (Karius test) is performed and detects the following organisms:

- ***Streptococcus mitis* – 520 MPM**
- ***Veillonella parvula* – 430 MPM**
- ***Actinomyces oris* – 310 MPM**
- ***Rothia dentocariosa* – 190 MPM**

Which of the following is the most appropriate interpretation of these results?

a. These results confirm polymicrobial bacteremia requiring broad-spectrum antimicrobial therapy.

b. These organisms most likely represent oral commensals with transient microbial translocation rather than invasive infection.

c. The organism with the highest MPM value should be considered the causative pathogen.

d. These results indicate contamination of the sequencing assay and should be disregarded.

Correct option: B. These organisms most likely represent oral commensals with transient microbial translocation rather than invasive infection. Plasma microbial cell-free DNA sequencing detects circulating microbial DNA fragments rather than viable organisms. Detection of multiple organisms that are consistent with oral commensal flora may reflect transient microbial translocation following mucosal disruption, such as a recent dental procedure (B). In this context, polymicrobial detection is unlikely to indicate invasive infection (A). While contamination is possible when conducting the sequencing assay, the detected flora is consistent with oral flora and translocation given the context (D). Importantly, MPM values should not be compared across different organisms to determine clinical significance (C).

Given these limitations, careful consideration should be given before ordering the assay, and most expert guidance emphasizes conservative, selective use.[2,9]

Plasma mcfDNA NGS For the Hospitalist

The discussion surrounding plasma microbial cell-free DNA sequencing centers on two key questions: when should the test be ordered, and how should its results be interpreted?

When to Order: In practice, mcfDNA NGS use is generally guided by institutional stewardship recommendations, expert opinion, and clinical context. Available guidance emphasizes that mcfDNA NGS should not be used as a screening tool for undifferentiated illness. Rather, the test is most appropriately applied in patients with a high pretest probability of infection in whom conventional diagnostic evaluation has been unrevealing.[2,10]

At present, there are no major society-endorsed consensus guidelines defining indications for plasma microbial cell-free DNA sequencing; however, the University of Nebraska Medical Center has published institutional guidance titled Clinical Guidance on the Use of Next Generation Sequencing (NGS) Tests for Infectious Diseases.[2] This document outlines three tiers of recommendations: clinical scenarios in which testing may be considered, clinical scenarios in which testing should usually be avoided, and clinical scenarios in which testing should not be used. The highest tier of recommendation, "may be considered," is limited to three clinical scenarios:

1. Culture-negative endovascular infection
2. Suspected deep-seated infection when invasive diagnostic procedures are contraindicated or undesirable
3. Suspected deep-seated infection with a nondiagnostic invasive evaluation with persistent imaging or pathologic evidence suggestive of infection[2,10]

Interpreting Results

Despite the limitations, mcfDNA NGS is increasingly used in clinical practice, making accurate interpretation of its results an important skill for hospitalists. Interpretation of plasma microbial cell-free DNA results requires careful integration of the patient's clinical presentation, pretest probability of infection, and the organisms detected. (Table 3)

When interpreting mcfDNA NGS results, clinicians should consider:

1. The pathogenic potential of the detected organism
2. Whether the organism fits the clinical syndrome
3. The quantity of microbial DNA detected
4. The possibility of colonization or mucosal translocation[1,9]

Several characteristics of mcfDNA NGS influence interpretation:

- Results are reported as molecules per microliter (MPM), representing the number of microbial DNA fragments detected per microliter of plasma. MPM values should not be directly compared across different organisms when assessing clinical significance.[1,2]
- Detection depends on microbial DNA entering the bloodstream. Localized or compartmentalized infections (e.g., abscess or osteomyelitis) may yield false-negative results if insufficient microbial DNA circulates in plasma.[2]
- Prior antimicrobial therapy may reduce circulating microbial DNA and contribute to false-negative results.[2]
- Polymicrobial results are common. In hospitalized or immunocompromised patients, detection of multiple organisms may reflect microbial translocation across disrupted mucosal barriers, particularly from gastrointestinal or oral microbiota.[2,9]
- Many detected organisms may represent commensals or latent viruses. Detection of these organisms, particularly at low levels, may not indicate invasive infection.[2,9]
- Clinical concordance is essential. Organisms that fit the patient's syndrome and risk factors are more likely to represent true pathogens, whereas organisms inconsistent with the clinical presentation should be interpreted cautiously.[2,9]
- Immunocompromised patients may have multiple concurrent infections, and polymicrobial detection may reflect true co-infection.[2]

Table 1: Plasma Microbial Cell-Free DNA Sequencing Study Overview and Definition of Positive and Negative Impacts

STUDY	SAMPLE SIZE	POSITIVE IMPACT	POSITIVE IMPACT DEFINITION	NEGATIVE IMPACT	NEGATIVE IMPACT DEFINITION
Hogan, C. A., et al. (2021)[3]	82	7.3%	New diagnosis based on Karius result and not confirmed by conventional microbiological methods. Earlier diagnosis based on Karius result and later confirmed by conventional microbiological methods. Karius result enabled avoidance of invasive surgical biopsy. Karius result enabled initiation of appropriate therapy. Karius result enabled de-escalation of antimibrobials.	3.7%	Karius result led to unnecessary treatment. Karius result led to additional unnecessary diagnostic investigations. Karius result led to longer length of stay
Olthoff, M., et al. (2024)[4]	37	16%	New diagnosis based on Karius result and not confirmed by conventional microbiological methods. Earlier diagnosis based on Karius result and later confirmed by conventional microbiological methods. Karius result enabled avoidance of invasive surgical biopsy.Karius result enabled initiation of appropriate therapy. Karius result enabled de-escalation of antimibrobials.	0%	Karius result led to unnecessary treatment. Karius result led to additional unnecessary diagnostic investigations. Karius result led to longer length of stay
Shishido, A., et al. (2022)[5]	80	43%	Test result led to a new diagnosis when conventional tests were negative. Test result confirmed clinical diagnosis. Test result led to an earlier diagnosis. Test result negated invasive or costly procedures or tests. Test result helped reduce length of hospital stay. Test result led to the initiation of appropriate antimicrobial therapy. Test result led to de-escalation or discontinuation of antimicrobial therapies.	3%	Test result led to unnecessary antimicrobial treatment. Test result led to unnecessary diagnostic investigation or procedures. Test result led to an unnecessarily prolonged hospital stay.
Jung, S., et al. (2025)[7]	88	12.5%	Faster/Only diagnosis; clinicians clearly acted on result.	23.9%	Either diagnosed existing infection or did not modify treatment.

Table 2: Plasma Microbial Cell-Free DNA Sequencing Study Overview and Definition of Clinical Impact

STUDY	SAMPLE SIZE	CLINICAL IMPACT	IMPACT DEFINITION
Lee, R. A., et al. (2020)[6]	59	8%	Clinical impact was arbitrated by all authors based on the actions of the treatment team after review and discussion of each case. Any case for which there was not an initial unanimous consensus was decided by a majority vote between the authors.

Application of Data

In this case, the pretest probability of infection is high, and identification of a pathogen could meaningfully influence antimicrobial therapy and clinical management. The patient presents with clinical findings highly suggestive of infective endocarditis, meeting criteria for "definite" disease by the updated Duke Criteria, though conventional microbiologic evalu-

Table 3: Example Plasma Microbial Cell-Free DNA Sequencing Scenarios and Results

RESULT	EXAMPLE MICROORGANISMS	EXAMPLE CLINICAL SCENARIO	INTERPRETATION
No microorganisms detected	N/A	Patient with suspected vertebral osteomyelitis and negative blood cultures	May represent true negative or source control. A negative result does not exclude infection. Sensitivity may be limited in localized infections with low circulating microbial DNA.
One microorganism with low detection	>316,000 MPM *Toxoplasma gondii*	Immunocompromised febrile patient following stem cell transplant	Context dependent. May represent early or late infection, colonizer, or contaminant.
Obligate pathogen with low quantification	48 MPM *Mycobacterium tuberculosis*	Patient with chronic cough, weight loss, and pulmonary cavitary lesions	May represent true positive. Typically associated with infection.
Microorganism with high quantification	18,400 MPM *Coxiella burnetii*	Patient with culture-negative endocarditis and underlying valvular disease	May represent true positive. Typically associated with advanced disease.
Polymicrobial, with multiple non-specific microorganisms	612 MPM *Streptococcus mitis*; 455 MPM *Veillonella parvula*; 310 MPM *Actinomyces oris*;188 MPM *Rothia dentocariosa*	Patient with fever following recent dental extraction	Multiple commensal organisms consistent with mucosal barrier injury and oral translocation. May represent transient bacteremia rather than a true invasive infection.
Polymicrobial, with multiple pathogenic microorganisms	2,960 MPM *Aspergillus fumigatus*;1,420 MPM *Pseudomonas aeruginosa*;870 MPM *Candida glabrata*	Immunocompromised patient with known invasive pulmonary aspergillosis who develops new fever and hypotension	Multiple pathogenic organisms detected. Detection may represent concurrent infections or a new infectious process, and results should be interpreted in conjunction with clinical findings and other diagnostic studies.
Polymicrobial, with one significant microorganism and multiple non-specific microorganisms	3,980 MPM *Histoplasma capsulatum*;740 MPM *Bacteroides fragilis*;412 MPM *Escherichia coli*;265 MPM *Enterococcus faecalis*	Adult with pulmonary nodules and fevers after recent travel to the Ohio River Valley	One organism (*Histoplasma capsulatum*) is likely the causative pathogen while the other organisms may represent GI translocation.

ation has been unrevealing.[11] Culture-negative endocarditis is one clinical scenario in which plasma mcfDNA NGS may be considered, and use of the assay in this setting may help identify a causative organism. However, results must still be interpreted cautiously within the clinical context, recognizing that false-negative results, detection of commensal organisms, or microbial DNA from transient translocation may occur.

Bottom Line

Testing using mcfDNA NGS may provide valuable diagnostic information, and results should complement rather than replace conventional microbiologic evaluation, recognizing that false-negative results, detection of commensal organisms, or microbial DNA from transient translocation may occur. ■

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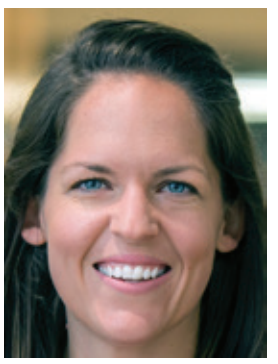
Pediatrics

Beyond Expertise: Influence, Trust, and the Future of Pediatric Advocacy

By Lauren Gambill, MD, MPA, FAAP, and Anika Kumar, MD, FAAP, SFHM



Dr. Gambill

Dr. Kumar

Dr. Gambill is an associate professor of pediatrics at The University of Texas at Austin Dell Medical School and a pediatric hospitalist in Austin, Texas. Her academic work focuses on child health policy, advocacy, and medical education. You can follow her work on Substack. Dr. Kumar is an assistant professor of pediatrics at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University and a pediatric hospitalist at Cleveland Clinic Children's. Her academic work focuses on professional development.

> [LG] work clinically in a children's hospital. I am the program director for a pediatric hospital medicine fellowship.
>
> But I'm not a normal hospitalist.

In addition to my medical training, I have a policy degree, and my scholarly work is in policy and advocacy. This half-hospitalist, half-advocacy mash-up has always made sense in my head. It has not always made sense to people outside of my head.

For a long time, advocacy was something relegated to outpatient pediatrics. But as hospitalists, we see things that others don't. And this perspective allows us to advocate in a way no one else can.

Dr. Paul Wise, a health policy professor at Stanford, is credited with noting that pediatricians are the ultimate witnesses to failed social policy.[1] All pediatricians see the fallout from bad policy around things like vaccines, healthcare

funding, and food insecurity. But as hospitalists, we often see the worst-case outcomes from policy disasters. We care for the individuals who end up hospitalized because systems failed them. We also see policy working in ways that are practically invisible to other people—Medicaid, for example.

Our clinical vantage point creates both an opportunity and a responsibility to advocate.

A few months ago, I was invited to attend the Mom 2.0 Summit, a professional conference for parenting influencers, content creators, and brands.[2] I was not invited because I am an influencer. I write a newsletter, but my following does not even qualify me as a nano-influencer—creators with a lowly one to ten thousand followers.

I just have interesting friends. A writer I have collaborated with invited me to tag along.

In medicine, we spend a lot of time pointing fingers at "influencers." These are valid grievances. Risky social media challenges land adolescents in our emergency departments and hospital wards. Anti-vaccine influencers spread misinformation and disinformation.[3] But pointing fingers does not really solve any of these issues.

I wondered if medicine could learn something from people who are extraordinarily good at reaching people.

When I arrived at Mom 2.0, I immediately recognized faces I had followed online for years. It was as though I had been passively scrolling and suddenly all of the characters from the screen emerged and morphed into walking, talking, real-life humans.

I recognized so many people, and yet I actually knew no one. It felt all at once familiar and strikingly lonely.

That experience highlighted one of the first lessons I took from the conference: we are living in an increasingly virtual world, but human connection is more valuable than ever.

As physicians, we are in one of the few professions where we have direct and constant access to real-life humans. As hospitalists, we talk to people face-to-face through what can be some of the most stressful days of their lives. That connection builds trust in a way that cannot be established online.

Trust Has Shifted. Not Vanished.

There is a lot of discussion about declining trust in physicians, but I think trust has shifted.[4-6]

For much of the 20th century, medicine operated in an Age of Authority. Knowledge was scarce. Information flowed in one direction. The physician knew. The patient listened. Authority was enough.

Today, we live in an Age of Influence. Knowledge is abundant. Information is everywhere. Trust—not information—is scarce.

In the past, people trusted doctors because we represented trusted institutions. They trusted us because we trained at prestigious universities, worked at beautiful hospitals, or belonged to respected professional organizations. Increasingly, that relationship has flipped. People may come to trust larger institutions only after they have come to trust the individual humans within them.

Key Points

- Hospitalists see what others don't. Our proximity to the downstream consequences of policy gives us both an opportunity and a responsibility to advocate for society's most vulnerable.
- The rules of influence have changed. In a world where information is abundant but trust and authentic human connection are scarce, expertise and institutional authority alone do not guarantee influence.
- Our individual voices matter. Hospitalists already possess trusted relationships with patients, families, and communities. We can use that trust to advocate without waiting for larger institutions to lead.

At Mom 2.0, I learned that the $250 billion creator economy understands this. The industry has even embraced the idea of "pico-influencers," people with fewer than 500 followers, because smaller creators often have the highest audience trust and loyalty. The smaller you are, the stronger you are—at least proportionally.

In healthcare, we are the pico-influencers.

This creates an extraordinary opportunity for hospitalists. We do not have to wait for our hospitals, professional organizations, or government agencies to speak before we act. Our individual credibility matters.

I learned this firsthand while testifying during the Texas legislative session on vaccine-related bills. During questioning, legislators suggested that I could not be trusted because I represented pharmaceutical companies or the healthcare industry at large.

Lucky for me, I wasn't representing anyone except pediatricians.

I had assumed I would be more powerful representing a large institution. Instead, my individual credibility and voice mattered more.

Mom 2.0 also forced me to rethink expertise itself. When I first learned that health economist Emily Oster was invited to speak about science and misinformation, I was annoyed.

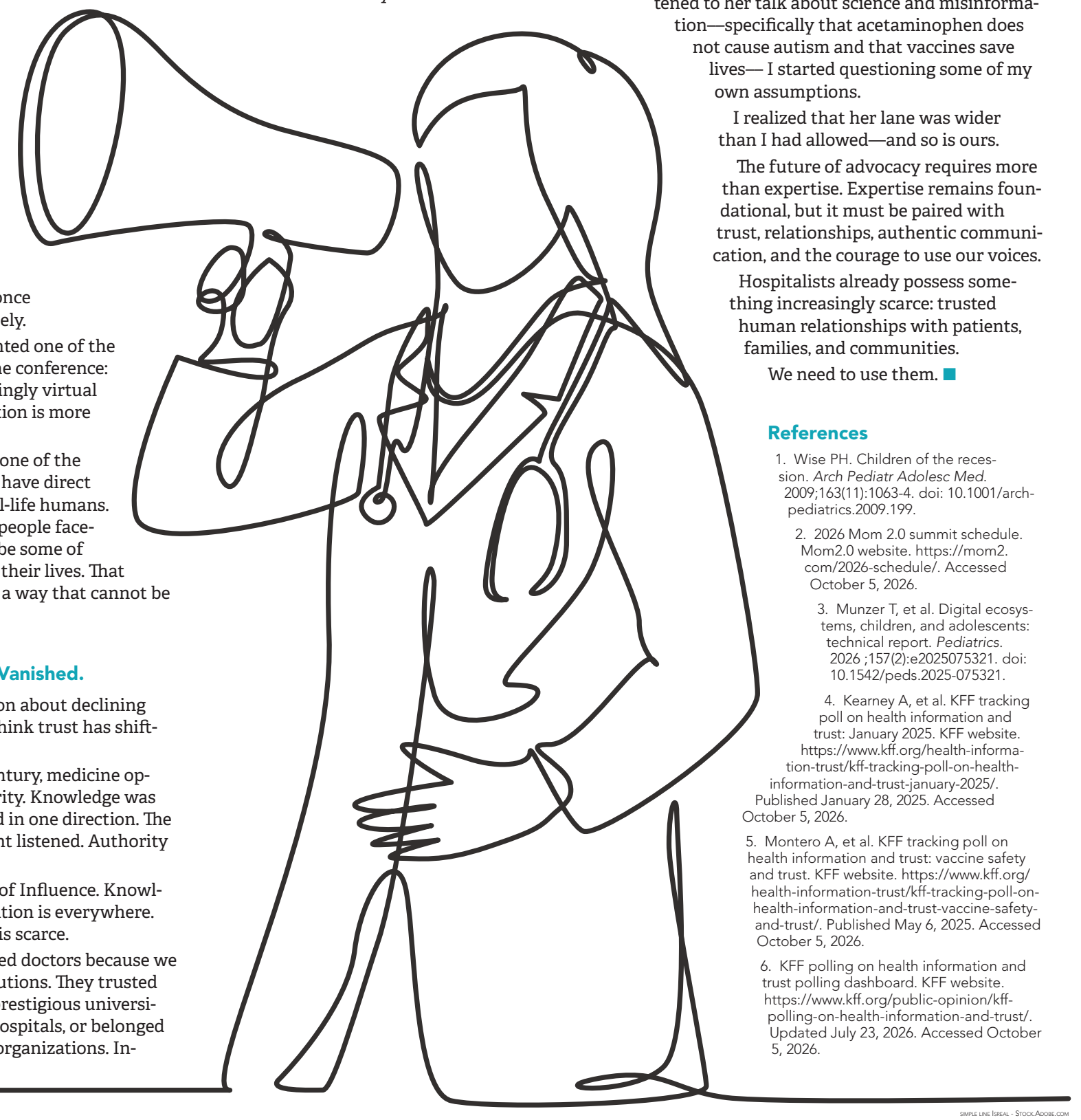
I had heard Oster dismissed as "an economist who likes to give medical advice." But as I listened to her talk about science and misinformation—specifically that acetaminophen does not cause autism and that vaccines save lives— I started questioning some of my own assumptions.

I realized that her lane was wider than I had allowed—and so is ours.

The future of advocacy requires more than expertise. Expertise remains foundational, but it must be paired with trust, relationships, authentic communication, and the courage to use our voices.

Hospitalists already possess something increasingly scarce: trusted human relationships with patients, families, and communities.

We need to use them. ■



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Top 10 Articles in Pediatric Hospital Medicine

By Sumeet Banker, MD, MPH, Morgan Cantor, MD, and Rachel Osborn, MD

This year's top 10 articles in pediatric hospital medicine (PHM), presented at PHM 2026 in Kansas City, Mo., featured a range of topics with important learning points for both pediatric and adult hospitalists. We reviewed publications from July 1, 2025, to June 30, 2026, in 18 journals using three guiding questions: was the methodology sound and rigorous; was the topic relevant to pediatric hospital medicine; and did the findings possibly change our practice?

Here are the highlights from those 10 articles.

1. Effectiveness and Impact of Maternal RSV Immunization and Nirsevimab on Medically Attended RSV in US Children

This study[1] found that both maternal respiratory syncytial virus (RSV) immunization and nirsevimab, a new long-acting monoclonal antibody delivered to infants, were effective at reducing RSV hospitalization with a relative risk reduction of 41%. Reducing the burden of RSV hospitalization can have a tremendous impact on bed utilization during the busiest times for children's inpatient floors, which is important to both regional and referral medical centers.

2. Improving the Safety of Pediatric ED-to-Inpatient Transfers of Care

This quality improvement project[2] sought to reduce rapid response activations for children admitted from the emergency department (ED). Using a huddle, newly identified clinical interventions better stabilized patients before transfer and significantly reduced—from 8% to 3.6%—the number of patients upgraded to the ICU post-intervention. This highlights the importance of automation prompting physician teams to reassess patients when they are ready to transfer out of the ED and illustrates that simple interventions can reduce safety events at transfer.

3. Pediatric Resident Psychological Safety, Learning, and Family Trust during Family-Centered Rounds

This qualitative study[3] addresses learners' stressors and fears in bedside rounding; a practice considered a standard of care for pediatric inpatient rounds and one that is gaining increasing traction in adult hospitals. Though residents worried that patients and families would lose trust in them if they were corrected during rounds, patients' families reported that trust was more related to their interpersonal skills. Discourse and disagreement on rounds do not undermine patient trust, and learners should feel safe sharing ideas at the bedside while remembering to treat patients and families with empathy and respect.

Dr. Banker

Dr. Cantor

Dr. Osborn

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4. Quality Assessment of AI-Generated Versus Human-Written Hospital Summaries Evaluating Detail, Usefulness, and Continuity of Care

This study[4] compares the quality metrics of discharge summaries for 100 adult patients written by large language models (LLMs) to those written by humans. Apart from length and readability, summaries written by LLMs outperformed those written by humans in all metrics and did not have any factual errors. The authors conclude by suggesting that a hybrid approach using LLMs to generate a first draft, followed by human editing, might allow for better ease and efficiency.

5. Balanced Fluid or 0.9% Saline in Children Treated for Septic Shock

This randomized open-label trial[5] compared renal outcomes in children who received normal saline to those treated with balanced

fluids for resuscitation in sepsis. The scope of the trial was impressive, involving dozens of sites across more than five countries, and ultimately there was no difference noted in the primary outcome. The authors note that the study may have been underpowered since the incidence of renal events in children was overall very low, and in the sickest children there was a trend favoring balanced fluids. These results should be extrapolated to adults with caution.

6. Pilot Testing an Equity and Trauma-Informed Communication Intervention for Family-Centered Rounds

This article[6] demonstrated the feasibility of a brief training program in improving communication on rounds for minoritized patients and families. This was a pilot single-center study involving eight hospitalists and 48 total encounters. It was selected as a top 10 article because it sought to address an ongoing healthcare inequity with a scalable intervention. Centers seeking to improve trust and perceptions of shared decision making could locally implement a similar approach with promising results.

7. Prediction of Bacteremia and Bacterial Meningitis Among Febrile Infants Aged 28 Days or Younger

This study[7] examined the Pediatric Emergency Care Applied Research Network prediction rule to identify febrile infants at low risk of bacteremia or bacterial meningitis in a younger population of infants, finding a negative predictive value of 99.4% when all criteria were met. Though conventional approaches would suggest a lumbar puncture and empiric treatment for all febrile infants less than 21 days of age, an infant in this age group with a negative urinalysis, a procalcitonin less than 0.5 ng/mL, and an absolute neutrophil count less than 4,000 could likely avoid a lumbar puncture and empiric antibiotics—another opportunity for hospitalists to potentially safely do less.

8. Prophylactic Dextrose Gel for Neonatal Hypoglycemia and Neurocognitive Function at 6 to 7 Years of Age: A Secondary Analysis of an RCT

In 2015 to 2019, multiple hospitals in New Zealand randomized newborns considered "at risk" of hypoglycemia because of birth weight or maternal diabetes to receive dextrose gel or placebo at one hour of life, reducing mild hypoglycemia in the intervention arm. This study[8] provides data from a secondary analysis of the subjects, now aged 6 to 7 years, in a variety of neurocognitive outcomes. The intervention group had worse scores in psychosocial functioning and emotional-behavioral difficulty despite their lower rates of hypoglycemia in the initial study. These findings question the routine use of prophylactic dextrose gel and highlight the perils of assuming the safety of an intervention based on observational and cohort data alone.

9. Infant Outcomes, Risk Factors, and Diagnostic Yield After a BRUE: A Systematic Review and Meta-Analysis

A brief resolved unexplained event (BRUE) is a challenging diagnosis for pediatric hospitalists, with significant testing burden for admitted infants. The pooled prevalence of a serious underlying diagnosis in available BRUE literature was just 6%. Importantly, age less than 60 days was not associated with an increased risk of a serious underlying diagnosis, calling into question the need for these infants to be routinely admitted for observation. The study[9] also highlighted the poor performance of diagnostic testing and proposes a risk-based approach for this common condition.

10. Symptom-Based Dosing for Neonatal Opioid Withdrawal

Neonatal opioid withdrawal, or NOW, remains a source of significant morbidity as the opioid epidemic continues nationwide. Though the "eat, sleep, and console" approach to care has demonstrated improved outcomes with decreased reliance on medications, the question remained whether an as-needed approach to medication would be as safe and effective when compared with a tapered-wean approach. This randomized cluster crossover study[10] demonstrated that a symptom-based dosing approach was safe, demonstrating a faster time to medical readiness for discharge amongst all pharmacologically treated infants without significant safety events.

Visit The Hospitalist online for more PHM 2026 session recaps. ■

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How We Did It

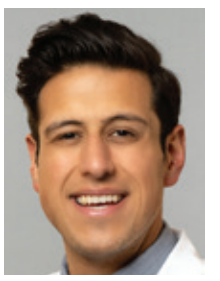
Extending Clinical Ownership Beyond Discharge Through a Dedicated Hospitalist Team

By Erin McKnight, MD, FHM, Courtney Murray, MHA, PA-C, Nicholas Patino, MPAS, PA-C, and Stacy Adil, PA-C

Timely hospital discharge is increasingly critical as medical centers face persistent emergency department (ED) boarding, high census pressure, and often, strained inpatient resources. Inpatient admissions are frequently prolonged pending result finalization or to obtain unnecessary diagnostic tests given concerns about unclear ownership during transitions of care.[1-3] While post-discharge and transitions-of-care clinics have shown success in mitigating these delays and allowing for earlier hospital discharge, they typically rely on resource-intensive in-person or telehealth visits that divert hospital-based practitioners into outpatient roles.[4-6] As outpatient access challenges have grown, care transitions have become recognized as a distinct area of hospital medicine practice, positioning hospitalists at the interface between inpatient and outpatient care.[7,8] We identified a need for a hospitalist-led model that would preserve clinical ownership after discharge, optimize inpatient resource utilization, reduce length of stay, and facilitate a safe transition to the outpatient setting.

Dr. McKnight

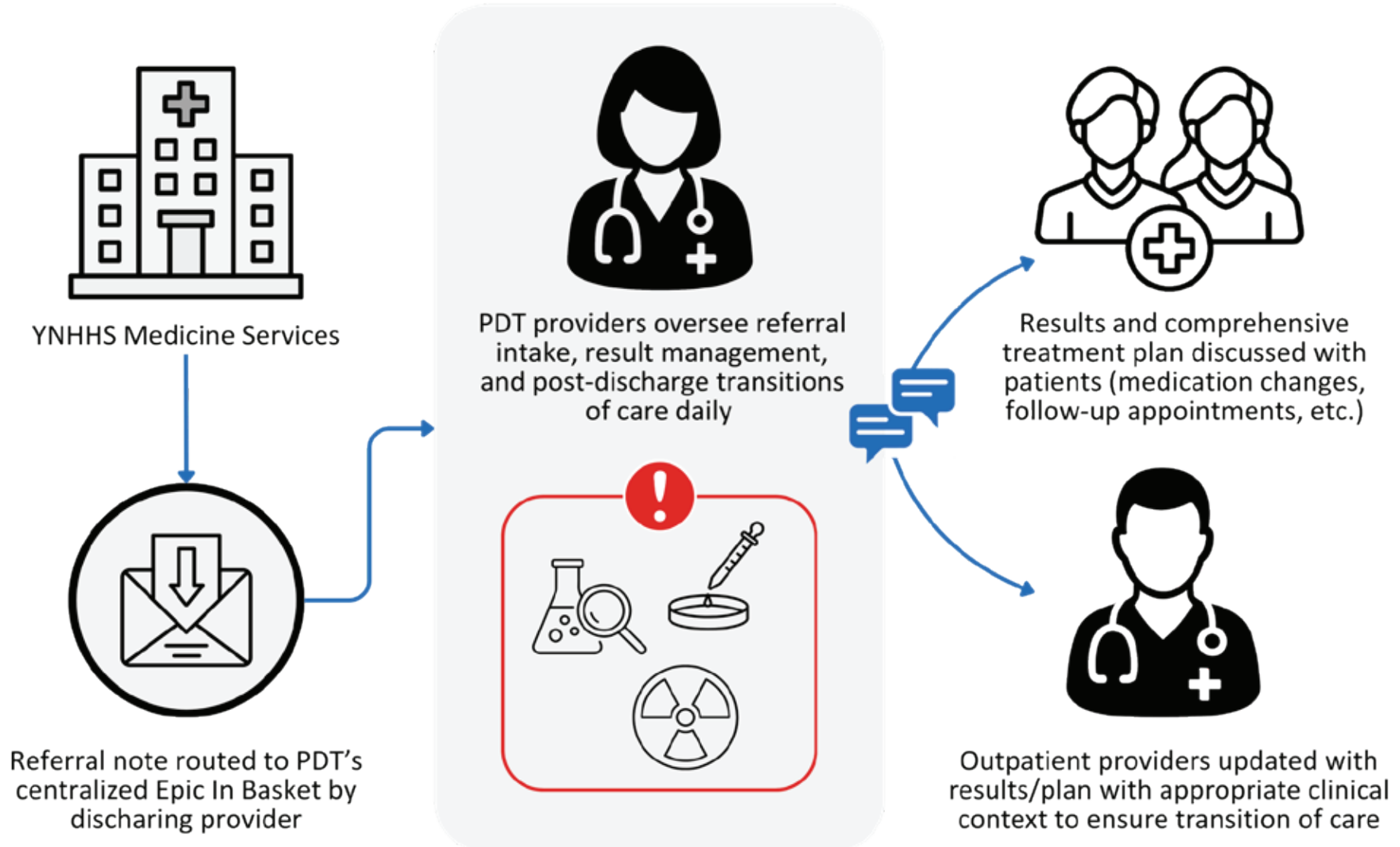
Ms. Murray


Mr. Patino

Ms. Adil

Dr. McKnight is associate director of the hospital medicine service at Yale New Haven Hospital and medical director of the post discharge team for Yale New Haven Health System in New Haven, Conn. Ms. Murray is a hospital medicine PA and helps coordinate daily operations for the hospitalist post discharge team at Yale New Haven Hospital in New Haven, Conn. Mr. Patino is a hospitalist PA, the clinical director for the hospitalist observation unit, and a member of the post discharge team at Yale New Haven Hospital in New Haven, Conn. Ms. Adil is an associate director of hospital medicine and manager of advanced practice professionals in hospital medicine at Yale New Haven Hospital in New Haven, Conn.

Figure 1. Workflow for the post-discharge team



Solution Overview

In early 2024, program development began with a review of common discharge barriers and care transition failures on the inpatient medicine service at Yale New Haven Hospital. The review revealed a common scenario in which clinically stable patients remained hospitalized while awaiting nonurgent imaging, laboratory results, surgical pathology, or culture data. In response, we designed the post discharge team (PDT), a centralized, hospitalist-led, clinical management service designed to extend hospital medicine oversight for up to two weeks beyond discharge. This program leveraged existing hospitalist expertise, standardized workflows, and centralized ownership without requiring new brick-and-mortar space or routine patient visits.

The program was implemented with a simple, referral-based workflow. Before the decision to discharge, the responsible inpatient clinician identifies a patient with a pending test result or outpatient imaging need and sends an electronic referral to the PDT through a shared Epic inbox (see Figure 1). The PDT assumes responsibility for the referred patient, which includes review of the finalized result, communication with the patient, initiation or modification of the treatment plan when indicated, and coordination of follow-up with the primary care clinician or outpatient specialist. Referrals remain active until either the issue is resolved or responsibility is formally transitioned to an outpatient clinician.

The program was intentionally built around four pillars: result management, resource stewardship, safe transitions of care, and operational excellence. By centralizing ownership rather than relying on individual clinicians to maintain personal tracking systems, the PDT standardizes transitions-of-care while allowing inpatient resources to be reserved for patients who truly require hospital-level care.

Key Points

- Because hospitalists have expertise in both the events of hospitalization and the risks commonly arising after discharge, we are uniquely positioned to oversee care transitions and facilitate reconnection to outpatient care providers.
- Centralized post-discharge management creates clear clinical ownership through standardized result management, timely outpatient imaging, and coordinated follow-up.
- Program success depended on the PDT's clinical effectiveness and the trust we generated amongst frontline clinicians. Hospitalists were confident that pending results would be appropriately managed during the care transition, which increased their comfort with earlier discharge.
- As utilization grew, improvements in transitions of care translated into operational and financial benefits, including more efficient use of inpatient resources, reductions in observed-to-expected length of stay, cost avoidance and revenue generation.

Implementation Process

At launch, the PDT operated with one physician or advanced practice practitioner (APP) working half time in the role while maintaining a moderately reduced direct inpatient care workload. The standardized referral process within Epic included the shared inbox, a shared patient worklist, documentation templates, and a longitudinal database. These tools allowed the PDT to receive referrals, track post-discharge needs, document patient interactions and interventions, and maintain ownership until the follow-up process was completed and care was transitioned to the patient's outpatient care team.

Before discharge, the referring inpatient clinician discusses the follow-up plan with the patient and completes a standardized Epic note template identifying the test requiring follow-up and recommendations for management of the result. The completed note is routed to the PDT's shared inbox. A standardized template was developed for the patient's discharge instructions indicating that the PDT will notify the patient of results and any changes to the treatment plan.

The initiative began with two referral categories: pending inpatient laboratory results and outpatient laboratory testing. Examples of inpatient laboratory referrals include surgical pathology or culture data needed to guide treatment or reference labs with long turnaround times. Examples of outpatient laboratory referrals include basic metabolic panels to monitor renal function or electrolytes after starting diuretics, hemoglobin monitoring after resuming anticoagulation, and liver function testing to ensure return to baseline after hospitalization. These two referral categories allowed the team to test and refine the PDT workflows before expanding the program's scope.

Once the initial referral structure was established, we collaborated with the radiology department to decompress the inpatient MRI queue by creating a workflow for expedited outpatient scheduling and management of non-urgent MRI studies. We aimed to transition select studies to the outpatient setting when deemed clinically appropriate and agreed upon by both the patient and primary team. At our institution,

nonurgent MRIs were frequently ordered in the inpatient setting to expedite the evaluation of chronic conditions or incidental findings because of long outpatient wait times. In our discussions with MRI leadership, we identified an average vacancy rate of 50% for the inpatient MRI scanner during the patient transport department's 7 a.m. shift change. Radiology leadership agreed to designate this slot for outpatient imaging coordinated through the PDT, creating access to outpatient MRIs within seven to 14 days of discharge.

Through collaboration with the MRI department, MRI safety nurses, our Epic analysts, and the prior authorization department, we developed a process that allowed PDT clinicians to order and schedule outpatient MRI studies. Over time, additional PDT MRI appointment slots were created, and similar processes were developed and implemented for outpatient ultrasounds and CT scans. Together, this work established outpatient imaging as the PDT's third referral category.

Timely outpatient specialty follow-up was identified early as a critical need when managing results after discharge. At our institution, access to certain specialties was limited, with wait times sometimes exceeding six months. When a result reviewed by the PDT indicated a need for a more urgent specialty evaluation, the dedicated PDT clinician had the capacity to contact scheduling teams directly and help secure follow-up within a clinically appropriate timeframe.

At program launch, referrals to the PDT were available exclusively to hospitalist clinicians. Rather than mandate adoption, the team introduced the program through team meetings, emails, direct outreach, and patient vignettes demonstrating how the PDT managed results and transitions of care. These examples helped build trust among hospitalists, while early adopters encouraged broader uptake through word of mouth. After the workflow had been established and refined within the hospitalist service, referrals were opened to medicine service lines staffed by resident teaching teams. To support system-wide expansion, we convened a summit of hospital leaders from each hospital, who then served as local champions and promoted adoption at their sites, with all referrals managed by our one central team.

Resource allocation grew alongside volume in the setting of additional referral sources. Over the past two years, the program has expanded to two full-time APPs who staff the role daily, with medical director oversight available for clinical decision making and program operational support.

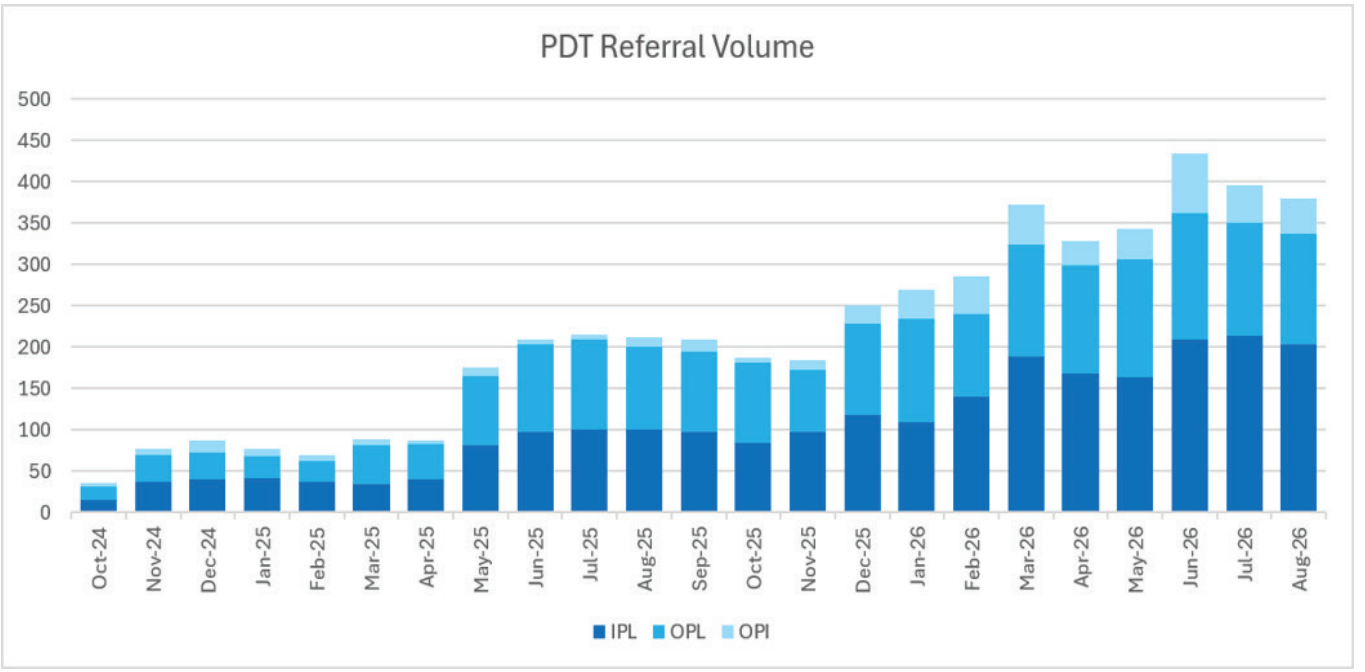


Figure 2. PDT referral volume by month. IPL, inpatient lab; OPL, outpatient lab; OPI, outpatient imaging

Outcomes and Impact

The PDT has evolved into a centralized transitions-of-care service that has managed post-discharge follow-up for more than 4,000 patients during its first two years (see Figure 2). The program now serves all five hospitals in the Yale New Haven Health System, while referral intake and management remain centralized at the site of origin through the established shared inbox. Referrals are received from medicine service lines across the health system, including resident teaching and oncology hospitalist services, and we currently average more than 350 referrals per month.

Expansion across the health system has allowed the program to scale resource stewardship. We now offer three imaging modalities (MRI, US, and CT) with multiple available appointments at various Yale New Haven Hospital locations. During the current fiscal year, the PDT has coordinated the transition of more than 250 imaging studies from the inpatient to the outpatient setting, with a projected positive financial impact of $750,000 from revenue generation and cost avoidance.

Early data from the program's first year also suggested a potential operational benefit. Patients referred to the PDT had a 16.5% lower observed-to-expected length of stay than the general medicine population. However, these findings should be interpreted cautiously because of concurrent length-of-stay reduction initiatives and potential referral bias. Further data analysis is ongoing to stratify patients by severity of illness and readmission risk.

Lessons Learned

Hospitalists strongly supported the centralized model because individual clinicians lacked a reliable way to monitor post-discharge follow-up after rotating off service or assuming responsibility for a new inpatient panel. With a dedicated team managing post-discharge needs, inpatient clinicians could focus on progressing care for their current patients. Over time, the PDT evolved to become an informal troubleshooting resource for a wide range of post-discharge needs, including medication access issues, patient questions, and other concerns that might otherwise fall back on the primary team.

Although the observed length-of-stay reduction cannot be attributed solely to the PDT because of confounding initiatives and referral selection bias, the outpatient imaging workflow produces measurable financial and operational benefits. Transitioning appropriate imaging studies to the outpatient setting allowed select patients to be discharged sooner and preserved inpatient imaging capacity for urgent and medically necessary studies.

We also learned that beginning with a smaller scope (laboratory referrals) allowed the team to refine the workflow before adding additional referral categories. The underlying infrastructure of a centralized inbox, a dedicated team, clearly defined responsibilities, standardized workflows, and a longitudinal database proved flexible enough to accommodate new referral types and expand scope across the health system without requiring the program to be rebuilt. Our network of operational partnerships and local clinical champions made expansion throughout the system both feasible and successful.

Future Directions

Future work will include a more direct collaboration with radiology at the point of imaging order entry and protocol review. Leveraging radiologist expertise will help triage studies that can safely be transitioned to the outpatient setting while allocating inpatient imaging resources for patients with urgent needs. This expanded workflow is in development and expected to roll out in the fall of 2026.

The underlying PDT infrastructure also creates an opportunity to expand the PDT model beyond the medicine service line, particularly where specialty-specific champions are available to support interpretation and management of results. This approach is already being used for cardiac MRI, with dedicated cardiologists assisting the PDT when their expertise is warranted. This partnership demonstrates how the framework can extend into specialty-driven result management while maintaining the centralized approach to result tracking and patient communication. Additional work will focus on defining the staffing and operational resources needed to sustain continued growth outside of the medicine service line. ■

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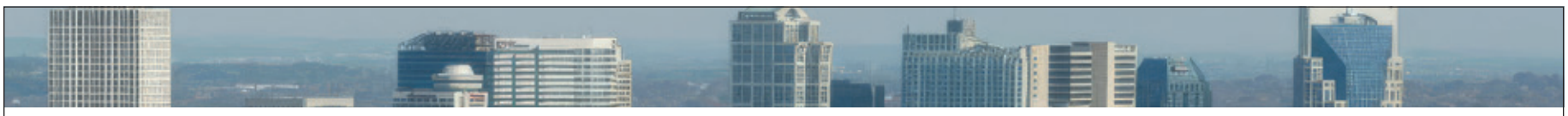

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