Rural hospitalists confront COVID-19
Unique demands of patient care in small hospitals

By Larry Beresford

In 2018, Atashi Mandal, MD, a hospitalist residing in Orange County, Calif., was recruited along with several other doctors to fill hospitalist positions in rural Bishop, Calif. She has since driven 600 miles round trip every month for a week of hospital medicine shifts at Northern Inyo Hospital.

Dr. Mandal said she has really enjoyed her time at the small rural hospital and found it professionally fulfilling to participate so fully in the health of its local community. She was building personal bonds and calling the experience the pinnacle of her career when the COVID-19 pandemic swept across America and the world, even reaching into Bishop, population 3,760, in the isolated Owens Valley.

The 25-bed hospital has seen at least 100 COVID patients in the past year and some months. Responsibility for taking care of these patients has been both humbling and gratifying, Dr. Mandal said. The facility’s hospitalists made a commitment to keep working through the pandemic.

“We were able to come together (around COVID) as a team and our teamwork really made a difference,” she said.

“One of the advantages in a smaller hospital is you can have greater cohesiveness and your communication can be tighter. That played a big role in how we were able to accomplish so much with fewer resources as a rural hospital.” But staffing shortages, recruitment, and retention remain a perennial challenge for rural hospitals.

Continued on page 22

Dr. Lisa Kaufmann is a hospitalist at Appalachian Regional Healthcare System, Boone, N.C.

Ilaria Gadalla, DMSc, PA-C

p8 Why does this round of COVID-19 feel worse?

Benjamin Kinnear, MD, MEd

p30 What does it mean to be a trustworthy male ally?
Why this round of COVID-19 feels worse
By Ilaria Gadalla, DMSc, PA-C


The recent round of COVID-19 is more frustrating than the first, with scientific evidence supporting ways we can prevent disease and disease progression (Lancet. 2020 Jun 27;395[10242]:1973-87). The health care team is no longer viewed as heroes but as the enemy, fraudulently proposing a vaccine and painting a fictional story of death, though it’s all true. The daily educational battle with patients and family members creates a challenging environment that cultivates hopelessness.

Clinicians are physically exhausted from the numerous COVID cases. Gone are the medical patients we trained for; who either remain home and risk their health or lack access to medical providers because of excessive wait times. Empathy for COVID patients is being tested even more with this new surge, and without the two-way bond of trust, clinicians are running out of fuel.

Anger and distrust regarding vaccination guidance dominate the interaction when patients present demanding urgent intervention, while clinicians know that more than 95% of hospitalized patients while clinicians know that more with this new surge, and with the two-way bond of trust, clinicians are running out of fuel.

The struggle to find the commitment to medicine and serving patients is made worse by the pandemic fog and loss of trust from patients. Every day, health care teams are running out of fuel. The underlying wave of exhaustion and frustration has not completely destroyed their empathy but has depleted their drive.

How can we regain this drive amid exhausting work hours and angry patients?
As much as we have heard it, we need to protect our time to recharge. The demand to pick up extra shifts and support our colleagues has affected our personal lives. Setting boundaries and building time for exercise, meditation, and connecting with family is essential for survival. Mental health is key to retaining empathy and finding hope.

Education is one path to reigniting the fires of critical thinking and commitment to patient care – consider precepting students to support the growth of health care teams. Memories of patient care before this pandemic give us hope that there is light at the end of this tunnel.

Dr. Gadalla is a hospitalist at Treasure Coast Hospitalists in Port St. Lucie, Fla. She is a member of the Hospitalist’s editorial advisory board and also serves as a physician assistant program director at South University in West Palm Beach, Fla. She disclosed no relevant financial relationships.

THE HOSPITALIST is the official newspaper of the Society of Hospital Medicine, reporting on issues and trends in hospital medicine. THE HOSPITALIST reaches more than 35,000 hospitalists, physician assistants, nurse practitioners, medical residents, and health care administrators interested in the practice and business of hospital medicine. Content for THE HOSPITALIST is provided by Frontline Medical Communications. Content for the Society Pages is provided by the Society of Hospital Medicine. Copyright 2021 Society of Hospital Medicine. All rights reserved. No part of this publication may be reproduced, stored, or transmitted in any form or by any means without the prior permission of the copyright holder. The views and opinions expressed in THE HOSPITALIST do not necessarily reflect those of the Society or the Publisher. The Society of Hospital Medicine and Frontline Medical Communications will not assume responsibility for damages, loss, or claims of any kind arising from or related to the information contained in this publication, including any claims related to the products, drugs, or services mentioned herein.

Letters to the Editor: rzz@dmdedge.com

The Society of Hospital Medicine’s headquarters is located at 1500 Spring Garden, Suite 501, Philadelphia, PA 19130.

Editorial Offices: 2275 Research Blvd, Suite 400, Rockville, MD 20850, 703-206-3343, fax 240-221-2548

PHYSICIAN EDITOR
Wejen W. Chang, MD, SFHM, FAAP
Wejen.ChangMD@BaystateHealth.org

PEDIATRIC EDITOR
Anika Kumar, MD, FHIM, FAAP
KumarA4@chcf.org

COORDINATING EDITORS
Alan Hall, MD
The FUTURE HOSPITALIST
Keri Holmes-Maybank, MD, FHIM
INTERPRETING DIAGNOSTIC TESTS

CONTRIBUTING WRITERS
Amir B. Bansal, MD, MBA, SFHM; Larry Beresford; Malachi Courtney, MD; Bradley Flansbaum, DO, MHM; Marcia Frelick; Ilana Gadalla, DMSc, PA-C; Allan J. Gray, MD; Tareq Islam, MD, MPH; Benjamim Kinnear, MD, Med; Jennifer Lubell; Matt Penya; Heidi Spletet; Nih N. Vu, MD

FRONTLINE MEDICAL COMMUNICATIONS EDITORIAL STAFF
Executive Editor Kathy Strickland, MD
Editor Richard Pizzi
Creative Director Louise A. Koening
Director, Production/Manufacturing Rebecca Slodobnik

EDITORIAL ADVISORY BOARD
Ramesh Advikhan, MD, MS; Hyung (Harry) Cho, MD, SFHM; Ilana Gadalla, DMSc, PA-C; James Kim, MD; Ponon Dileep Kumar, MD, FACP, CPE; Shym Odeti, MD, MS, FHIM; Venkataraman Palabandla, MD, SFHM; Tiffani M. Panek, MA, SFHM, CLHM; Kranthi Sittamagari, MD; Arthik Skandhan, MD, FHIM; Lonika Soor, J. Gray, MD, FACP, FHIM; Armit Vashist, MD, FACP

THE SOCIETY OF HOSPITAL MEDICINE Phone: 800-843-3360
Fax: 267-702-2690
Website: www.HospitalMedicine.org

Chief Executive Officer
Eric E. Howell, MD, MHM

Director of Communications
Brad Radler
bradler@HospitalMedicine.org

Communications Specialist
Myles Daigneault
mdaigneault@hospitalmedicine.org

SHM BOARD OF DIRECTORS
President
Jerome C. S, MD, MHA, SFHM
President-Elect
Rachel Thompson, MD, MPH, SFHM
Treasurer
Kris Rehm, MD, SFHM
Immediate Past President
Danielle Schreur, MD, MSC, SFHM

Board of Directors
Tracy Cardin, ACNP-BC, SFHM
Bryce Garland, MD, SFHM
Elen C. Manjarez, MD
Mark W. Shen, MD, SFHM

Frontline Medical Communications Advertising Staff
Senior Director Business Development
Angelique Rocco, 703-206-2335
cell 917-532-5383 annci@mdedge.com

Recruitment Sales Representative
Linda Wilson, 703-290-8243
lwilson@mdedge.com

Senior Director of Classified Sales
Tim LaPolla, 848-921-5001
cell 610-506-3474 tlapolla@mdedge.com

Advertising Offices
7 Century Drive, Suite 302, Parsippany, NJ 07054-4609
703-206-3343, fax 703-206-9378

COMMENTARY
THE HOSPITALIST
Why this round of COVID-19 feels worse
By Ilaria Gadalla, DMSc, PA-C

E

unrest. Defeat. Hopelessness. Physicians, nurses, physician assistants, and nurse practitioners are overwhelmed with burnout.

The recent round of COVID-19 is more frustrating than the first, with scientific evidence supporting ways we can prevent disease and disease progression (Lancet. 2020 Jun 27;395[10242]:1973-87). The health care team is no longer viewed as heroes but as the enemy, fraudulently proposing a vaccine and painting a fictional story of death, though it’s all true. The daily educational battle with patients and family members creates a challenging environment that cultivates hopelessness.

Clinicians are physically exhausted from the numerous COVID cases. Gone are the medical patients we trained for; who either remain home and risk their health or lack access to medical providers because of excessive wait times. Empathy for COVID patients is being tested even more with this new surge, and without the two-way bond of trust, clinicians are running out of fuel.

Anger and distrust regarding vaccination guidance dominate the interaction when patients present demanding urgent intervention, while clinicians know that more than 95% of hospitalized patients are unvaccinated (Morb Mortal Wkly Rep. 2021;70:1150-5).

The struggle to find the commitment to medicine and serving patients is made worse by the pandemic fog and loss of trust from patients. Every day, health care teams risk their personal well-being to provide medical care and intervention. Not by choice do we gown up, mask up, and glove up. Each time we enter a COVID patient’s room, we expose ourselves and risk our own lives and the lives of our families for the patients who have elected to ignore medical guidance.

This national wave of resistance to vaccination is spurring an exodus from health care. Physicians are retiring early and physician assistants and nurse practitioners are seeking non-patient-facing positions to improve their own wellness and balance. A national nursing shortage is impacting patients seeking care in every medical discipline. The underlying wave of exhaustion and frustration has not completely destroyed their empathy but has depleted their drive.

How can we regain this drive amid exhausting work hours and angry patients?
As much as we have heard it, we need to protect our time to recharge. The demand to pick up extra shifts and support our colleagues has affected our personal lives. Setting boundaries and building time for exercise, meditation, and connecting with family is essential for survival. Mental health is key to retaining empathy and finding hope.

Education is one path to reigniting the fires of critical thinking and commitment to patient care – consider precepting students to support the growth of health care teams. Memories of patient care before this pandemic give us hope that there is light at the end of this tunnel.
**In the Literature**

Clinician reviews of HM-centric research

By Amit B. Bansal, MD, MBA, SFHM; Malachi Courtney, MD; Bradley Flansbaum, DO, MHM; Tareq Islam, MD, MPH

**Division of Hospital Medicine, Geisinger Medical Center, Danville, Pa.**

**IN THIS ISSUE**

1. Albumin infusions do not benefit hospitalized patients with cirrhosis
2. Colchicine in secondary prevention of coronary artery disease
3. Toward a definition of persistent *S. aureus* bacteremia

---

1. **Albumin infusions do not benefit hospitalized patients with cirrhosis**

**CLINICAL QUESTION:** Do albumin infusions help reduce infection, kidney dysfunction, or death in patients hospitalized with liver cirrhosis?

**BACKGROUND:** Patients with decompensated cirrhosis are highly susceptible to infection, causing renal failure and death. Albumin is recommended for patients with large-volume paracentesis, spontaneous bacterial peritonitis, and hepatorenal syndrome. Some studies support an anti-inflammatory role for albumin, but clinical trials for benefit from albumin infusions to reduce infection and prevent renal dysfunction have shown conflicting results.

**STUDY DESIGN:** Prospective, interventional, multicenter, randomized, open-label trial.

**SETTING:** 35 hospitals across England, Scotland, and Wales.

**SYNOPSIS:** Of patients with decompensated cirrhosis, 777 were randomized to receive either 20% human albumin solution to target serum albumin levels 30 g/Liter and higher or standard care. Most patients had alcohol-related liver disease with mean baseline albumin level of 23.2 plus/minus 3.7 g per liter. A median of 200 g of albumin was administered in the albumin group to bring albumin level above 30 g per liter, as compared with a median of 20 g in the standard care group. The primary end point was a composite of infection, renal dysfunction, or death. A total of 113 patients (29.7%) in the albumin group and 120 patients (30.2%) in the control group had a primary end point event (adjusted odds ratio, 0.98; 95% confidence interval, 0.71-1.33; *P* = .87). There were no differenc

---

2. **Colchicine in secondary prevention of coronary artery disease**

**CLINICAL QUESTION:** Can colchicine reduce the risk of major adverse cardiovascular events (MACE) in patients with coronary artery disease (CAD)?

**BACKGROUND:** Colchicine has broad anti-inflammatory properties and has shown therapeutic benefit in conditions such as gouty arthritis, rheumatoid arthritis, familial Mediterranean fever, and pericarditis. However, for patients with established CAD, the therapeutic benefits and harms of colchicine remain inconclusive. This meta-analysis addresses colchicine use and the incidence of MACE in patients with CAD.

**STUDY DESIGN:** Meta-analysis of randomized controlled trials (RCTs).

**SETTING:** Systematic search in electronic databases of PubMed, The Cochrane Library, and Scopus to identify eligible studies.

**SYNOPSIS:** Investigators included five RCTs that met criteria to be included in the meta-analysis. These RCTs were published between 2013 and 2020 and had follow-up duration of greater than 6 months. Of a total of 11,790 patients with CAD, 5,906 were assigned to the colchicine group and 5,884 to the control group. Average age of patients was 60-66 years, and 83% of patients were men. Dosages of colchicine were 0.5 mg once or twice daily. There were a total 362 events in the colchicine group and 321 events in the control group. Compared with placebo, colchicine treatment was associated with a reduced risk of MACE (relative risk, 0.65; 95% CI, 0.52-0.82; *P* less than .001). There was no impact on cardiovascular mortality, and rates of adverse events were similar in both groups.

**LIMITATIONS**

- The definition of MACE varies among studies.
- There is no consensus on how long to continue colchicine treatment after an event.

---

3. **Toward a definition of persistent *S. aureus* bacteremia**

**CLINICAL QUESTION:** In *Staphylococcus aureus* bacteremia, how are mortality and metastatic infections impacted according to the duration of bacteremia?

**BACKGROUND:** Persistent *S. aureus* bacteremia is not universally defined, and the impact of the duration of positive blood cultures on mortality has not been determined.

**STUDY DESIGN:** Secondary analysis of a prospective cohort study.

**SETTING:** 17 European tertiary care hospitals 2013-2015.

**SYNOPSIS:** Patients from 17 tertiary care hospitals who were diagnosed with *S. aureus* bacteremia included in this study. Median duration of bacteremia was 3 days. Patients with more than 1 day of bacteremia had increased SOFA scores, C-reactive proteins, and Charlson comorbidity index score. There was a relatively low prevalence of MRSA at 11% of patients. Mortality at 90 days significantly increases from 22% with 1 day of bacteremia, 39% with 2-4 days of bacteremia, 43% with 5-7 days, and 36% with more than 7 days of bacteremia. With use of bootstrapping methods with 1,000 iterations, it was found that 2 or...
A third-generation cephalosporin was reported to be effective. It was presumed a fourth-generation cephalosporin would also be active. Of the 26,036 patients included in the study, 4,165 (19%) received initial inappropriate antimicrobial therapy. The majority of bacterial isolates that were found to be discordant were of the Enterobacteriales group (45%) or Staphylococcus aureus (32%). Regardless of in vitro susceptibility of the bacteria, presence of sepsis, or septic shock, inappropriate empiric antimicrobial therapy alone was associated with increased risk of mortality in all patients with bacteremia.

**BOTTOM LINE:** To decrease mortality associated with discordant treatment of bloodstream infections, the study results suggest the significance of identifying bacteria and the sensitivity patterns early in bloodstream infections. These findings are especially important for S. aureus and Enterobacteriales infections.


---

**SHORT TAKES**

**Bundled payments in commercially insured population reduce costs for surgical procedures**

An Employer-Provider Direct Payment Program modeled on Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement was implemented by several self-insured employers. The adoption of this program for three high-cost surgical procedures—joint replacement, spinal fusion, and bariatric surgery—was associated with average $4,229 (10.7%) reduction in cost. Both employer and employee costs decreased and a significant reduction in price variation was seen.


---

**Four strategies targeting ED physician decision-making could modify admission rates**

**CLINICAL QUESTION:** ED physicians play a vital role in the decision to admit a patient. What is the physician-level variation in hospital admission rates for Medicare patients?

**BACKGROUND:** Rates of admission vary widely across both regions of the country and hospitals. Prior studies have documented variations in admission rates for Medicare beneficiaries, but these studies have focused on regional and hospital-level variation. The extent to which admission rates from the ED vary across physicians within institutions remains poorly understood.

**STUDY DESIGN:** Investigators examined Medicare fee-for-service claims for a 20% random sample of beneficiaries from January 2012 through September 2015 in a retrospective analysis analyzing the association of admission rates between ED physicians from within the same hospital. The researchers adjusted the data set for both physician and patient characteristics and comorbidities.

**SETTING:** ED visits to nonfederal hospitals (excluding Indian Health Service and Veterans Affairs hospitals) located in all 50 states and Washington, D.C.

**SYNOPSIS:** Given the widespread use of diabetic agents, the paper highlights and includes helpful tables outlining strategies for approaching various insulin and oral drugs before procedures. Most recommendations should be familiar to active practitioners (i.e., holding preparations taken orally and reducing insulin dosages the morning of surgery). Continue thyroid preparations and assess steroid dosages and compensate based on operative stress, using established guidelines. As for hormonal risks, administer them after consulting with VTE risk-assessment scores. For osteoporotic compounds, providers should hold bisphosphonates. As for urologic drugs, consultants can continue most compounds with PDE-5 inhibitors and anticholinergics being the exceptions.

**BOTTOM LINE:** Hospitals can apply this SPAQI review of perioperative endocrine and urologic medications to update their working knowledge of the lesser prioritized meds they will encounter during surgical evaluation.


---

**6 Strategies targeting ED physician decision-making could modify admission rates**

**CLINICAL QUESTION:** ED physicians play a vital role in the decision to admit a patient. What is the physician-level variation in hospital admission rates for Medicare patients?

**BACKGROUND:** Rates of admission vary widely across both regions of the country and hospitals. Prior studies have documented variations in admission rates for Medicare beneficiaries, but these studies have focused on regional and hospital-level variation. The extent to which admission rates from the ED vary across physicians within institutions remains poorly understood.

**STUDY DESIGN:** Investigators examined Medicare fee-for-service claims for a 20% random sample of beneficiaries from January 2012 through September 2015 in a retrospective analysis analyzing the association of admission rates between ED physicians from within the same hospital. The researchers adjusted the data set for both physician and patient characteristics and comorbidities.

**SETTING:** ED visits to nonfederal hospitals (excluding Indian Health Service and Veterans Affairs hospitals) located in all 50 states and Washington, D.C.

**SYNOPSIS:** Given the widespread use of diabetic agents, the paper highlights and includes helpful tables outlining strategies for approaching various insulin and oral drugs before procedures. Most recommendations should be familiar to active practitioners (i.e., holding preparations taken orally and reducing insulin dosages the morning of surgery). Continue thyroid preparations and assess steroid dosages and compensate based on operative stress, using established guidelines. As for hormonal risks, administer them after consulting with VTE risk-assessment scores. For osteoporotic compounds, providers should hold bisphosphonates. As for urologic drugs, consultants can continue most compounds with PDE-5 inhibitors and anticholinergics being the exceptions.

**BOTTOM LINE:** Hospitals can apply this SPAQI review of perioperative endocrine and urologic medications to update their working knowledge of the lesser prioritized meds they will encounter during surgical evaluation.


---

**SHORT TAKES**

**Bundled payments in commercially insured population reduce costs for surgical procedures**

An Employer-Provider Direct Payment Program modeled on Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement was implemented by several self-insured employers. The adoption of this program for three high-cost surgical procedures—joint replacement, spinal fusion, and bariatric surgery—was associated with average $4,229 (10.7%) reduction in cost. Both employer and employee costs decreased and a significant reduction in price variation was seen.


---

**Four strategies targeting ED physician decision-making could modify admission rates**

**CLINICAL QUESTION:** ED physicians play a vital role in the decision to admit a patient. What is the physician-level variation in hospital admission rates for Medicare patients?

**BACKGROUND:** Rates of admission vary widely across both regions of the country and hospitals. Prior studies have documented variations in admission rates for Medicare beneficiaries, but these studies have focused on regional and hospital-level variation. The extent to which admission rates from the ED vary across physicians within institutions remains poorly understood.

**STUDY DESIGN:** Investigators examined Medicare fee-for-service claims for a 20% random sample of beneficiaries from January 2012 through September 2015 in a retrospective analysis analyzing the association of admission rates between ED physicians from within the same hospital. The researchers adjusted the data set for both physician and patient characteristics and comorbidities.

**SETTING:** ED visits to nonfederal hospitals (excluding Indian Health Service and Veterans Affairs hospitals) located in all 50 states and Washington, D.C.

**SYNOPSIS:** Given the widespread use of diabetic agents, the paper highlights and includes helpful tables outlining strategies for approaching various insulin and oral drugs before procedures. Most recommendations should be familiar to active practitioners (i.e., holding preparations taken orally and reducing insulin dosages the morning of surgery). Continue thyroid preparations and assess steroid dosages and compensate based on operative stress, using established guidelines. As for hormonal risks, administer them after consulting with VTE risk-assessment scores. For osteoporotic compounds, providers should hold bisphosphonates. As for urologic drugs, consultants can continue most compounds with PDE-5 inhibitors and anticholinergics being the exceptions.

**BOTTOM LINE:** Hospitals can apply this SPAQI review of perioperative endocrine and urologic medications to update their working knowledge of the lesser prioritized meds they will encounter during surgical evaluation.


---

**SHORT TAKES**

**Bundled payments in commercially insured population reduce costs for surgical procedures**

An Employer-Provider Direct Payment Program modeled on Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement was implemented by several self-insured employers. The adoption of this program for three high-cost surgical procedures—joint replacement, spinal fusion, and bariatric surgery—was associated with average $4,229 (10.7%) reduction in cost. Both employer and employee costs decreased and a significant reduction in price variation was seen.


---

**Four strategies targeting ED physician decision-making could modify admission rates**

**CLINICAL QUESTION:** ED physicians play a vital role in the decision to admit a patient. What is the physician-level variation in hospital admission rates for Medicare patients?

**BACKGROUND:** Rates of admission vary widely across both regions of the country and hospitals. Prior studies have documented variations in admission rates for Medicare beneficiaries, but these studies have focused on regional and hospital-level variation. The extent to which admission rates from the ED vary across physicians within institutions remains poorly understood.

**STUDY DESIGN:** Investigators examined Medicare fee-for-service claims for a 20% random sample of beneficiaries from January 2012 through September 2015 in a retrospective analysis analyzing the association of admission rates between ED physicians from within the same hospital. The researchers adjusted the data set for both physician and patient characteristics and comorbidities.

**SETTING:** ED visits to nonfederal hospitals (excluding Indian Health Service and Veterans Affairs hospitals) located in all 50 states and Washington, D.C.

**SYNOPSIS:** Given the widespread use of diabetic agents, the paper highlights and includes helpful tables outlining strategies for approaching various insulin and oral drugs before procedures. Most recommendations should be familiar to active practitioners (i.e., holding preparations taken orally and reducing insulin dosages the morning of surgery). Continue thyroid preparations and assess steroid dosages and compensate based on operative stress, using established guidelines. As for hormonal risks, administer them after consulting with VTE risk-assessment scores. For osteoporotic compounds, providers should hold bisphosphonates. As for urologic drugs, consultants can continue most compounds with PDE-5 inhibitors and anticholinergics being the exceptions.

**BOTTOM LINE:** Hospitals can apply this SPAQI review of perioperative endocrine and urologic medications to update their working knowledge of the lesser prioritized meds they will encounter during surgical evaluation.

indicates physician-level tendencies mattered as they relate to hospital admission.

**BOTTOM LINE:** There is significant variation among ED physicians within the same hospital, suggesting an opportunity to devise targeted interventions to influence physician decision-making. Additionally, “average” group-based performance measures accounting for a large department may be deceiving; a composite score may conceal the actual drivers of an outcome (one to two doctors over an entire group).


---

**SHORT TAKES**

**Lower risk of hypoglycemia with long-acting insulin analogs among older adults**

Retrospective study among older (age 65 years or older) community-residing patients found that the initiation of use of insulin with glargine or detemir was associated with a nearly 30% reduced risk of ED visits or hospitalizations for hypoglycemia, compared with the initiation of NPH (Neutral Protamine Hagedorn) insulin use.


---

**IV radiocontrast has no harmful effect on kidney function**

**CLINICAL QUESTION:** Is intravenous radiocontrast associated with significant kidney injury?

**BACKGROUND:** Many hospitalists consider radiocontrast to be nephrotoxic. However, contemporary observational studies find no evidence of an association between intravenous contrast and kidney injuries. As observational studies cannot establish causality, would employing an alternative study design (likening to “effective randomization”) confirm current trends in thinking?

**STUDY DESIGN:** The investigators applied a creative regression discontinuity strategy in their analysis. While performing a randomized controlled trial would be impractical, a pseudorandomized design was the most effective approach to evaluate an exposed and nonexposed contrast group for the purposes of minimizing confounding. By recruiting patients at risk for a pulmonary embolism, above and below the 500-ng/mL D-dimer eligibility cutoff for computed tomographic pulmonary angiogram (CTPA), the research team recruited two cohorts of patients. Contrast administration was the sole distinction between the groups.

**SETTING:** The Canadian province of Alberta between 2013 and 2018.

**SYNOPSIS:** Of adult patients in the ED, 156,028 were included in the results. At baseline, the patients just above and below the CTPA eligibility cutoff were similar in terms of measured confounders. The investigators did not find associations between CTPA contrast and estimated glomerular filtration rate (eGFR), acute kidney injury, need for kidney replacement therapy, or death at 6 months. Overall, there was a mean change in eGFR of -0.4 mL/min/1.73 m² (95% CI, -4.9-4.0) correlated with CTPA exposure. Subgroup analyses by risk factors such as age or diabetes showed no associations between dye exposure and long-term eGFR.

**BOTTOM LINE:** A more meticulous study design adds to our prior knowledge base, further establishing intravenous contrast as a surrogate and not a causal agent in eGFR declines.


By Tareq Islam, MD, MPH

**Cryoblation or drug therapy for initial treatment of AFib?**

**CLINICAL QUESTION:** Does catheter ablation as initial treatment for symptomatic atrial fibrillation lower

Continued on following page

---

I’ve been with SHM since the first hospital medicine meeting in San Francisco in 1997. My favorite part about being an SHM member is the opportunity to contribute to the organization’s development and evolution. I value the networking opportunities, relationships I’ve built, diverse educational and professional offerings, local Chapter support, and Special Interest Groups. It is a privilege to know and work alongside so many talented individuals and leaders. SHM has helped me grow both professionally and as a hospital leader.

“Together, We Are the Power of Care.”

We invite you to join our SHM family. hospitalmedicine.org/join

Kenneth Simone, DO, SFHM

SHM Member - 24 Years
Continued from previous page

the incidence of AFib recurrence more than antiarrhythmic medication as initial therapy?

**BACKGROUND:** For the patient with symptomatic AFib, antiarrhythmic drugs are the initial therapy of choice according to the guideline. Often these medications have somewhat limited efficacy. When they fail, catheter ablation is superior to medication in maintaining sinus rhythm and improvement of quality of life. This study compared the efficacy of the use of catheter cryoballoon ablation with antiarrhythmic drugs to prevent the recurrence of atrial tachyarrhythmia.

**STUDY DESIGN:** Investigator-initiated, multicenter, open-label, randomized trial, blinded endpoint.

**SETTING:** 18 centers in Canada.

**SYNOPSIS:** Of adult patients (older than 18 years of age) who had symptomatic AFib, 303 were randomized in a 1:1 ratio to an initial strategy of catheter cryoballoon ablation (pulmonary vein isolation, n = 156) or antiarrhythmic drug therapy (mostly flecainide, n = 149). At the time of enrollment, all the patients underwent insertion of an implantable cardiac monitor to detect the timing of occurrence of arrhythmia and quantification of AFib burden. The main endpoint was the first recurrence of any atrial tachyarrhythmia (AFib, atrial flutter, or atrial tachycardia) lasting 30 seconds or longer between 91 days and 365 days after either treatment strategy. At 1 year, 42.9% of patients who underwent cryoballoon had documented recurrence of atrial tachyarrhythmia, compared with 67.8% among the antiarrhythmic drugs group (hazard ratio, 0.48; 95% CI, 0.35-0.66; P less than .001).

The rate of adverse events was 3.2% and 4.0% among the ablation group and antiarrhythmic drug group, respectively. One limitation was lack of power to examine cardiovascular outcome, limited to 1 year follow-up.

**BOTTOM LINE:** Catheter ablation as initial therapy for symptomatic AFib had a significantly lower rate of recurrence of atrial tachyarrhythmia than antiarrhythmic drug therapy.

**Hospitalists helped plan pandemic field hospitals**

*It’s a great thing to be overprepared*

By Larry Beresford

At the height of the COVID-19 pandemic’s terrifying first wave in the spring of 2020, dozens of hospitals in high-incidence areas either planned or opened temporary, emergency field hospitals to cover anticipated demand for beds beyond the capacity of local permanent hospitals. Chastened by images of overwhelmed health care systems in Northern Italy and other hard-hit areas, the planners used available modeling tools and estimates for projecting maximum potential need in worst-case scenarios. Some of these temporary hospitals never opened. Others opened in convention centers, parking garages, or parking lot tents, and ended up being used to a lesser degree than the worst-case scenarios.

But those who participated in the planning – including, in many cases, hospitalists – believe they created alternate care site manuals that could be quickly revived in the event of future COVID surges or other, similar crises. Better to plan for too much, they say, than not plan for enough.

Field hospitals or alternate care sites are defined in a recent journal article in Prehospital Disaster Medicine as “locations that can be converted to provide either inpatient and/or outpatient health services when existing facilities are compromised by a hazard impact or the volume of patients exceeds available capacity and/or capabilities.”

The lead author of that report, Sue Anne Bell, PhD, FNP-BC, a disaster expert and assistant professor of nursing at the University of Michigan, was one of five members of the leadership team for planning UM’s field hospital. They used an organizational unit structure based on the U.S. military’s staffing structure, with their work organized around six units of planning: personnel and labor, security, clinical operations, logistics and supply, planning and training, and communications. This team planned a 519-bed step-down care facility, the Michigan Medicine Field Hospital, for a 73,000-foot indoor track and performance facility at the university, 3 miles from UM’s main hospital. The aim was to provide safe care in a resource-limited environment.

“We were prepared, but the need never materialized as the peak of COVID cases started to subside,” Dr. Bell said. The team was ready to open within days using a “T-Minus” framework of days remaining on an official countdown clock. But when the need and deadlines kept getting pushed back, that gave them more time to develop clearer procedures.

Two Michigan Medicine hospitalists, Christopher Smith, MD, and David Paje, MD, MPH, both professors at UM’s medical school, were intimately involved in the process. “I was the medical director for the respiratory care unit that was opened for COVID patients, so I was pulled in to assist in the field hospital planning,” said Dr. Smith.

Dr. Paje was director of the short-stay unit and had been a medical officer in the U.S. Army, with training in how to set up military field hospitals. He credits that background as helpful for UM’s COVID field hospital planning, along with his experience in hospital medicine operations.

“We expected that these patients would need the expertise of hospitalists, who had quickly become familiar with the peculiarities of the new disease. That played a role in the decisions we made. Hospitalists were at the front lines of COVID care and had unique clinical insights about managing those with severe disease,” Dr. Paje added.

“When we started, the projections were dire. You don’t want to believe something like that is going to happen. When COVID started to cool off, it was more of a relief to us than anything else,” Dr. Smith said. “Still, it was a very worthwhile exercise. At the end of the day, we put together a comprehensive guide, which is ready for the next crisis.”

**A convention center hospital**

A COVID-19 field hospital was planned and executed at an exhibit hall in the Baltimore Convention Center, starting in March 2020 under the leadership of Johns Hopkins Bayview hospitalist Eric E. Howell, MD, MHM, who eventually handed over responsibilities as chief medical officer when he assumed the position of CEO for the Society of Hospital Medicine in July of that year. Hopkins collaborated with the University of Maryland health system and state leaders, including the Secretary of Health, to open a 252-bed temporary facility, which at its peak carried a census of 48 patients, with no on-site mortality or cardiac arrests, before it was closed in June 2021 – ready to reopen if necessary. It also served as Baltimore’s major site for polymerase chain reaction COVID-19 testing, vaccinations, and monoclonal antibody infusions, along with medical research.

“My belief at the time we started was that my entire 20-year career as a hospitalist had prepared me for the challenge of opening a COVID field hospital,” Dr. Howell said. “I had learned how to build clinical programs. The difference was that instead of months and years to build a program, we only had a few weeks.”

His first request was to bring on an associate medical director for the field hospital, Melinda E. Kant-siper, MD, a hospitalist and director of clinical operations in the Division of Hospital Medicine at Johns Hopkins Bayview. She became the field hospital’s chief medical officer when Dr. Howell moved to SHM. “As hospitalists, we are trained to care for the patient in front of us while at the same time creating systems that can adjust to rapidly changing circumstances,” Dr. Kantsiper said. “We did what was asked and set up a field hospital that cared for a total of 1,500 COVID patients.”

Hospitalists have the tools that are needed for this work, and shouldn’t be reluctant to contribute to field hospital planning, she said. “This was a real eye-opener for me. Eric explained to me that hospitalists really practice acute care medicine, which doesn’t have to be within the four walls of a hospital.”

The Baltimore field hospital has been a fantastic experience, Dr. Kantsiper added. “But it’s not a building designed for health care delivery.” For the right group of providers, the experience of working in a temporary facility such as this can be positive and exhilarating. “But we need to make sure we take care of our staff. It takes a toll. How we keep them safe – physically and emotionally – has to be top of mind,” she said.

The leaders at Hopkins Medicine and their collaborators truly engaged with the field hospital’s mission, Dr. Howell added. “They gave us a lot of autonomy and helped us break down barriers. They gave us the political capital to say proper PPE was absolutely essential. As hard and devastating as the pandemic has been, one takeaway is that we showed that we can be more flexible and elastic in response to actual needs than we used to think.”

**Range of challenges**

Among the questions that need to be answered by a field hospital’s planners, the first is “where to put it?” The answer is, hopefully, somewhere not too far away, large enough, with ready access to supplies and intake. The next question is “who is the patient?” Clinicians must determine who goes to the field hospital versus who stays at the standing hospital. How sick should these patients be? And when do they need to be discharged? The Renown COVID-19 field hospital photographed under construction in Reno.
Continued from previous page

What about patients with substance abuse or psychiatric comorbidities? “Are we going to do paper charting? How will that work out for long-term documentation and billing?” Dr. Bell said. A clear reporting structure and communication pathways are essential. Among the other operational processes to address, outlined in Dr. Bell’s article, are orientation and training, PPE donning and doffing procedures, the code or rapid response team, patient and staff food and nutrition, infection control protocols, pharmacy services, access to radiology, rounding procedures, staff support, and the morgue.

One other issue that shouldn’t be overlooked is health equity in the field hospital. “Providing safe and equitable care should be the focus. Thinking who goes to the field hospital should be done within a health equity framework,” Dr. Bell said. She also wonders if field hospital planners are sharing their experience with colleagues across the country and developing more collaborative relationships with other hospitals in their communities.

“Field hospitals can be different things,” Dr. Bell said. “The important take-home is it doesn’t have to be in a tent or a parking garage, which can be suboptimal.” In many cases, it may be better to focus on finding unused space within the hospital – whether a lobby, staff lounge, or unoccupied unit – closer to personnel, supplies, pharmacy, and the like. “I think the pandemic showed us how unprepared we were as a health care system, and how much more we need to do in preparation for future crises.”

Limits to the temporary hospital

In New York City, which had the country’s worst COVID-19 outbreak during the first surge in the spring of 2020, a 1,000-bed field hospital was opened at the Jacob Javits Center in March 2020 and closed that June. “I was in the field hospital early, in March and April, when our hospitals were temporarily overrun,” said hospitalist Mona Krouss, MD, FACP, CPPS, NYC Health + Hospitals’ director of patient safety. “My role was to figure out how to get patients on our medical floors into these field hospitals, with responsibility for helping to revise admission criteria,” she said.

“No one knew how horrible it would become. This was so unanticipated, so difficult to operationalize. What they were able to create was amazing, but there were just too many barriers to have it work smoothly,” Dr. Krouss said.

“The military stepped in, and they helped us so much. We wouldn’t have been able to survive without their help.” But there is only so much a field hospital can do to provide acute medical care. Later, military medical teams shifted to roles in temporary units inside the permanent hospitals. “They came to the hospital wanting to be deployed,” she said.

“We could only send patients to the field hospital who were fairly stable, and choosing the right ones...
was difficult.” Dr. Krouss said. In the end, not a lot of COVID patients from NYC Health + Hospitals ended up going to the Javits Center, in part because paperwork and logistics were barriers. A process was established for referring doctors to speak with a New York City Department of Health employee to go through the criteria for admission to the field hospital.

“That could take up to 30 minutes before getting approval. Then you had to go through the same process all over again for sign-out to another physician, and then register the patient with a special bar code. Then you had to arrange ambulance transfer. Doctors didn’t want to go through all of that – everybody was too busy,” she explained. Hospitalists have since worked on streamlining the criteria. “Now we have a good process for the future. We made it more seamless,” she noted.

Susan Lee, DO, MBA, hospitalist and chief medical officer for Renown Regional Medical Center in Reno, Nev., helped to plan an alternate care site in anticipation of up to a thousand COVID patients in her community – far beyond the scope of the existing hospitals. Hospitalists were involved the entire time in planning, design of the unit, design of staffing models, care protocols, and the like, working through an evidence-based medical committee and a COVID-19 provider task force for the Renown Health System.

“Because of a history of fires and earthquakes in this region, we had an emergency planning infrastructure in place,” Dr. Lee said. “We put the field hospital on the first and second floors of a parking garage, with built-in negative pressure capacity. We also built space for staff break rooms and desk space. It took 10 days to build the hospital, thanks to some very talented people in management and facility design.”

Then, the hospital was locked up and sat empty for 7 months, until the surge in December 2020, when Reno was hit by a bigger wave – this time exceeding the hospitals’ capacity. Through mid-January of 2021, clinicians cared for approximately 240 COVID-19 patients, up to 47 at a time, in the field hospital. A third wave in the autumn of 2021 plateaued at a level lower than the previous fall, so the field hospital is not currently needed.

Replicating hospital workflows

“We ensured that everybody who needed to be within the walls of the permanent hospitals was able to stay there,” said Dr. Lee’s colleague, hospitalist Adnan (Eddy) Akbar, MD. “The postacute system we ordinarily rely on was no longer accepting patients. Other hospitals in the area were able to manage within their capacity because Renown’s field hospital could admit excess patients.”

When the field hospital finally opened, Dr. Akbar said, “we had a good feeling. We were ready. If something more catastrophic had come down, we were ready to care for more patients. In the field hospital you have to keep monitoring your workflow – almost on a daily basis. But we felt privileged to be working for a system where you knew you can go and care for everyone who needed care.”

One upside of the field hospital experience for participating clinicians, Dr. Lee added, is the opportunity to practice creatively. “The downside is it’s extremely expensive, and has consequences for the mental health of staff. Like so many of these things, it wore on people over time. And recently the patients have become a lot less gracious.”

Amy Baughman, MD, a hospitalist at Massachusetts General Hospital in Boston, was co–medical director of the post–acute care section of a 1,000-bed field hospital, Boston Hope Medical Center, opened in April 2020 at the Boston Convention and Exhibition Center. The other half of the facility was dedicated to undomiciled COVID-19 patients who had no place else to go. Peak census was around 100 patients, housed on four units, each with a clinical team led by a physician.

“Dr. Baughman’s field hospital experience has taught her the importance of ‘staying within your domain of expertise. Physicians are attracted to difficult problems and want to do everything themselves. Next time I won’t be the one installing hand sanitizer dispensers.’ A big part of running a field hospital is logistics, she said, and physicians are trained clinicians, not logistics engineers.

“So it’s important to partner with logistics experts. A huge part of our success in building a facility in 9 days of continuous construction was the involvement of the National Guard,” she said. An incident command system was led by an experienced military general, incident commander, with two clinical directors. The U.S. army also sent in full teams of health professionals.

The facility admitted far fewer patients than the worst-case projections before it closed in June 2020. “But at the end of the day, we provided a lot of excellent care,” Dr. Baughman said.

“This was about preparing for a disaster. It was all hands on deck, and the hands were health professionals,” she said. “We spent a lot of money for the patients we took care of, but we had no choice, based on what we believed could happen. At that time, so many nursing facilities and homeless shelters were closed to us. It was impossible to predict what utilization would be.”

Subsequent experience has taught that a lot of even seriously ill COVID-19 patients can be managed safely at home, for example, using accelerated home oxygen monitoring with telelinked pulse oximeters. But in the beginning, Dr. Baughman said, “it was a new situation for us. We had seen what happened in Europe and China. It’s a great thing to be overprepared.”

For a complete list of references, see the online version of this article at www.the-hospitalist.org.
A study that compared three types of direct oral anticoagulants (DOACs) found that rivaroxaban was associated with a much higher risk of overall and major gastrointestinal bleeding than apixaban or dabigatran.

The results, which were published in Annals of Internal Medicine, could help guide DOAC selection for high-risk groups with a prior history of peptic ulcer disease or major GI bleeding, said lead study authors Arnar Bragi Ingason, MD, and Einar S. Björnsson, MD, PhD.

DOACs treat conditions such as atrial fibrillation, venous thromboembolism, and ischemic stroke and are known to cause GI bleeding. Previous studies have suggested that rivaroxaban poses a higher GI bleeding risk than other DOACs.

These studies, which used large administrative databases, "had an inherent risk of selection bias due to insurance status, age, and comorbidities due to their origin from insurance/administrative databases. In addition, they lacked phenotypic details on GI bleeding events," said Dr. Björnsson and Dr. Ingason, who are both of Landspitali University Hospital, Reykjavik, Iceland.

Rivaroxaban is administered as a single daily dose, compared with apixaban's and dabigatran's twice-daily regimens. "We hypothesized that this may lead to a greater variance in drug plasma concentration, making these patients more susceptible to GI bleeding," the lead authors said.

Using data from the Icelandic Medicine Registry, a national database of outpatient prescription information, they compared rates of GI bleeding among new users of apixaban, dabigatran, and rivaroxaban from 2014 to 2019. Overall, 5,868 patients receiving one of the DOACs took part in the study. Among these participants, 3,217 received rivaroxaban, 2,157 received apixaban, and 494 received dabigatran.

The researchers used inverse probability weighting, Kaplan–Meier survival estimates, and Cox regression to compare GI bleeding.

Compared with dabigatran, rivaroxaban was associated with a 63%-104% higher overall risk for GI bleeding and 39%-95% higher risk for major GI bleeding. Rivaroxaban also had a 40%-42% higher overall risk for GI bleeding and 49%-50% higher risk for major GI bleeding, compared with apixaban. The investigators were surprised by the low rate of upper-GI bleeding for dabigatran, compared with the other two drugs. "However, these results must be interpreted in the context that the dabigatran group was relatively small," said Dr. Björnsson and Dr. Ingason.

Overall, the study cohort was small, compared with previous registry studies.
VEKLURY is indicated for the treatment of adults and pediatric patients ≥12 years old and weighing ≥40 kg requiring hospitalization for COVID-19. VEKLURY should only be administered in a hospital or healthcare setting capable of providing acute care comparable to inpatient hospital care.

**IMPORTANT SAFETY INFORMATION**

**Contraindication**

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

**Warnings and precautions:**

- **Hypersensitivity, including infusion-related and anaphylactic reactions:**
  - Hypersensitivity, including infusion-related and anaphylactic reactions, has been observed during and following administration of VEKLURY. Monitor patients under close medical supervision for hypersensitivity reactions during and following administration of VEKLURY. Symptoms may include hypotension, hypertension, tachycardia, bradycardia, hypoxia, fever, dyspnea, wheezing, angioedema, rash, nausea, diaphoresis, and shivering. Slower infusion rates (maximum infusion time ≤120 minutes) can potentially prevent these reactions. If a severe infusion-related hypersensitivity reaction occurs, immediately discontinue VEKLURY and initiate appropriate treatment (see Contraindications).

- **Increased risk of transaminase elevations:**
  - Transaminase elevations have been observed in healthy volunteers and in patients with COVID-19 who received VEKLURY; these elevations have also been reported as a clinical feature of COVID-19. Perform hepatic laboratory testing in all patients (see Dosage and administration). Consider discontinuing VEKLURY if ALT levels increase to >10x ULN. Discontinue VEKLURY if ALT elevation is accompanied by signs or symptoms of liver inflammation.

- **Risk of reduced antiviral activity when coadministered with chloroquine or hydroxychloroquine:**
  - Coadministration of VEKLURY with chloroquine phosphate or hydroxychloroquine sulfate is not recommended due to antagonism observed in cell culture, which may lead to a decrease in antiviral activity of VEKLURY.

**Adverse reactions**

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

**Drug interactions**

- Drug interaction trials of VEKLURY and other concomitant medications have not been conducted in humans.

---

Investigators also did not account for socioeconomic status or lifestyle factors, such as alcohol consumption or smoking. “However, because the cost of all DOACs is similar in Iceland, selection bias due to socioeconomic status is unlikely,” the investigators reported in their paper.

“We are currently working on comparing the rates of thromboembolisms and overall major bleeding events between the drugs,” the lead authors said.

Though retrospective, the study by Ingason et al. “is likely as close as is feasible to a randomized trial as is possible,” said Don C. Rockey, MD, of the Medical University of South Carolina, Charleston, in an interview.

“It is important to take away that there may be differences among the DOACs in terms of where in the GI tract the bleeding occurs,” he said.

In the study, the greatest differences appeared to be in the upper-GI tract, with rivaroxaban outpacing apixaban and dabigatran. In patients who are at risk for upper-GI bleeding, it may be reasonable to consider use of dabigatran or apixaban, Dr. Rockey suggested.
HEPA filters may clean SARS-CoV-2 from the air

By Marcia Frellick

High-efficiency particulate air (HEPA) filters and ultraviolet-light sterilization effectively remove SARS-CoV-2 particles from the air — the first such evidence in a real-world test, researchers reported in the preprint server medRxiv.

The journal Nature reported Oct. 6 that the research, which has not been peer-reviewed, suggests the filters may help reduce the risk of hospital-acquired SARS-CoV-2.

Researchers, led by intensivist Andrew Conway-Morris, MBChB, PhD, with the division of anaesthesia in the school of clinical medicine at University of Cambridge (England), write that earlier experiments assessed air filters’ ability to remove inactive particles in carefully controlled environments, but it was unknown how they would work in a real-world setting.

Coauthor Vilas Navapurkar, MB-ChB, an ICU physician at Addenbrooke’s Hospital in Cambridge, said that hospitals have used portable air filters when their isolation facilities are full, but evidence was needed as to whether such filters are effective or whether they provide a false sense of security.

The researchers installed the filters in two fully occupied COVID-19 wards – a general ward and an ICU. They chose HEPA filters because they can catch extremely small particles. The team collected air samples from the wards during a week when the air filters were on and 2 weeks when they were turned off, then compared results.

According to the study, “airborne SARS-CoV-2 was detected in the ward on all five days before activation of air/UV filtration, but on none of the five days when the air/UV filter was operational; SARS-CoV-2 was again detected on four out of five days when the filter was off.”

Airborne SARS-CoV-2 was not frequently detected in the ICU, even when the filters were off.

The authors suggest several potential explanations for this, “including slower viral replication at later stages of the disease.” Therefore, the authors say, filtering the virus from the air might be more important in general wards than in ICUs.

The filters significantly reduced the other microbial bioaerosols in both the ward (48 pathogens detected before filtration, 2 after; \( P = .05 \)) and the ICU (45 pathogens detected before filtration, 5 after; \( P = .05 \)).

National Institute for Occupational Safety and Health cyclonic aerosol samplers and PCR tests were used to detect airborne SARS-CoV-2 and other microbial bioaerosol.

David Fisman, MD, an epidemiologist at the University of Toronto, who was not involved in the research, said in the Nature article, “This study suggests that HEPA air cleaners … are a cheap and easy way to reduce risk from airborne pathogens.”
What makes a urinary tract infection complicated?

Key Clinical Question
What makes a urinary tract infection complicated?
Consider anatomical and severity risk factors

By Nhi N. Vu, MD; and Adam J. Gray, MD

Background
The urinary tract is divided into the upper tract, which includes the kidneys and ureters, and the lower urinary tract, which includes the bladder, urethra, and prostate. Infection of the lower urinary tract is referred to as cystitis, while infection of the upper urinary tract is pyelonephritis. A UTI is the colonization of pathogen(s) within the urinary system that causes an inflammatory response resulting in symptoms and requiring treatment. UTIs occur when there is reduced urine flow and an increase in colonization risk, and when there are factors that facilitate ascent such as catheterization or incontinence.

There are an estimated 150 million cases of UTIs worldwide per year, accounting for $6 billion in health care expenditures.1 In the inpatient setting, about 40% of nosocomial infections are associated with urinary catheters. This equates to about 1 million catheter-associated UTIs per year in the United States, and up to 40% of hospital gram-negative bacteremia per year are caused by UTIs.2 UTIs are often classified as either uncomplicated or complicated infections, which can influence the depth of management. UTIs have a wide spectrum of symptoms and can manifest anywhere from mild dysuria treated successfully with outpatient antibiotics to florid sepsis. Uncomplicated simple cystitis is often treated as an outpatient with oral nitrofurantoin or trimethoprim-sulfamethoxazole.2 Complicated UTIs are treated with broader antimicrobial coverage, and depending on severity, could require intravenous antibiotics. Many factors affect how a UTI manifests and determining whether an infection is “uncomplicated” or “complicated” is an important first step in guiding management. Unfortunately, there are differing classifications of “complicated” UTIs, making it a complicated issue itself. We outline two common approaches.

Anatomic approach
A commonly recognized definition is from the American Urological Association, which states that complicated UTIs are symptomatic cases associated with the presence of “underlying, predisposing conditions and not necessarily clinical severity, invasiveness, or complications.”3 These factors include structural or functional urinary tract abnormalities or urinary instrumentation (see Table 1). These predisposing conditions can increase microbial colonization and decrease therapy efficacy, thus increasing the frequency of infection and relapse.

This population of patients is at high risk of infections with more resistant bacteria such as extended-spectrum beta-lactamase (ESBL) producing Escherichia coli since they often lack the natural genitourinary barriers to infection. In addition, these patients more often undergo multiple antibiotic courses for their frequent infections, which also contributes to their risk of ESBL infections. Genitourinary abnormalities interfere with normal voiding, resulting in impaired flushing of bacteria. For instance, obstruction inhibits complete urinary drainage and increases the persistence of bacteria in biofilms, especially if there are stones or indwelling devices present. Biofilms usually contain a high concentration of organisms including Proteus mirabilis, Morganella morganii, and Providencia spp.4 Keep in mind that, if there is an obstruction, the urinalysis might be without pyuria or bacteriuria.

Instrumentation increases infection risks through the direct introduction of bacteria into the genitourinary tract. Despite the efforts in maintaining sterility in urinary catheter placement, catheterization increases the risk of infection. According to the American Urological Association, which states that complicated UTIs are symptomatic cases associated with the presence of “underlying, predisposing conditions and not necessarily clinical severity, invasiveness, or complications.”3 These factors include structural or functional urinary tract abnormalities or urinary instrumentation (see Table 1). These predisposing conditions can increase microbial colonization and decrease therapy efficacy, thus increasing the frequency of infection and relapse.

This population of patients is at high risk of infections with more resistant bacteria such as extended-spectrum beta-lactamase (ESBL) producing Escherichia coli since they often lack the natural genitourinary barriers to infection. In addition, these patients more often undergo multiple antibiotic courses for their frequent infections, which also contributes to their risk of ESBL infections. Genitourinary abnormalities interfere with normal voiding, resulting in impaired flushing of bacteria. For instance, obstruction inhibits complete urinary drainage and increases the persistence of bacteria in biofilms, especially if there are stones or indwelling devices present. Biofilms usually contain a high concentration of organisms including Proteus mirabilis, Morganella morganii, and Providencia spp.4 Keep in mind that, if there is an obstruction, the urinalysis might be without pyuria or bacteriuria.

Instrumentation increases infection risks through the direct introduction of bacteria into the genitourinary tract. Despite the efforts in maintaining sterility in urinary catheter placement, catheterization increases the risk of infection. According to the American Urological Association, which states that complicated UTIs are symptomatic cases associated with the presence of “underlying, predisposing conditions and not necessarily clinical severity, invasiveness, or complications.”3 These factors include structural or functional urinary tract abnormalities or urinary instrumentation (see Table 1). These predisposing conditions can increase microbial colonization and decrease therapy efficacy, thus increasing the frequency of infection and relapse.

This population of patients is at high risk of infections with more resistant bacteria such as extended-spectrum beta-lactamase (ESBL) producing Escherichia coli since they often lack the natural genitourinary barriers to infection. In addition, these patients more often undergo multiple antibiotic courses for their frequent infections, which also contributes to their risk of ESBL infections. Genitourinary abnormalities interfere with normal voiding, resulting in impaired flushing of bacteria. For instance, obstruction inhibits complete urinary drainage and increases the persistence of bacteria in biofilms, especially if there are stones or indwelling devices present. Biofilms usually contain a high concentration of organisms including Proteus mirabilis, Morganella morganii, and Providencia spp.4 Keep in mind that, if there is an obstruction, the urinalysis might be without pyuria or bacteriuria.

Instrumentation increases infection risks through the direct introduction of bacteria into the genitourinary tract. Despite the efforts in maintaining sterility in urinary catheter placement, catheterization increases the risk of infection.
Multiorgan dysfunction (sepsis, renal failure, developing symptoms. Catheters will develop bacteriuria general patients with indwelling. These systemic findings would suggest an extension of infection or other findings of sepsis would be classified as a complicated UTI. The argument for a symptomatic-based approach of classification is that the severity of symptoms should dictate the degree of management. Not all UTIs in the anatomic approach are severe. In fact, populations that are considered at risk for complicated UTIs by the severity approach, systemic findings such as fever, chills, emesis, flank pain, costovertebral angle tenderness, or other findings of sepsis would be classified as a complicated UTI. The conclusion of this approach to classifying complicated UTIs is that the severity approach is often considered. Although the existence of algorithmic approaches can help guide clinical judgment, accounting for the spectrum of host and bacterial factors should ultimately determine the complexity of the disease and management.3 Using clinical suspicion to determine when a UTI should be treated as a complicated infection can ensure effective treatment and decrease the likelihood of sepsis, renal scarring, or end-stage disease.5 Uncomplicated UTIs from the AUA guidelines can cause severe infections that might require longer courses of broad-spectrum antibiotics. On the other hand, people with anatomic abnormalities can present with mild symptoms that can be treated with a narrow-spectrum antibiotic for a standard time course.

**Severity approach**

There are other schools of thought that categorize uncomplicated versus complicated UTIs based on the severity of presentation (see Table 2). An uncomplicated UTI would be classified as symptoms and signs of simple cystitis limited to dysuria, frequency, urgency, and suprapubic pain. With a symptom severity approach, systemic findings such as fever, chills, emesis, flank pain, costovertebral angle tenderness, or other findings of sepsis would be classified as a complicated UTI. These systemic findings would suggest an extension of infection beyond the bladder.

### Additional reading


### Table 2: The severity approach

<table>
<thead>
<tr>
<th>Signs and symptoms suggesting ascending infection beyond the bladder</th>
<th>Fever, chills, rigors</th>
<th>Flank pain, costovertebral angle tenderness</th>
<th>Nausea, emesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of systemic complications</td>
<td>Bacteremia</td>
<td>Multorgan dysfunction (sepsis, renal failure, encephalopathy)</td>
<td></td>
</tr>
</tbody>
</table>

**Quiz**

A 68-year-old woman with type 2 diabetes mellitus presents to the emergency department with acute fever, chills, dysuria, frequency, and suprapubic pain. She has associated nausea, malaise, and fatigue. She takes metformin and denies recent antibiotic use. Her temperature is 102.6°F, heart rate 118 beats per minute, blood pressure 118/71 mm Hg, and her respiratory rate is 24 breaths per minute. She is ill-appearing and has mild suprapubic tenderness. White blood cell count is 18 k/mcL. Urinalysis is positive for leukocyte esterase, nitrites, and bacteria. Urine microscopy has 120 white blood cells per high power field. What is the most appropriate treatment?

- A. Azithromycin
- B. Ceftriaxone
- C. Cefepime and vancomycin
- D. Nitrofurantoin

**Explanation of correct answer**

The answer is B. The patient presents with sepsis secondary to a urinary tract infection. Using the anatomic approach, this would be classified as uncomplicated. Using the severity approach, this would be classified as a complicated UTI. With fever, chills, and signs of sepsis, it is likely her infection extends beyond the bladder. Given the severity of her presentation, we’d favor treating her as a complicated UTI with intravenous ceftriaxone. There is no suggestion of resistance or additional methicillin-resistant Staphylococcus aureus risk factors requiring intravenous vancomycin or cefepime. Nitrofurantoin, although a first-line treatment for uncomplicated cystitis, would not be appropriate if there is suspicion infection extends beyond the bladder. Azithromycin is a first-line option for chlamydia trachomatis, but not a UTI.
Hospitalist movers and shakers

A season of career transitions

By Matt Pesyna

Vineet Chopra, MD, MSc, FHM, recently became chair of the Department of Medicine at the University of Colorado School of Medicine, Aurora. He had previously been the chief of the Division of Hospital Medicine at the University of Michigan Health system. He assumed his new role in October 2021.

Dr. Chopra, who specializes in research and mentorship in patient safety, helped create innovations in care delivery at the University of Michigan, including direct care hospitalist services at VA Ann Arbor Health Care and two other community hospitals.

In his safety-conscious research, Dr. Chopra focuses on preventing complications created within the hospital environment. He also is the first hospitalist to be named deputy editor of the Annals of Internal Medicine. He has written more than 250 peer-reviewed articles. Among the myriad awards he has received, Dr. Chopra recently earned the Kaiser Permanente Award for Clinical Teaching at the UM School of Medicine.

Steve Phillipson, MD, FHM, has been named regional director of hospital medicine at Aspirus Health (Wausau, Wis.). Dr. Phillipson will oversee the hospitalist programs at 17 Aspirus hospitals in Wisconsin and Michigan.

Dr. Phillipson has worked with Aspirus since 2009, with stints in the emergency department and as a hospitalist. As Aspirus Wausau Hospital director of medicine, he chaired the facility’s COVID-19 treatment team.

Hackensack (N.J.) Meridian University Medical Center has hired Patricia (Patti) L. Fisher, MD, MHA, to be the institution’s chief medical officer. Dr. Fisher joined the medical center from Central Vermont Medical Center where she served as chief medical officer and chief safety officer, with direct oversight of hospital risk management, operations of all hospital-based services, IS services and quality including patient safety and regulatory compliance.

As a board-certified hospitalist, Dr. Fisher also served as clinical assistant professor in the Department of Family Medicine at the University of Vermont, Burlington. Dr. Fisher earned her medical degree from The University of Texas in Houston and completed residency through Forbes Family Practice Residency in Pittsburgh.

Martin Chaney, MD, has been chosen by the Maury Regional Health Board of Trustees to serve as interim chief executive officer. He was formerly the chief medical officer at MRH, which is based in Columbia, Tenn. Dr. Chaney began his new role in October, replacing Alan Watson, the CEO since 2012.

Dr. Chaney has spent 18 of his 25 years in medicine with MRH, where most recently he has focused on clinical quality, physician recruitment, and establishing and expanding the hospital medicine program.

Hyung (Harry) Cho, MD, SFHM, has been placed on Modern Healthcare’s Top 25 Innovators list for 2021, getting recognized for innovation and leadership in creating value and safety initiatives in New York City’s public health system. Dr. Cho became NYC Health + Hospitals’ first chief value officer in 2019, and his programs have created an estimated $11 million in savings per year by preventing unnecessary testing and treatment that can lead to patient harm.

A member of the Society of Hospital Medicine’s editorial advisory board, Dr. Cho is also SHM’s hospitalist liaison with the COVID-19 Real-Time Learning Network, which collaborates with the Centers for Disease Control and Prevention and the Infectious Diseases Society of America.

Raymond Kiser, MD, a hospitalist and nephrologist at Columbus (Ind.) Regional Health, has been named the Douglas J. Leonard Caregiver of the Year. The award is given by the Indiana Hospital Association to health care workers whose care is considered exemplary by both peers and patients.

Dr. Kiser has been with CRH for 7 years, including stints as associate chief medical officer and chief of staff.

Justin Buchholz, DO, has been elevated to medical director of the hospitalist teams at Regional Medical Center (Alamosa, Colo.) and Conejos County Hospital (La Jara, Colo.). Dr. Buchholz has been a full-time hospitalist and assistant medical director at Parkview Medical Center (Pueblo, Colo.) for the past 3 years. He also worked on a part-time basis seeing patients at the Regional Medical Center.

Dr. Buchholz completed his residency at Parkview Medical Center and was named Resident of the Year in his final year with the internal medicine program.

Kenneth Mishark, MD, SFHM, a hospitalist with the Mayo Clinic Hospital (Tucson, Ariz.), will serve on the board of directors for Anigent, a drug diversion-prevention company based in Chesterfield, Mo. He will be charged with helping Anigent better serve health systems with its drug-diversion software.

Dr. Mishark is vice-chair of diversion prevention across the whole Mayo Clinic. A one-time physician in the United States Air Force, Dr. Mishark previously has been the Mayo Clinic’s Healthcare Information Coordination Committee chair.

Core Clinical Partners (Tulsa, Okla.) has announced it will join with Hillcrest HealthCare System (Tulsa) to provide hospitalist services to Hillcrest’s eight sites across Oklahoma. The partners will begin at four locations in December 2021, and four others in March 2022.

In expanding its services, Core Clinical Partners will create 70 new physician positions, as well as a systems-wide medical director. Core will manage hospitalist operations at Hillcrest Medical Center, Hillcrest Hospital South, Hillcrest Hospital Pryor, Hillcrest Hospital Claremore, Bailey Medical Center, Hillcrest Hospital Cushing, Hillcrest Hospital Henryetta, and Tulsa Spine and Specialty Hospital.

Back to the case

The case presents an elderly woman with diabetes presenting with sepsis from a UTI. Because of a normal urinalysis and no prior instrumentation, by the AUA definition, she would be classified as an uncomplicated UTI; however, we would classify her as a complicated UTI based on the severity of her presentation. She has a fever, tachycardia, flank pain, and costovertebral-angle tenderness that are evidence of infection extending beyond the bladder. She has sepsis warranting inpatient management. Prior urine culture results could aid in determining empiric treatment while waiting for new cultures. In her case, an intravenous antibiotic with broad gram-negative coverage such as ceftriaxone would be appropriate.

Bottom line

There are multiple interpretations of complicated UTIs including both an anatomical and severity approach. Clinical judgment regarding infection severity should determine the depth of management.

References
Rural hospitals

Continued from page 1

‘And COVID only exacerbated the problems,’ she said. ‘I’ve had my challenges trying to make proper treatment plans without access to specialists.’

It was also difficult to witness so many patients severely ill or dying from COVID, Dr. Mandal said, especially since patients were not allowed family visitors – even though that was for a good reason, to minimize the virus’s spread.

HM in rural communities

Hospital medicine continues to extend into rural communities and small rural hospitals. In 2018, 35.7% of all rural counties in America had hospitals staffed with hospitalists, and 63.3% of rural hospitals had hospitalist programs (compared with 79.2% of urban hospitals). These numbers come from Medicare resources files from the Department of Health & Human Services, analyzed by Peiyin Hung, PhD, assistant professor of health services management and policy at the University of South Carolina, Columbia. Hospitalist penetration rates rose steadily from 2011 to 2017, with a slight dip in 2018, Dr. Hung said in an interview.

A total of 138 rural hospitals have closed since 2010, according to the Cecil G. Sheps Center for Health Services Research in Chapel Hill, N.C. Nineteen rural hospitals closed in 2020 alone, although many of those were caused by factors pre-dating the pandemic. Only one has closed so far in 2021. But financial pressures, including low patient volumes and loss of revenue from canceled routine services like elective surgeries during the pandemic, have added to hospitals’ difficulties.

Pandemic relief funding may have helped some hospitals stay open, but that support eventually will go away.

Experts emphasize the diversity of rural America and its health care systems. Rural economies are volatile and more diverse than is often appreciated. The hospital may be a cornerstone of the local economy; when one closes, it can devastate the community. Workforce is one of the chief components of a hospital’s ability to meet its strategic vision, and hospitalists are a big part in that. But while hospitalists are valued and appreciated, if the hospital is suffering severe financial problems, that will impact its doctors’ jobs and livelihoods.

“Bandwidth” varies widely for rural hospitalists and their hospitalist groups, said Ken Simone, DO, SFHM, executive chair of SHM’s Rural Special Interest Group and founder and principal of KGS Consultants, a Hospital Medicine and Primary Care Practice Management Consulting company. They may face scarce resources, scarce clinical staffing, lack of support staff to help operations run smoothly, lack of access to specialists locally, and lack of technology. While practicing in a rural setting presents various challenges, it can be rewarding for those clinicians who embrace its autonomy and broad scope of services, he said.

SHM’s Rural SIG focuses on the unique needs of rural hospitalists, providing them with an opportunity to share their concerns, challenges and solutions through roundtable discussions every other month and a special interest forum held in conjunction with the SHM Converge annual conference. Dr. Simone said, ‘The next SHM Converge will be April 7-10, 2022, in Nashville, Tenn.’ The Rural SIG also collaborates with other hospital medicine SIGs and committees and is working on a white paper, ‘Key Principles and Characteristics of an Effective Rural Hospital Medicine Group.’ It is also looking to develop a rural mentorship exchange program.

COVID reaches rural America

Early COVID caseloads tended to be in urban areas, but subsequent surges of infections have spread to many rural areas. Some rural settings became epicenters for the pandemic in November and December 2020. More recent troubling rises in COVID cases, particularly in areas with lower vaccination rates – suggest that the challenges of the pandemic are still not behind us. ‘By no means is the crisis done in rural America,’ said Alan Morgan, CEO of the National Rural Health Association, in a Virtual Rural Health Journalism workshop on rural health care sponsored by the Association of Health Care Journalists.

Mr. Morgan’s colleague, Brock Slabach, NRHA’s chief operations officer, said in an interview that, while 453 of the 1,800 hospitals in rural areas fit NRHA criteria as being vulnerable to closure, the rest are not, and are fulfilling their missions for their communities. Hospitalists are becoming more common in these hospitals, he said, and rural hospitalists can be an important asset in attracting primary care physicians – who might not appreciate being perpetually on call for their hospitalized patients – to rural communities.

In many cases, traveling doctors like Dr. Mandal or telemedicine backup, particularly for after-hours coverage or ICU beds, are important pieces of the puzzle for smaller hospitals. There are different ways to use the spectrum of telemedicine services to interact with a hospital’s daytime and night routines. In some isolated locations, nurse practitioners or physician assistants provide on-the-ground coverage with virtual backup. Rural hospitals often affiliate with telemedicine networks within health systems – or else contract with independent specialized providers of telemedicine consultation.

Mr. Slabach said another alternative for staffing hospitals with smaller ED and inpatient volumes is to have one doctor on duty who can manage patients for a maximum of 24 hours.

Community connections and proactive staffing

Lisa Kaufmann, MD, works as a hospitalist for a two-hospital system in North Carolina, Appalachian Regional Health Care. She practices at Watauga Medical Center, with 100 licensed beds in Boone, and at...
Cannon Memorial Hospital, a critical access hospital in unincorporated Linville. "We are proud of what we have been able to accomplish during the pandemic," she said.

A former critical care unit at Watauga had been shut down, but its wiring remained intact. "We turned it into a COVID unit in 3 days. Then we opened another COVID unit with 18 beds, but that still wasn’t enough. We converted half of our med/surg capacity into a COVID unit. At one point almost half of all our acute beds were for COVID patients. We made plans for what we would do if it got worse, since we had almost run out of beds," she said. Demand peaked at the end of January 2021.

"The biggest barrier for us was if someone needed to be transferred, for example, if they needed ECMO [extracorporeal membrane oxygenation], and we couldn’t find another hospital to provide that technology." In ARHC’s mountainous region – known as the “High Country” – weather can also make it difficult to transport patients. "Sometimes the ambulance can’t make it off the mountain, and half of the time the medical helicopter can’t fly. So we have to be prepared to keep people who we might think ought to be transferred," she said.

Like many rural communities, the High Country is tightly knit, and its hospitals are really connected to their communities, Dr. Kauffman said. The health system already had a lot of community connections beyond acute care, and that meant the pandemic wasn’t experienced as severely as it was in some other rural communities. "But without hospitalists in our hospitals, it would have been much more difficult."

Proactive supply fulfillment meant that her hospitals never ran out of personal protective equipment. "Staffing was a challenge, but we were proactive in getting traveling doctors to come here. We also utilized extra doctors from the local community," she said. Another key was well-established disaster planning, with regular drills, and a robust command structure, which just needed to be activated in the crisis. "Small hospitals need to be prepared for disaster," Dr. Kauffman said.

For Dale Wiersma, MD, a hospitalist with Spectrum Health, a 14-hos-

nal system in western Michigan, telemedicine services are coordinated across 8 rural regional hospitals. "We don’t tend to use it for direct hospitalist work during daytime hours, unless a facility is swamped, in which case we can cross-cover. We do more telemedicine at night. But during daytime hours we have access to stroke neurology, cardiology, psychiatry, critical care, and infectious disease specialists who are able to offer virtual consults," Dr. Wiersma said. A virtual critical care team of doctor and nurse is often the only intensivist service covering Spectrum’s rural hospitals.

"In our system, the pandemic accelerated the adoption of telemedicine," Dr. Wiersma said. "We had been working on the tele-ICU program, trying to get it rolled out. When the pandemic hit, we launched it in just 6 weeks."

There have been several COVID surges in Michigan, he said. "We were stretched pretty close to our limit several times, but never to the breaking point. For our physicians, it was the protracted nature of the pandemic that was fatiguing for everyone involved. Our system worked hard to staff up as well as it could, to make sure our people didn’t go over the edge." It was also hard for hospitals that typically might see one or two deaths in a month to suddenly have five in a week.

Another Spectrum hospitalist, Christopher Skinner, MD, works at two rural Michigan hospitals 15 minutes apart in Big Rapids and Reed City. "I provide after-hours coverage in rural areas. I’ve never had an ambition to be a top dog. I like the style of practice where you don’t have all of the medical subspecialties on site. It frees you up to use all your skills," Dr. Skinner said.

But that approach was put to the test by the pandemic, since it was harder to transfer those patients who normally would not have stayed at these rural hospitals. "We had to make do," he said, although virtual backup and second opinions from Spectrum’s virtual critical care team helped.

"It was a great collaboration, which helped us to handle critical care cases that we hadn’t had to manage pre-COVID. We’ve gotten used to it, with the backup, so I expect we’ll still be taking care of these kind of sick ventilator patients even after the pandemic ends," Dr. Skinner said. "We’ve gotten pretty good at it."

Sukhbir Pannu, MD, a hospitalist in Denver and CEO and founder of Rural Physicians Group, said the pandemic was highly impactful, operationally and logistically, for his firm, which contracts with 54 hospitals to provide hospitalist staffing. "There was no preparation. Everything had to be done on the fly. Initially, it was felt that rural areas weren’t at as great a risk for COVID, but that proved not to be true. Many experienced a sudden increase in very sick patients. We set up a task force to manage daily census in all of our contracted facilities."

"How did Rural Physicians Group manage through the crisis? "The short answer is telemedicine," he said. "We had physicians on the ground in these hospitals. But we needed intensivists at the other end of the line to support them. Conversations about telemedicine were already going on in the company, but the pandemic provided the impetus to launch its network, which has grown to include rheumatologists, pulmonologists, cardiologists, infection medicine, neurology, and psychiatry, all reachable through a central command structure."

Telemedicine is not a cure-all, Dr. Pannu said. It doesn’t work in a vacuum. It requires both a provider on the ground and specialists available remotely. "But it can be a massive multiplier."

Critical medicine

Other hospitals, including small and rural ones, have reported taking on the challenge of covering critical care with nonintensivist physicians because the pandemic demanded it. David Aymond, MD, a hospitalist at 60-bed Byrd Regional Hospital in Leesville, La., population 6,612, has advocated for years for expanded training and credentialing opportunities in intensive care medicine beyond the traditional path of becoming a board-certified intensivist. Some rural hospitalists were already experienced in providing critical care for ICU patients even before the pandemic hit.

"What COVID did was to highlight the problem that there aren’t enough intensivists in this country, particular for smaller hospitals,"

Dr. Pannu

Dr. Aymond said. Some hospitalists who stepped into crisis roles in ICUs during COVID surges showed that they could take care of COVID patients very well.

Dr. Aymond, who is a fellowship-trained hospitalist with primary training in family medicine, has used his ICU experience in both fellowship and practice to make a thorough study of critical care medicine, which he put to good use when the seven-bed ICU at Byrd Memorial filled with COVID patients. "Early on, we were managing multiple ventilators throughout the hospital," he said. "But we were having good outcomes. Our COVID patients were surviving." That led to Dr. Aymond being interviewed by local news media, which led to other patients across the state asking to be transferred to the “COVID specialist who practises at Byrd.”

Dr. Aymond would like to see opportunities for abbreviated 1-year critical care fellowships for hospitalists who have passed enough ICU experience in practice or in residency, and to make room for family medicine physicians in such programs. He is also working through SHM with the Society of Critical Care Medicine to generate educational content, such as a critical care lecture series: www.hospitalmedicine.org/clinical-topics/critical-care/.

Dr. Mandal, who also works as a pediatric hospitalist, said that experience gave her more familiarity with using noninvasive methods for delivering respiratory therapies like high-flow oxygen. "When I saw a COVID patient who had hypoxia but was still able to talk, I didn’t hesitate to deliver oxygen through noninvasive means." Eventually hospital practice generally for COVID caught up with this approach.

Throughout the pandemic, she never wavered in her commitment to rural hospital medicine and its opportunities for working in a small and wonderful community, where she could practice at the top of her license, with a degree of autonomy not granted in other settings. For doctors who want that kind of practice, she said, “the rewards will be paid back in spades. That’s been my experience.”

For a complete list of references, see the online version of this article at www.the-hospitalist.org.

the-hospitalist.org 23 November 2021
Hiring Hospitalists at Atlantic Health System- Leading Hospital System in New Jersey

Overview
Atlantic Health System seeks Hospitalists for award-winning New Jersey Facilities – Chilton Medical Center, Overlook Medical Center and Morristown Medical Center in New Jersey. Be a part of a thriving Hospitalist program, Both Teaching and Non-Teaching program opportunities some of which are Medicare 5 Star and Leapfrog Grade A, Healthgrades Top 50. Morristown Medical Center is nationally ranked in 2 specialties and is the #1 hospital in New Jersey, according to U.S. News & World Report’s.

Responsibilities
We are seeking a full-time Board-Eligible or Board-Certified Hospitalists and Nocturnists to join one of our thriving Hospitalist programs.

We offer:
- Flexible Scheduling
- Closed or Co-managed ICUs
- EPIC EMR Full Subspecialty Support
- Moonlighting Opportunities
- Paid Time Off and Generous Incentive Compensation
- Comprehensive Health Benefits

About Us
Powered by a workforce of almost 17,000 team members and 4,800 affiliated physicians dedicated to building healthier communities, Atlantic Health System serves more than half of the state of New Jersey including 11 counties and 4.9 million people. The system offers more than 400 sites of care, including seven hospitals: Morristown Medical Center in Morristown, NJ, Overlook Medical Center in Summit, NJ, Newton Medical Center in Newton NJ, Chilton Medical Center in Pompton Plains, NJ, Hackettstown Medical Center in Hackettstown, NJ, Goryeb Children’s Hospital in Morristown, NJ, and Atlantic Rehabilitation Institute in Madison, NJ.

We are confident that you will find success within Atlantic Health System, which has been named for the 13th year in a row to Fortune’s “Top 100 Best U.S. Companies to Work For” list.

To learn more about this opportunity please contact Ritu Vedi, Physician Recruiter at ritu.vedi@atlantichealth.org or call at 973-521-2210.

HOSPITALIST OPPORTUNITY IN SCENIC CENTRAL PENNSYLVANIA COMMUNITY HOSPITAL SETTINGS

Full Time Hospitalist position opportunity at Penn State Health Holy Spirit Medical Center and our brand new facility, Penn State Health Hamden Medical Center. This is an excellent opportunity for physicians who wish to enjoy a high-quality of life while providing care within a community setting employed by the Penn State Health system.

Our Hospitalists diagnose and treat hospital inpatients; prescribe medications and other treatment regimens; stabilize critically ill patients; order or interpret test results; coordinate admission/discharge; and teach and oversee medical residents, students, and other trainees.

What we’re seeking:
- M.D., D.O., or foreign equivalent
- Completion of 3-year ACGME-approved Internal Medicine residency
- Ability to acquire a license to practice in the Commonwealth of Pennsylvania
- BC/BE in internal medicine
- Must be available for night and weekend coverage.

What we’re offering:
- 7a – 7p; 7-on/7-off schedule
- Experienced colleagues and collaborative leadership
- Imbedded moonlighting opportunities
- Competitive compensation plan
- Comprehensive benefits with time off and retirement package
- Experienced colleagues and collaborative leadership
- Imbedded moonlighting opportunities
- Competitive compensation plan
- Comprehensive benefits with time off and retirement package

About Penn State Health:
Penn State Health is a multi-hospital system serving patients and communities across central Pennsylvania. The system includes Penn State Health St. Joseph Medical Center in Reading, Pa., Penn State Health Milton S. Hershey Medical Center, Penn State Children’s Hospital, Penn State Cancer Institute, and Penn State Health Rehabilitation Hospital (jointly owned), based in Hershey, Pa., as well as more than 1,300 physicians and direct care providers at 78 medical office locations. The system also has jointly owned health care providers, including Hershey Outpatient Surgery Center, Hershey Endoscopy Center, Horizon Home Healthcare and the Pennsylvania Psychiatric Institute. Penn State Health shares an integrated strategic plan and operations with Penn State College of Medicine, the University's medical school.

Please contact Physician Recruiter Heather Peffley at hpeffley@pennstatehealth.psu.edu for additional information.

Penn State Health is fundamentally committed to the diversity of our faculty and staff. We believe diversity is unapologetically expressing itself through every person’s perspectives and lived experiences. We are an equal opportunity and affirmative action employer. All qualified applicants will receive consideration for employment without regard to age, color, disability, gender identity or expression, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information.
Hospitalist Opportunities Northwest of Boston

Location, Location, Location

Concord - 30 minutes from Boston

Location, Location, Location

Come join a collegial and supportive hospitalist team at Emerson Hospital located in historic Concord, Massachusetts. Enjoy living in the suburbs with convenient access to metropolitan areas such as Boston, New York and Providence as well as the mountains, lakes and coastal areas.

Emerson Hospital is seeking a Director of Clinical Operations as well as full or part time hospitalists to join our well-established team of 12 attending physicians and 3 nurse practitioners.

- Manageable daily census
- Flexible scheduling to ensure work life balance
- Dedicated nocturnist program
- Intensivist coverage of critical care unit
- Competitive compensation and bonus structure
- Comprehensive benefit package including CME allowance
- Access to top specialty care

For more information please contact:
Diane M Forte Willis
Director of Physician Recruitment and Relations
phone: 978-287-3002
e-mail: dfortewillis@emersonhosp.org

Not a J-1 or H1B opportunity
Prisma Health is a not-for-profit health company and the largest healthcare system in South Carolina. With nearly 30,000 team members, 18 acute and specialty hospitals, 2,947 beds and more than 300 outpatient sites with nearly 2,000 physicians, Prisma Health serves more than 1.2 million unique patients annually in its 21-county market area that covers 50% of South Carolina. Prisma Health’s goal is to improve the health of all South Carolinians by enhancing clinical quality, the patient experience and access to affordable care, as well as conducting clinical research and training the next generation of medical professionals.

Greenville, South Carolina is a beautiful place to live and work and is located on the I-85 corridor between Atlanta and Charlotte and is one of the fastest growing areas in the country(101,454),(742,701). Ideally situated near beautiful mountain ranges, beaches and lakes, we enjoy a diverse and thriving economy, excellent quality of life and wonderful cultural and educational opportunities. Check out all that Greenville, SC has to offer! #yeahTHATgreenville

**Ideal Candidates:**
- BC/BE Internal Medicine Physicians
- IM procedures highly desired, but not required. Simulation center training & bedside training available if needed.
- Comfort managing critically ill patients.

**Details Include:**
- Group comprised of career hospitalists with low turnover
- Relocation allowance available
- EPIC Electronic Medical Record system
- 7 on/7 off schedule with 1 week of vacation per year
- Additional shifts paid at a premium

**Available Opportunities:**

**Nocturnist, Laurens County Hospital**
- $342K base salary with $40K incentive bonus and CME stipend
- Up to $40K sign on bonus for a 4 year commitment

**Nocturnist, Baptist Easley Hospital**
- $342K base salary with $40K incentive bonus and CME stipend
- Up to $40K sign on bonus for a 4 year commitment as a Nocturnist

Please submit a letter of interest and CV to:
Natasha Durham, Physician Recruiter, Natasha.Durham@PrismaHealth.org • ph: 864-797-6114

To learn more, visit www.the-hospitalist.org and click "Advertise" or contact
Linda Wilson • 973-290-8243 • lwilson@mdedge.com

**Mercy Clinic**

**POSITIONS IN THE GREATER ST. LOUIS AREA**

Mercy Clinic is actively recruiting Day Hospitalists and Nocturnists to join our established groups on-campus at two of our Mercy Hospital locations in the Greater St. Louis Metropolitan Area.

Qualified candidates can be IM or FM trained.

**Opportunities Offer:**
- Integrated health system with competitive base salary, quarterly bonus, and incentives
- $25,000 Commencement Bonus
- Providing clinical services at one hospital location
- Ability to moonlight at other Mercy Hospitals in St. Louis and surrounding areas
- Eligibility for sponsorships of H1B Visas
- Comprehensive benefits including health, dental, vacation and $5000 annual CME allowance
- Relocation assistance and professional liability coverage

Locations include Mercy Hospital South in South St. Louis and Mercy Hospital Jefferson in Festus. Both locations have quick and easy access to downtown St. Louis and local amenities.

*Become a part of our legacy and help us build a healthier future.*

For more information, please contact: Joan Humphries | Director, Physician Recruitment Office: 314-364-3021 Joan.Humphries@mercy.net | careers.mercy.net AA/EEO/Minorities/Females/Disabled/Veterans
Find fulfillment with Franciscan! Our close-knit, collaborative hospitalist teams are growing across Indiana. Franciscan Health is seeking BOARD CERTIFIED/BOARD ELIGIBLE INTERNAL MEDICINE OR FAMILY MEDICINE HOSPITALISTS to meet the growing demand of our stable, established hospitalist programs at locations throughout Indiana.

With 13 hospitals, Franciscan Health is one of the largest Catholic health care systems in the Midwest. Of our 260+ locations, many are nationally recognized Centers of Health Care Excellence. Franciscan Health takes pride in providing compassionate, comprehensive care for our patients and the communities we serve.

Our facilities have earned Centers of Excellence designations, five-star quality awards and top rankings in our state and nationwide.

LET US TELL YOU MORE ABOUT FRANCISCAN HOSPITALIST OPPORTUNITIES!

844-FPN-DOCS (376-3627)
practice@franciscanalliance.org
jobs.franciscanhealth.org
Atlantic Health System is seeking full time Hospitalists, Nocturnist and a Medical Director to join our dynamic team in Hackettstown (Warren county) and Newton (Sussex county) New Jersey. Both Hackettstown Medical Center and Newton Medical Center are award winning community hospitals. The Hospitalist is responsible for the provision of in-patient Internal Medicine services to patients under their care within the Medical Center.

- Open ICU with 24-hour Intensivist Telemedicine support.
- Need for strong competent physicians to run RRT and codes.
- Advanced Practice Nursing support
- Designated Observation Unit
- Flexible scheduling

Powered by a workforce of almost 17,000 team members and 4,800 affiliated physicians dedicated to building healthier communities, Atlantic Health System serves more than half of the state of New Jersey including 11 counties and 4.9 million people. The system offers more than 400 sites of care, including seven hospitals: Morristown Medical Center in Morristown, NJ, Overlook Medical Center in Summit, NJ, Newton Medical Center in Newton NJ, Chilton Medical Center in Pompton Plains, NJ, Hackettstown Medical Center in Hackettstown, NJ, Goryeb Children’s Hospital in Morristown, NJ, and Atlantic Rehabilitation Institute in Madison, NJ.

We are confident that you will find success within Atlantic Health System, which has been named for the 13th year in a row to Fortune’s “Top 100 Best U.S. Companies to Work For” list.

Comprehensive health benefits package and competitive salary
- We can assist with NJ medical licensing, provide relocation bonus.
- CME & Tuition Reimbursement
- Work/Life Balance - Flexible Schedule
- Live and work within a short drive of New York City, Poconos, Philadelphia.

To learn more about this opportunity please contact Ritu Vedi, Physician Recruiter at ritu.vedi@atlantichealth.org or call at 973-521-2210.
**Hospitalists/Nocturnists**

Ochsner Health is seeking physicians to join our hospitalist team. BC/BE Internal Medicine and Family Medicine physicians are welcomed to apply. Highlights of our opportunities are:

- Hospital Medicine was established at Ochsner in 1992. We have a stable 50+ member group.
- 7 on 7 off block schedule with flexibility
- Dedicated nocturnists cover nights
- Base plus up to 40 K in incentives
- Average census of 14-18 patients
- ICU intensivist support with open ICUs at the community hospitals
- EPIC medical record system with remote access capabilities
- Dedicated RN and Social Work Clinical Care Coordinators
- Community based academic appointment
- The only Louisiana Hospital recognized by U.S. News and World Report Distinguished Hospital for Clinical Excellence award in 3 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students.
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

Ochsner Health is a system that delivers health to the people of Louisiana, Mississippi and the Gulf South with a mission to Serve, Heal, Lead, Educate and Innovate. Ochsner Health is a not-for-profit committed to giving back to the communities it serves through preventative screenings, health and wellness resources and partnerships with innovative organizations that share our vision. Ochsner Health healed more than 876,000 people from across the globe in 2019, providing the latest medical breakthroughs and therapies, including digital medicine for chronic conditions and telehealth specialty services. Ochsner Health is a national leader, named the top hospital in Louisiana and a top children’s hospital by U.S. News & World Report. As Louisiana’s leading healthcare educator, Ochsner Health and its partners educate thousands of healthcare professionals annually. Ochsner Health is innovating healthcare by investing in new technologies and research to make world-class care more accessible, affordable, convenient and effective. Ochsner’s team of more than 26,000 employees and 4,500 providers are working to reinvent the future of health and wellness in the region. To learn more about Ochsner Health, please visit www.ochsner.org. To transform your health, please visit www.ochsner.org/healthyyou.


Sorry, no opportunities for J1 applications.

Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law.

**Core Physicians**

**Hospitalist – in Exeter, New Hampshire**

- BC/BE Internal Medicine.
- 100-bed community based hospital
- Full subspecialty back-up.
- Group consist of over 20 healthcare providers.
- Mixed medical/surgical ICU staffed by BC Intensivists and Critical Care Certified nurses.

We are located in the beautiful Seacoast region of New Hampshire — just a few minutes from the beach and just one hour from Boston, MA and Portland, Maine. While practicing medicine within our community, you will also enjoy fantastic four season recreation, no state sales or income taxes, and a superb quality of life with one of the lowest crime rates in the nation.

Requirements: Completion of accredited MD/DO, BC/BE, unrestricted medical license, current DEA without restriction and CPR with AED within 6 months of hire.

For more information contact Physician Recruitment Ph: 603.580.7131 E: providerrecruitment@ehr.org www.CorePhysicians.org

**Hospitalist Opportunity**

UC Health Hospitalist Group at West Chester Hospital seeking a board certified/prepared Internal Medicine or Family Medicine physician to join our growing Hospitalist group. West Chester Hospital is a community hospital, located just north of Cincinnati OH, with academic affiliation to the University of Cincinnati Health System.

Seeking candidates for a dedicated nocturnist position. Schedule is a 5 on 10 off rotation. The position is supported by dedicated night NPs as well as daytime partners covering “swing shifts.” There is also 24hr Critical Care Services.

Excellent benefits and retirement packages through the UC Health and the UC College of Medicine. Faculty appointed position at UC College of Medicine with hire. Qualified candidate must be ACLS certified.

CONTACT: Dr. Brad Evans, Director
UC Health Hospitalist Group
evansb7@ucmail.uc.edu
513-298-7325

**Ochsner Health**

Serve, Heal, Lead, Educate and Innovate. Ochsner Health is a system that delivers health to the people of Louisiana, Mississippi and the Gulf South with a mission to Serve, Heal, Lead, Educate and Innovate. Ochsner Health is a not-for-profit committed to giving back to the communities it serves through preventative screenings, health and wellness resources and partnerships with innovative organizations that share our vision. Ochsner Health healed more than 876,000 people from across the globe in 2019, providing the latest medical breakthroughs and therapies, including digital medicine for chronic conditions and telehealth specialty services. Ochsner Health is a national leader, named the top hospital in Louisiana and a top children’s hospital by U.S. News & World Report. As Louisiana’s leading healthcare educator, Ochsner Health and its partners educate thousands of healthcare professionals annually. Ochsner Health is innovating healthcare by investing in new technologies and research to make world-class care more accessible, affordable, convenient and effective. Ochsner’s team of more than 26,000 employees and 4,500 providers are working to reinvent the future of health and wellness in the region. To learn more about Ochsner Health, please visit www.ochsner.org. To transform your health, please visit www.ochsner.org/healthyyou.


Sorry, no opportunities for J1 applications.

Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law.
If you want to be trusted, be trustworthy.
– Stephen Covey

A few years ago, while working in my office, a female colleague stopped by for a casual chat. During the course of the conversation, she noticed that I did not have any diplomas or certificates hanging on my office walls. Instead, there were clusters of pictures drawn by my children, family photos, and a whiteboard with my ‘to-do’ list. The only wall art was a print of Banksy’s ‘The Thinker Monkey,’ which depicts a monkey with its fist to its chin similar to Rodin’s famous sculpture, ‘Le Penseur.’

When asked why I didn’t hang any diplomas or awards, I replied that I preferred to keep my office atmosphere light and fun, and to focus on future goals rather than past accomplishments. I could see her jaw tense. Her frustration appeared deep, but it was for reasons beyond just my self-righteous tone. She said, “You know, I appreciate your focus on future goals, but it’s a pretty privileged position to not have to worry about sharing your accomplishments publicly.”

What followed was a discussion that was generative, enlightening, uncomfortable, and necessary. I had never considered what I chose to hang (or not hang) on my office walls as a privilege, and that was exactly the point. She described numerous episodes when her accomplishments were overlooked or (worse) attributed to a male colleague because she was a woman. I began to understand that graceful self-promotion is not optional for many women in medicine, it is a necessary skill.

This is just one example of how my privilege as a male in medicine contributed to my ignorance of the gender inequities that my female coworkers have faced throughout their careers. My colleague showed a lot of grace by taking the time to help me examine my male privilege in a constructive manner. I decided to learn more about gender inequities, and eventually determined that I was woefully inadequate as a male ally, not by refusal but by ignorance. I wanted to start earning my colleagues’ trust that I would be an ally that she could count on.

Trustworthiness
I wanted to be a trustworthy ally, but what does that entail? Perhaps we can learn from medical education. Trust is a complex construct that is increasingly used as a framework for assessing medical students and residents, such as with entrustable professional activities (EPAs). Multiple studies have examined the characteristics that make a learner “trustworthy” when determining how much supervision is required. Ten Cate and Chen performed an interpretivist, narrative review to synthesize the medical education literature on learner trustworthiness in the past 15 years, developing five major themes that contribute to trustworthiness: Humility, Capability, Agency, Reliability, and Integrity. Let’s examine each of these through the lens of male allyship.

Humility
Humility involves knowing one’s limits, asking for help, and being receptive to feedback. The first thing men need to do is to put their egos in check and recognize that women do not need rescuing; they need partnership. Systemic inequities have led to men holding the majority of leadership positions and significant sociopolitical capital, and correcting these inequities is more feasible when those in leadership and positions of power contribute. Women don’t need knights in armor; they need collaborative activism.

Humility also means a willingness to admit fallibility and to ask for help. Men often don’t know what they don’t know. As David G. Smith, PhD and W. Brad Johnson, PhD, write in their book, “Good Guys,” “There are no perfect allies. As you work to become a better ally for the women around you, you will undoubtedly make a mistake.”

Men must accept feedback on their shortcomings as allies without feeling as though they are losing their sociopolitical standing. Allyship for women does not mean there is a devaluing of men. We must escape a “zero-sum” mindset. Mistakes are where growth happens, but only if we approach our missteps with humility.

Capability
Capability entails having the necessary knowledge, skills, and attitudes to be a strong ally. Allyship is not intuitive for most men for several reasons. Many men do not experience the same biases or systemic inequities that women do, and therefore perceive them less frequently. I want to acknowledge that men can be victims of other systemic biases such as those against one’s race, ethnicity, gender identity, sexual orientation, religion, or any number of factors. Men who face inequities for these other reasons may be more cognizant of the biases women face. Even so, allyship is a skill that few men have been explicitly taught. Even if taught, few standard or organized mechanisms for feedback on allyship capability exist. How then, can men become capable allies?

Just like in medical education, men must become self-directed learners who seek to build capability and receive feedback on their performance as allies. Men should seek allyship training through local women-in-medicine programs or organizations, or through the increasing number of national education options such as the recent ADVANCE PHM Gender Equity Symposium. As with learning any skill, men should go to the literature, seeking knowledge from experts in the field. I recommend starting with “Good Guys: How Men Can Be Better Allies for Women in the Workplace” or “Athena Rising: How and Why Men Should Mentor Women.” Both books, by Dr. Smith and Dr. Johnson, are great entry points into the gender allyship literature. Seek out other resources from local experts on gender equity and allyship. Both aforementioned books were recommended to me by a friend and gender equity expert; without her guidance I would not have known where to start.

Agency
Agency involves being proactive and engaged rather than passive or apathetic. Men must be enthusiastic allies who seek out opportunities to mentor and sponsor women rather than waiting for others to ask. Agency requires being curious and passionate about improving. Most men in medicine are not openly and explicitly misogynistic or sexist, but many are only passive when it comes to gender equity and allyship. Trustworthy allyship entails turning passive support into active change.

Not sure how to start? A good first step is to ask female colleagues questions such as, “What can I do to be a better ally for you in the workplace?” or “What are some things at work that are most challenging to you, but I might not notice because I’m a man?” Curiosity is the springboard toward agency.

Reliability
Reliability means being conscientious and accountable, and doing what we say we will do. Nothing undermines trustworthiness faster than making a commitment and not following through. Allyship cannot be a show or an attempt to get public plaudits. It is a longitudinal commitment to supporting women through individual mentorship and sponsorship, and to work toward institutional and systems change.

Reliability also means taking an equitable approach to what Dr. Smith and Dr. Johnson call “office housework.” They define this as “administrative work that is necessary but undervalued, unlikely to lead to promotion, and disproportionately assigned to women.” In medicine, these tasks include organizing...

Continued on following page

Dr. Kinnear is associate professor of internal medicine and pediatrics in the Division of Hospital Medicine at Cincinnati Children’s Hospital Medical Center and University of Cincinnati Medical Center. He is associate program director for the Med-Peds and Internal Medicine residency programs.
Identify and empower women leaders

By Heidi Splete
MDedge News

Many potential leaders in academic medicine go unidentified, and finding those leaders is key to improving gender equity in academic medicine, said Nancy Spector, MD, in a presentation at the virtual Advance PHM Gender Equity Conference. “I think it is important to reframe what it means to be a leader, and to empower yourself to think of yourself as a leader,” said Dr. Spector, executive director for executive leadership in academic medicine program at Drexel University, Philadelphia.

“Some of the best leaders I know do not have titles,” she emphasized.

Steps to stimulate the system changes needed to promote gender equity include building policies around the life cycle, revising departmental and division governance, and tracking metrics at the individual, departmental, and organizational level, Dr. Spector said.

Aligning gender-equity efforts with institutional priorities and navigating politics to effect changes in the gender equity landscape are ongoing objectives, she said.

Dr. Spector offered advice to men and women looking to shift the system and promote gender equity. She emphasized the challenge of overcoming psychological associations of men and women in leadership roles. “Men are more often associated with agentic qualities, which convey assertion and control,” she said. Men in leadership are more often described as aggressive, ambitious, dominant, self-confident, forceful, self-reliant, and individualistic.

By contrast, “women are associated with communal qualities, which convey a concern for compassionate treatment of others,” and are more often described as affectionate, helpful, kind, sympathetic, sensitive, gentle, and well spoken, she noted.

Although agentic traits are most often associated with effective leadership, in fact, “the most effective contemporary leaders have both agentic and communal traits,” said Dr. Spector.

However, “if a woman leader is very communal, she may be viewed as not assertive enough, and it she is highly agentic, she is criticized for being too domineering or controlling,” she said.

To help get past these associations, Dr. Spector said, changes are needed at the individual, leader, and institutional levels.

On the individual level, women seeking to improve the situation for gender equity should engage with male allies and build a pipeline of mentorship and sponsorship to help identify future leaders, she said.

Women and men should obtain leadership training, and “become a student of leadership,” she advised. “Be in a learning mode,” and then think how to apply what you have learned, which may include setting challenging learning goals, experimenting with alternative strategies, learning about different leadership styles, and learning about differences in leaders’ values and attitudes.

For women, being pulled in many directions is the norm. ‘Are you being strategic with how you serve on committees?’ Dr. Spector asked.

Steps to stimulate the system changes needed to promote gender equity include building policies around the life cycle, revising departmental and division governance, and tracking metrics at the individual, departmental, and organizational level, Dr. Spector said. Aligning gender-equity efforts with institutional priorities and navigating politics to effect changes in the gender equity landscape are ongoing objectives, she said.

Dr. Spector’s strategies for institutions include quantifying disparities by using real-time dashboards to show both leading and lagging indicators, setting goals, and measuring achievements.

“Create an infrastructure to support women’s leadership,” she said. Such an infrastructure could include not only robust committees for women in science and medicine, but also support for women to attend leadership training both inside and outside their institutions.

Dr. Spector noted that professional organizations also have a role to play in support of women’s leadership. She encouraged professional organizations to tie diversity and inclusion metrics to performance reviews, and to prioritize the examination and mitigation of disparities, and report challenges and successes.

References


This advertisement is not available for the digital edition.