The pros, cons of subspecialization in hospital medicine

As the field of hospital medicine grows, some hospitalists are gravitating toward subspecialty services. In recent years we’ve witnessed a proliferation of “hyphenate” hospitalists. Are now surgeons, laborists, psychiatric hospitalists—even hepato-hospitalists.

The numbers of “hyphenate hospitalists” are not tracked by SHM, but the subspecialization trend highlights questions about hospital medicine’s evolution. Among the issues:

- What does this growth of hospitalist subspecialists foreshadow about the strength of the hospitalist movement?
- Does subspecialization always convey positive changes for the hospitalist?
- Do physicians risk trade-offs when their hospital medicine practices are rooted solely in one subspecialty?

What about retaining the opportunity to see and treat a variety of patients and conditions—presumably one of the initial attractions of a career in internal medicine and family medicine?

The founder of hospital medicine, a noted pediatric hospitalist, the chair of the SHM’s membership committee, and a former hepato-hospitalist recently shared their experiences and views on these issues.

Success Spreads Hospital medicine pioneer Robert M. Wachter, MD, has observed at his and other hospitals the increasing dependence on hospitalists’ services.

“Hospitalists have traditionally done more than just take care of medical patients,” says Dr. Wachter, professor and chief of the division of hospital medicine, associate professor of medicine at UCSF.

...
Psychiatric hospitalists diagnose, treat mental illness

By Jane Jerrard

Within hospital medicine lives a small subspecialty that addresses a specific and real need in today’s hospitals: psychiatric hospitalists. These physicians provide medical and psychiatric care to hospitalized patients, negating the need for a referral to a psychiatrist.

“There’s little or no compensation for a psychiatrist consultation on a medical patient, so they don’t want to do it,” says Robert P. Albanese, MD, associate professor of psychiatry and medicine at Medical University of South Carolina (MUSC) in Charleston. A psychiatric hospitalist can diagnose and treat medical conditions as well as often overlooked or untreated conditions, such as schizophrenia, major depression, and delirium, as well as substance abuse issues.

Many hospitalized patients with these problems are either on Medicare or uninsured; some are homeless. Because these patients seek emergency care for advanced diseases, general hospitalists are likely to treat their medical problems.

A small percentage of medical facilities across the U.S. have hired psychiatric hospitalists to screen patients, provide psychiatric consultations, and take pressure off other hospital staff, including general hospitalists. This summer, St. Luke’s Episcopal Hospital in Houston added a psychiatric hospitalist to its team of five hospitalists and plans to hire a second.

Built-In Roadblocks

Psychiatric hospitalists are limited partly because hospitals don’t have the patient load to necessitate hiring them.

“Back in the ’50s, there were around 650,000 hospital beds for patients with mental illness,” says Dr. Albanese. “Today, it’s estimated that there are between 25,000 and 45,000, according to the National Alliance on Mental Illness [NAMI].”

That drastic reduction is in state psychiatric facilities. Across the U.S., state budget cuts have resulted in mass closings of public psychiatric hospitals over the past 40 years—and the so-called “deinstitutionalization” of patients—while remaining state facilities have suffered significant cuts in funding. According to NAMI, there were 50,000 mentally ill homeless people in California because of deinstitutionalization between 1957 and 1988.

“There’s not a lot out there on psychiatric hospitalists because there aren’t many beds—they’ve kicked out [the patients],” explains Dr. Albanese. “Time’s arrow points to no major increase in the number of beds any time soon. This is a big problem everywhere because there are still a lot of psychiatric patients out there.”

Another factor keeping the number of psychiatric hospitalists fairly static is that most psychiatric medical students aren’t interested in inpatient care, says Dr. Albanese.

Dual-Boarded Specialists

According to the Accreditation Council for Graduate Medical Education, 29 universities offer a combined residency program in internal medicine and psychiatry or family medicine and psychiatry. Dr. Albanese’s university, MUSC, is one of them.

“Our focus is on training young physicians who are interested in becoming dual-boarded to work in a psychiatric setting,” he says. “We’re looking at hospital psychiatry as a special area within our expertise.”

MUSC’s program is highly selective.

“We have a five-year residency, and we take two medical students each year,” says Dr. Albanese. “I believe that Rush-Presbyterian in Chicago has the largest program. They take four students per year.”

Despite the lack of beds for mentally ill patients, Dr. Albanese hopes for more psychiatric hospitalists to address those patients’ needs.

“These patients have such a shortened life expectancy, I think there will be increased focus on meeting their needs,” he says. He points to an article in USA Today from May 3, “Mentally ill die 25 year earlier on average,” that documented the trend.

Jane Jerrard is a frequent contributor to The Hospitalist.
**Contents**

**Features**

- **CLINICAL**
  - 26 Fly Solo
    The promise—and perils—of being a lone hospitalist
  - 31 Transfer Training
    Make sure trainees get the know-how they need to do hand-offs
  - 34 Key Clinical Questions
    What is the best medical therapy for secondary prevention of stroke?
  - 36 Diagnose Misdiagnosis
    Hospitalists’ thought patterns can be a roadblock to the right calls

- **GERIATRIC HOSPITAL MEDICINE**
  - 18 New Take on Elder Care
    San Francisco hospital embraces the Acute Care for the Elderly unit
  - 42 Experts in the Elderly
    Geriatric hospitalists bring heightened sensitivity to treating seniors

- **PRACTICE MANAGEMENT**
  - 24 The Bad Hire
    Take steps to bring the right people into your hospitalist group

**Columns & Departments**

- **SHM NEWS**
  - 6 Society Pages: SHM News
  - 10 In the Literature
  - 13 The Hospital Pharmacy
  - 14 JHM Sneak Peek
  - 15 Career Development
  - 16 Public Policy
  - 17 Legal Eagle
  - 51 SHM Career Center Classifieds
  - 83 Point of View
  - 84 From the Editor’s Desk
  - 85 Practice Management
  - 86 Dr. Hospitalist
The Life of a Task Force

SHM’s Performance and Standards unit refines hospital medicine measures

By Jill Epstein, MA

The Performance and Standards Task Force (PSTF) was formed a little more than a year ago after SHM leadership recognized the need for a coordinated approach to working with external organizations in the performance and standards quality arena.

As SHM’s senior advisor for quality standards and compliance, I work with PSTF Chairman Patrick Torcson, MD, (medical director of hospital medicine at the St. Tammany Parish Hospital in Covington, La.) along with senior staff and leadership of the Public Policy Committee (PPC). We monitor the performance and quality landscape at national organizations charged with measuring development and building consensus. We also develop relationships with other professional medical societies and organizations.

Since its inception in spring 2006, the PSTF has become engaged in the American Medical Association’s (AMA) Physician Consortium for Performance Improvement (PCPI) and the National Quality Forum (NQF). The NQF is a nonprofit organization instructed by Congress to endorse consensus-based national standards for measurement and public reporting of healthcare performance data. Specifically, NQF aims to influence the development of physician-level performance measures as part of the Centers for Medicare and Medicaid Service’s (CMS) Physician Quality Reporting Initiative (PQRI).

Of the 74 measures included in the PQRI, 11 have specifications allowing reporting by hospitalists, underscoring the importance of SHM’s influence and participation in the PCPI process. Dr. Torcson and Eric Siegal, MD, (regional medical director, Cogent Healthcare, Madison, Wis.) co-chaired a CMS-led SHM member conference call focused on PQRI and how it affects hospitalists. The program was well received by SHM members.

When SHM became a member of the NQF last summer, it nominated several members who were selected to participate on various technical advisory panels overseeing work on the development of consensus standards for hospital care. This project, sponsored by the Agency for Healthcare Research and Quality (AHRQ), is addressing patient safety, pediatrics, and inpatient care.

This fall, Greg Seymann, MD, will attend the 8th Annual Meeting. Dr. Seymann is an assistant professor with the Department of Medicine, Hospital Medicine Program, at the University of California San Diego Medical Center.

Goals for 2008, Beyond

By taking an active role in the performance and standard arena, SHM senior staff and leadership have been able to build key relationships. This has paved the way for influencing the current physician reporting program and taking the lead on developing measures that will most reflect hospital medicine in the future.

The task force intends to be at the helm of the development of performance measures that more accurately reflect services provided by hospitalists.

Reporting Initiative (PQRI).

By joining the PCPI, SHM has aligned with other medical specialties to develop performance measures in geriatrics, emergency medicine, outpatient parenteral antimicrobial therapy, and facets of anesthesiology such as perioperative normothermia and critical care.

Additionally, SHM has given feedback during public comment periods on perioperative care, chronic kidney disease, and other measures. The task force continues to evaluate which workgroups it should appoint members to participate in, depending on the topic.

SHM leadership has continued to foster relationships with CMS by sending letters in support of the 2007 PQRI. SHM was able to influence changes to the 2007 measure specifications so hospitalists would have measures to report.

SOCIETY PAGES

OCTOBER 2007

Oral antiplatelet therapy for Documentation of an advanced I

News and information about the Society of Hospital Medicine

SHM’s Performance and Standards unit refines hospital medicine measures

CHAPTERS SUMMARY

CHICAGO

The Chicago Chapter of SHM met June 7. Attendees came from organizations such as Signature Healthcare Solutions, Advocate Healthcare, Northwestern University, and University of Chicago. The meeting began with an update from the SHM national annual meeting given by Chapter President Tarek Karaman, MD, lead hospitalist, Advocate Health Centers, and hospitalist program director, Department of Internal Medicine, Advocate Illinois Masonic Medical Center, Chicago.

This was followed by a presentation on DVT/pulmonary embolism prophylaxis and treatment from SHM board member Alpesh Amin, MD, executive director of the hospitalist program and vice chair for clinical affairs and quality in the department of medicine at the University of California, Irvine. For the first time, the chapter had a panel discussion with two primary care physicians from Northwestern University, John Butler, MD, and Sean O’Connor, MD, shared their thoughts regarding the interaction between primary care physicians and hospitalists.

Ideas were given on how to strengthen working relationships between the two.

ST. LOUIS

SHM’s St. Louis chapter met June 11. Michael Cox, MD, gave a presentation on DVT prevention and treatment followed by a presentation given by SHM CEO Larry Wellikson, MD, on the challenges and opportunities for hospital medicine. The meeting was attended by more than 50 hospitalists from the greater St. Louis area, as well as numerous hospital administrative personnel, vice presidents of medical affairs, and internal medicine residents. The presentation was well received, and numerous individuals spoke with Dr. Wellikson after the presentation. Dr. Wellikson also met with leaders of various hospitalist groups to discuss topics of interest and ways to energize the local chapter. Six hospitalist groups attended. The group discussed challenges in recruitment and in training internists to be true hospitalists.

HOSPITALIST MEASURES

Physician Quality Reporting Initiative measures with specifications allowing reporting by hospitalists.

ACE inhibitor or angiotensin receptor blocker therapy for left ventricular systolic dysfunction;

Oral antplatelet therapy for patients with coronary artery disease;

Beta-blocker for patients with prior myocardial infarction;

Beta-blocker at time of arrival for acute myocardial infarction;

Stroke and stroke rehabilitation measures, including deep-vein thrombosis, prophylaxis, discharge on antplatelet therapy, anticoagulant therapy prescribed for atrial fibrillation at discharge, tissue plasminogen activator considered on arrival, screening for dysphagia, and consideration of rehabilitation services; and

Documentation of an advanced care plan.

Continued on page 8
In July, SHM, along with the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the American Geriatrics Society (AGS), formed a steering committee to convene a transitions of care consensus conference. This multispecialty, multidisciplinary group reviewed the principles and standards that came from the ABIM Foundation’s Stepping Up to the Plate (SUTTP) Alliance, which met this spring. SHM and PCPI are working to form an expert workgroup that will develop six to eight care transitions measures for inclusion in the 2009 PQRI.

SHM also is exploring collaboration with the American Hospital Association and its Hospital Quality Alliance (HQA), which coordinates the promotion of quality measurement, transparency, and improvement in the hospital setting.

In addition to its work with these external national groups, task force members would also like to start a resource room on the SHM Web site, www.hospitalmedicine.org, which would be devoted to member efforts in research related to quality and performance standards, as well as the member go-to place for tools and references on best practices in performance standards and pay for reporting initiatives.

Finally, Dr. Torcson hopes to shape and disseminate a national research agenda for hospitalist performance measurement and reporting. TM
The Education and Quality Initiatives Department’s (EQID) mission is to lead and manage an integrative program that brings resources to improve patient care. With the help of many individuals and organizations, this is work- ing toward improved care for inpatients. Let’s review our progress as we begin the second quarter of SHM’s fiscal year.

Educational Programs

Our focus over the past few months has been the development of “Hospital Medicine 2008,” which will be held April 3–5 in San Diego. Under the leadership of Sylvia McKean, MD, head of the hospitalist service at Brigham and Women’s Hospital and assistant professor of medicine at Harvard Medical School in Boston, the Annual Meeting Committee has developed an innovative program. The session will include a new evidence-based rapid fire track and previ- ously teaching skills pre-course for academic and clinical educators. EQID obtains an- nouncements, communicates with faculty, and fine- tunes logistical efforts.

Leadership Academy Level I is a mainstay of SHM’s educational efforts. EQID supports Eric Howell, MD, chair of the Leadership Committee, as it focuses on addressing attendee input and encouraging the revision of the program in a continuous quality improvement effort. Dr. Howell is director of the Collaborative Inpatient Medicine Service and director of the Zieve Medical Services for Johns Hopkins Bayview Medical Center in Baltimore. 

Along with Level I, Leadership Academy Level II will be presented again this year Nov. 5–8 in San Antonio. It builds upon the success of last fall’s first offering by expanding on the concepts presented in the Level I academy.

A new educational initiative, supported by Sanofi-Aventis, provides five training sessions at regional chapters or other designated meetings across the country. The meetings educate hospitalists on best practices for glycemic control, heart failure, and transitions of care. Meetings will highlight successful interventions as outlined in the respective quality improvement (QI) implementation guides and resource rooms. Meetings will aim to include 20 to 50 participants.

Quality Initiatives

Over the past several years, SHM has developed initiatives that range from convening a panel to assess the state of the art of a QI intervention to developing a Web-based resource room. Projects EQID is involved with:

- SHM is in the early stages of a three-year effort to develop resources and promote teaching skills pre-course for academic and clinical educators. EQID obtains announcements, communicates with faculty, and fine-tunes logistical efforts.
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The last piece of the SHM Heart Failure Quality Improvement Initiative is in its final planning stages, and a third CME module for Team Communications as it relates to the heart failure patient will be developed in the coming months. This initiative is supported by Scios Inc. and led by Lakshmi Halasaayami, MD, associate chairperson of the Department of Internal Medicine at St. Joseph Mercy Hospital in Ann Arbor, Mich.

SHM INITIATIVES

- An Advisory Board charged primarily with providing and managing an integrative program that brings resources to improve patient care. With the help of many individuals and organizations, this is working toward improved care for inpatients. Let’s review our progress as we begin the second quarter of SHM’s fiscal year.
- A collection of clinical tools (such as standardized order sets, charting tools, guidelines) to support QI implementation and definition of measures, metrics, and related tools for capturing data essential to a specific disease state or population.
- A Web-based QI resource room that provides easy access to the educational materials and decision support tools endorsed or developed by the Advisory Board. Resource rooms address antimicrobial resistance, glycemic control, heart failure, stroke, care transitions for older adults, and VTE. A resource room is being developed for acute coronary syndrome.
- Education targeted at hospitalists, including face-to-face instruction through workshops or symposia at annual meetings, as well as interactive Web-based modules such as a video round table discussion (Point/Counterpoint).
- Outreach to the hospitalist community, to foster use of the resource rooms, educational materials, and decision tools.
- A mentored implementation program that uses the resources developed by SHM and SHM behind the scenes

Quality is our middle name by Geri Barnes

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IN THIS EDITION

- Pay-for-performance associated with limited benefits on quality in acute myocardial infarction patients.
- Meta-analysis finds increased risk of acute myocardial infarction with use of rosiglitazone.
- Rosiglitazone increases risk of heart failure, but not acute myocardial infarction or death, interim analysis shows.
- Surgery versus prolonged conservative treatment for severe sciatica.
- Predicting poor outcomes in upper gastrointestinal bleeds.
- Discharging patients with unresolved medical issues.

By Danielle Scheurer, MD, MSCR, and Sylvia McKean, MD; Brigham and Women’s Hospital, Harvard Medical School, Boston.

Does Pay for Performance Improve Hospital Quality?

**Background:** In 2003, the Centers for Medicare and Medicaid Services (CMS) instituted a pay-for-performance (P4P) pilot program in which participating hospitals would be reimbursed more if they met specific quality standards of care for patients with certain conditions, including acute myocardial infarction (AMI). It is unknown if this type of financial incentive produces improvements in the processes or outcomes of care.

**Study design:** Observational cohort.

**Setting:** 500 hospitals across the U.S.

**Synopsis:** This study compared compliance with CMS quality indicators in the treatment of more than 100,000 patients with acute non-ST-elevation myocardial infarction at 54 participating and 446 non-participating hospitals in the P4P pilot. They found no significant differences in mortality or in a composite measure of the six quality indicators but a slight improvement in two of the six quality indicators (aspirin at discharge and smoking cessation counseling). They did not find that P4P adversely affected indicators not subject to financial incentives.

**Bottom line:** P4P is associated with limited improvements in compliance with CMS quality indicators in patients with AMI.


Is Rosiglitazone Associated with Adverse Cardiovascular Outcomes in a Meta-analysis?

**Background:** Rosiglitazone (Avandia) is one of two approved oral thiazolidinedione drugs used for diabetic control. Muraglitazar, another thiazolidinedione drug, was not approved for market due to adverse cardiovascular outcomes. The cardiovascular effects of rosiglitazone had not previously been evaluated.

**Study design:** Meta-analysis.

**Setting:** All clinical trials (published and unpublished) involving rosiglitazone.

**Synopsis:** The authors reviewed data from all randomized trials of rosiglitazone versus placebo or other drugs for at least 24 weeks. From the 42 included trials (including more than 28,000 patients) researchers found a statistically significant increased risk of the odds of AMI (odds ratio 1.43, confidence interval 1.03-1.98) in the rosiglitazone group, and a non-significant risk of death from any cardiovascular cause (odds ratio 1.64, confidence interval 0.98-2.74) and all-cause mortality (odds ratio 1.18, confidence interval 0.89-1.55). The meta-analysis was criticized due to the small number of events (fewer than 100 acute AMIs in each group) and lack of patient-level data, but one expert wrote that “in view of the potential cardiovascular risks and in the absence of evidence of other health advantages ... the rationale for prescribing rosiglitazone at this time is unclear.”

The study raised larger concerns regarding Food and Drug Administration drug approvals, because the drug was approved due to its effect on lowering blood sugar levels (a surrogate outcome) without enough scrutiny of other patient outcomes.

**Bottom line:** Rosiglitazone is associated with increased risk of AMI. Alternative oral agents should be considered first for blood sugar control in diabetics.


Is Rosiglitazone Associated with Adverse Cardiovascular Outcomes in Interim Analysis?

**Background:** In response to a meta-analysis, an interim analysis of an ongoing open-label manufacturer-sponsored trial was undertaken to determine the cardiovascular risks of rosiglitazone.

**Study design:** Unplanned interim analysis of an randomized, multicenter, open-label, non-inferiority trial.

**Subjects:** Outpatient, inadequately controlled type 2 diabetics.

**Synopsis:** This was an unplanned interim analysis of an open-label manufacturer-sponsored trial. There were 4,447 inadequately controlled type 2 diabetics on either metformin or sulfonylurea. The patients were randomized to receive both drugs (controls) or add-on rosiglitazone. After a mean follow up of 3.7 years, there was no statistically significant difference between the groups in the primary end point (hospitalization or death from cardiovascular causes), or other end points (MI and death from cardiovascular causes or any cause). However, rosiglitazone was associated with an increased risk of heart failure (hazard ratio 2.15, confidence interval 1.30-3.57). Because this was an unplanned interim analysis for a trial expected to continue for six years, experts caution that the results are inconclusive due to low statistical significance and small event rates.

**Bottom line:** Rosiglitazone is associated with an increased risk of heart failure, but the risks of hospitalization, death, and acute MI remain unclear.


How Often do Discharged Patients with Unresolved Medical Issues Require Outpatient Workups?

**Background:** Patients are often discharged from the hospital with incomplete workups, but it is unknown how often and what factors affect the completion of the intended workup.

**Study design:** Retrospective cohort.

**Setting:** Single institution teaching hospital.

**Synopsis:** The authors evaluated the inpatient and outpatient medical records of all patients discharged from the medicine or geriatric service over 18 months. Of almost 700 discharges, 28% of the patients had outpatient workups recommended (48% diagnostic procedures, 35% referrals, and 17% lab tests) by the discharging physician. Completion of the workup did not occur 36% of the time, and the likelihood of non-completion increased with time to the first follow-up appointment and lack of availability of the discharge summary.


Can We Predict Patients at Low Risk for Complications from Acute Upper Gastrointestinal Bleeds?

**Background:** Although multiple risk-prediction scales exist for patients with upper gastrointestinal (UGI) bleeds, few have been prospectively validated or widely used in clinical practice.

**Study design:** Prospective cohort.

**Setting:** Veterans Affairs (VA) hospitals.

**Synopsis:** VA researchers created and validated a risk predictor in 391 patients with acute upper gastrointestinal bleeding. Data from the derivation set (two-thirds of the patients) was used to create the model tested on the validation set (one-third of the patients). Outcome one (re-bleeding, need for intervention to stop bleeding, or all-cause hospital mortality) was predicted by an APACHE score ≥11, stigmata of recent bleeding, or varices. Outcome two (outcome one plus new/worsening co-morbidity at admission). In the validation group, outcome one occurred in 1%, 5%, and 25% of patients with zero, one, and two or more factors. Outcome two occurred in 6%, 18%, and 49%, respectively. A score of zero accurately identified 93% and 91% of patients for outcomes one and two. The authors speculated that these patients could be safely treated as outpatients. The study excluded patients on anticoagulation, and this VA cohort (99% male) may not be generalizable to other populations.

**Bottom line:** This validated prediction model can accurately predict more than 90% of patients at low-risk of poor outcomes with UGI bleeding, which could be used to stratify patients in need of hospitalization.

Continued on page 12

Does Surgery or Conservative Therapy Improve Symptoms of Sciatica Faster?

Background: The optimal timing and benefit of lumbar disk surgery in patients with symptomatic lumbar disk herniation is unknown. Study design: Multicenter randomized trial. Setting: Netherlands. Synopsis: 283 patients with severe sciatica were randomly chosen to receive early surgery or conservative treatment (with surgery as needed) for six to 12 weeks. The methods for determining the three primary outcomes were: score on the Roland Disability Questionnaire, leg pain score, and self-report of perceived recovery. At one year, 89% of the surgery group and 39% of the control group underwent surgery after a mean of 2.2 and 18.7 weeks, respectively. There was no difference between the groups in the disability score, but time to relief of leg pain and recovery was faster in the surgery group. At one year, 95% in each group reported perceived recovery.

Bottom line: Rates of pain relief and perceived recovery are faster with early surgery than conservative treatment in patients with severe sciatica, but one-year recovery rates are the same.

Citation: Peul WC, Van Houwelingen HC, van den Hout WB, et al. Surgery versus prolonged conservative treatment for sciatica. NEJM. 2007 May;356(22):2245-2256.
**Stress Ulcer Agents**

**Sucralfate, antacids, H₂ receptor antagonists are valid classes**

**NEW INDICATIONS**

The two oldest low molecular heparin (LMWH) injection products, Fragmin (dalteparin, Pfizer) and Lovenox (enoxaparin, Sanofi-Aventis) have each added new indications to their U.S. labels. Fragmin is now indicated for extended treatment of symptomatic venous thromboembolism (VTE) including both proximal deep vein thrombosis (DVT) and/or pulmonary embolism (PE) to reduce VTE recurrence in patients with cancer. Its other FDA-approved uses:

- **Prophylaxis of DVT** (which may lead to PE) in patients undergoing hip replacement surgery.
- **Prophylaxis of DVT** in patients undergoing abdominal surgery who are at risk for thromboembolic (TE) complications.
- **Prophylaxis of DVT in patients who are at-risk for TE complications due to severely restricted mobility during acute illness** and
- **Prophylaxis of ischemic complications due to unstable angina and non-Q-wave myocardial infarction (MI)** when used along with aspirin.

Lovenox is now also indicated for treatment of patients with acute ST-segment elevation MI (STEMI), managed medically or with subsequent percutaneous coronary intervention (PCI).

**Its other FDA-approved uses:**

- **Prophylaxis of DVT in abdominal surgery.**
- **Prophylaxis of DVT in hip replacement surgery.**
- **Prophylaxis of DVT in knee replacement surgery.**
- **Prophylaxis of DVT in medical patients with severely restricted mobility during acute illness.**
- **Inpatient treatment of acute DVT with or without PE.**
- **Outpatient treatment of acute DVT without PE.**
- **Prophylaxis of ischemic complications of unstable angina and non-Q-wave STEMI managed medically or with subsequent PCI.**

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**NEW AND PIPELINE DRUGS**

**Thrombin-JMI Epistaxis Kit.** Although most likely to be used in emergency departments (EDs) and trauma centers, the new Thrombin-JMI Epistaxis Kit (topical bovine thrombin, King) may find its way to hospitals and physician offices.

This new intranasal spray delivery device for hemostatic treatment of oozing blood and minor bleeding of accessible capillaries or small venous vessels, was recently FDA approved. Some high-risk groups require rapid intervention to curb epistaxis (e.g., the elderly) to prevent complications or life-threatening events. The Thrombin-JMI intranasal spray delivery device works directly by clotting fibrinogens. It should not be used on large blood vessels. The kit is supplied in a package that includes a 20,000 IU vial of thrombin with 20 mL diluent, a spray pump, and actuator. It is expected to be available in EDs and trauma centers by year’s end.

**Selzentry (maraviroc, Pfizer).** FDA-approved on Aug. 6, it is the first agent in a new class of anti-HIV drugs known as HIV entry blockers. This agent holds promise for HIV-positive patients who no longer respond to other anti-HIV drugs (e.g., protease inhibitors, reverse transcriptase inhibitors). Maraviroc is effective against a specific strain of HIV known as CCR5-tropic HIV-1. Maraviroc binds to CCR5, blocking HIV from binding to this receptor. When CCR5 is unavailable, CCR5-tropic HIV cannot engage a CD4 cell to infect it. In clinical trials, patients were tested for the presence of CCR5-tropic HIV-1 using a co-receptor tropism assay, Trolifex (MonogramBiosciences Inc.), which predicts a patient’s likelihood for response to maraviroc. Maraviroc received a priority review at the FDA and a priority review in the European Union. Monogram Biosciences released Trolifex on Aug. 6 to coincide with the commercial availability of maraviroc. SCH-D (viciroivoc, Schering-Plough) is another entry blocker. It is in Phase III clinical trials.

**A n article published this year in the American Journal of Health-System Pharmacy defined stress ulcers as “acute superficial inflammatory lesions of the gastric mucosa induced when an individual is subjected to abnormally high physiologic demands.” These stress ulcers are believed to be caused by an imbalance between gastric acid production and the normal physiologic protective mucosal mechanisms in the gastrointestinal (GI) tract. Reduction of blood flow to the gastric mucosa may also lead to ischemic damage to the GI mucosa.

The development of stress ulcers, or stress-related mucosal disease (SRMD), occurs in 75% to 100% of critically ill patients within 24 hours of intensive care unit (ICU) admission. Although bleeding risk has decreased over the years, mortality from stress-related bleeding nears 50%. According a peer-reviewed guideline from the American Society of Health-System Pharmacists (ASHP), indications for SRMD in the ICU setting include:

- Coagulopathy;
- Mechanical ventilation longer than 48 hours;
- History of GI ulceration or bleeding within one year of the current admission;
- Glasgow Coma score of 10 or less (or if unable to obey simple commands);
- Thermal injury to more than 35% of the body surface area;
- Partial hepatectomy;
- Multiple trauma;
- Transplantation peroperatively in the ICU;
- Spinal cord injury;
- Hepatic failure; and
- Two or more of the following risk factors: sepsis, ICU stay of a week or longer, occult bleeding for more than six days, or high-dose corticosteroids (more than 250 mg a day of hydrocortisone or the equivalent).

Other risk factors for SRMD in ICU patients include multiorgan failure, chronic renal failure, major surgical procedures, shock, and tetraplegia.

Recommended SRMD prophylaxis agents should be institution-based, taking into account the administration route (e.g., functioning GI tract), daily dosing regimens, adverse effect profile, drug interactions, and total costs. Classes that can be used include sucralfate, antacids, H₂ receptor antagonists (H₂RAs), and proton-pump inhibitors (PPIs).

Some patients may prefer the oral route. Some agents can be given in solution or suspension and administered via a nasogastric tube—but be aware of drug interactions. There are limited comparative data for preventing SRMD with these classes. The H₂RA and PPI classes of agents are available in intravenous forms, which may be preferable in critically ill patients. However, none of the PPIs are FDA-approved for SRMD prophylaxis.

In the general patient population, SRMD prophylaxis with H₂RAs or PPIs is common in 30% to 50% of patients without clear evidence of benefit. Qadeer, et al., identified a 0.4% bleeding rate in their retrospective case-control study of nearly 18,000 patients over a four-year period. In their study, the key risk factor for development of nosocomial GI bleeding was treatment with full-dose acoagulation or clopidogrel.

Another concern they identified is that when a patient commences an SRMD prophylaxis agent in the hospital, they continue on it post-discharge when it is not needed. This creates an unnecessary cost burden and risks adverse drug interactions.

Todd Janicki, MD, and Scott Stewart, MD, both with the department of medicine at the State University of New York at Buffalo, this year reported on a review of evidence for SRMD prophylaxis in general medicine patients from the peer-reviewed literature. They found limited data, identifying only five citations meeting their evaluation criteria. Two of these studies noted only a 3% to 6% reduction in clinically significant bleeding utilizing SRMD prophylaxis.

Michele Kaufman is a clinical/managed care consultant and medical writer based in New York City.

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When Discharge Fails
Follow-up is critical to ensure patients comply with post-hospital regimen

A significant percentage of patients do not remember or understand the instructions they receive before leaving the hospital, according to a study in this month's Journal of Hospital Medicine.

"Anyone who's taken care of patients or put together a discharge plan only to have things not work out knows how frustrating that can be," says lead author Jonathan Flacker, MD.

Dr. Flacker, assistant professor of medicine in the Division of Geriatric Medicine and Gerontology, Emory University School of Medicine, Atlanta, and coauthors Wansoo Park, PhD, and Addie Sims, MSW, surveyed a group of elderly patients shortly after discharge to determine their recall and comprehension of their pre-discharge instructions. Dr. Park is an assistant professor of social work at the University of Windsor in Ontario, Canada. Dr. Sims is director of Senior Services at Grady Health System in Atlanta.

They conducted telephone interviews with 269 patients 70 or older, or their caregivers, within 10 days of discharge from Grady Memorial Hospital in Atlanta. Most interviews were conducted within a mean of three days of discharge and lasted 20 to 30 minutes. No effort was made to determine the patients' cognitive status or degree of health literacy.

The survey was an offshoot of Aging Atlanta, a project funded by the Robert Wood Johnson Foundation to study the overall care of older adults in the community. It asked 57 questions covering patients' financial resources and activities of daily living as well as the nature of their discharge instructions.

The authors found the survey "feasible and easily administered," but its results were somewhat discouraging. In 52% of the cases, respondents claimed no one spoke to them prior to discharge about caring for themselves at home. Almost as many (47%) says they were not given a phone number or the name of a person to call if they experienced problems at home. "Yet the number was on the discharge papers; 100% of the people received it," says Dr. Flacker.

Also, 41% says they were not told what to do if they experienced problems at home. On a more positive note, only 13% of the patients had to call concerning problems, and 84% felt they had received enough help after returning home.

Of the 115 (43%) patients who said the received instructions prior to discharge, 103 (90%) remembered how they were delivered: verbally in 68 cases (63%), written in 11 cases (11%), and both ways in 24 cases (23%).

"Patients receiving instructions both verbally and in writing were more likely to report that they understood care instruction 'very well' versus 'somewhat' or 'very little,'" the authors wrote. Of those who recalled being instructed on how to take their medication, 86% says they took their medicine correctly, compared with 62% who had no such recollection.

To those who can't understand how someone might completely forget receiving discharge instructions, Dr. Flacker suggests thinking back to the first day of residency or medical school when "you're handed a whole pile of stuff" while trying to acclimate to unfamiliar surroundings. "Add to that being uncomfortable, sick, and uncertain about the future, and a lot of what is said goes untransferred," he says.

In an elderly population, cognitive status and poor health literacy are certainly important potential confounders, but "based on my experience, our results are not a whole lot different than those of other investigators who accounted for those factors," says Dr. Flacker.

These findings suggest that merely transmitting information is not sufficient. Some follow-up is needed to ensure that patients understand the information as their healthcare providers intend, Dr. Flacker and his colleagues wrote. Anything less might violate the spirit of Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards requiring the clear and routine provision of information to patients.

Because of this study, Grady has revised its discharge sheet so information concerning telephone numbers, medication, and other important details are displayed more prominently. The hospital has retrained its nurses to deliver the information more effectively. Follow-up studies will assess how these changes affect patient comprehension and outcomes.

If hospitalists perceive their responsibility to the patient ending not at hospital discharge, but when the patient resumes seeing his or her primary care physician, then "their job is to ensure that the patient understands the discharge instructions," Dr. Flacker points out.

He suggests they have a social worker or other staff member call patients within a few days after discharge to see how they're doing and nip any problems in the bud. Admittedly, "a lot depends on where you want to put your resources," he says. Time and budgets can be stretched only so far. Nevertheless, he maintains, "Post-discharge contact is a critically important piece of the process."

Norra MacReady is a medical writer based in California.

READ THIS RESEARCH

Find this study ("Discharge information and older patients: Do they get what they need?") in the September-October 2007 Journal of Hospital Medicine.

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contribution to The Hospitalist

Hospitalists can have a social worker or other staff member call patients within a few days after discharge to see how they’re doing and nip any problems in the bud.
Group Growth
When hospitalists build relationships, their careers prosper

Ambitious hospitalists may be eager to add an MBA or a PhD to their credentials, in the belief those magic letters will open doors to leadership positions or higher compensation. But before you fork over tuition for an advanced degree program, consider whether that degree will pay off.

Choose Your Career Path
If you're considering pursuing a Master of Business Administration (MBA), Master of Public Health (MPH), Master of Health Administration (MHA), or even a doctorate degree, the first thing you should consider is which career path within hospital medicine you're interested in. What position would you ultimately like to hold? And which, if any, advanced degree can help you get there?

“Explore the idea [of earning an advanced degree], but the most important steps are to try to get some work experience and set some goals,” says Mary Jo Gorman, MD, MBA, the CEO of Advanced ICU Care, St. Louis, Mo. “Along the way, find out what you have an aptitude for.” Once you know your general or specific career goals, you can consider whether to earn an advanced degree.

“It’s a significant monetary and time commitment, so make sure it makes sense for where you want to go,” advises Dr. Gorman. “I’d also advise career counseling to help with this. Great people to talk to are recruiters. They’ll tell you what you need in order to apply for certain positions.”

It should be obvious that some positions will require certain degrees beyond an MD or a DO. Look at the next—or final—job you want. Is the job held by someone with an MBA, a PhD, or another degree? Is that person’s successor likely to need specific education?

“If you want to be the chief operating officer of a hospital, or the CEO of a large medical group, you’re not getting that without an MBA,” Dr. Gorman says. “In fact, if you’re planning to apply for a position that requires strong financial expertise, they’re not going to accept you without [an MBA] unless you’re of a certain age and have a great track record that shows you can do the job.”

On the other hand, many experienced hospitalist leaders don’t have an MBA and won't need one. “A lot of community-based hospitalists are already doing these things and don’t need the degree,” Dr. Gorman points out. “They created the job, or they created the group.”

A New Way of Thinking
Perhaps the most valuable aspect of any higher degree is the training one receives, which can provide new ways to approach one’s work, problem solving and general thought processes.

“The degree alone won’t help if you haven’t learned while getting it,” explains Sanjay Saint, MD, MPH, hospitalist and professor of internal medicine, Ann Arbor Veterans Affairs (VA) Medical Center and University of Michigan Medical School. “That’s the real value: Learn the material and it will alter how you approach things.”

Fred A. McCurdy, MD, who holds a PhD and an MBA, was recently promoted from pediatric department chair at Texas Tech University Health Sciences Center at Amarillo to associate dean for faculty development. He earned his MBA with an eye on becoming department chair and says that the MBA program “gave me a background in thought process. From there, I could build on that foundation.”

As for his PhD, Dr. McCurdy says the degree “has its place. The program taught me methodology and scientific process. It taught me how to break down a problem into researchable questions, and I can apply that to areas like education. If your job calls for thinking logically and critically, a PhD gives experience in using scientific methods.”

Earning an MPH also bears fruit, says Dr. Saint. “In addition to helping you learn how to research, how to be a better user of literature, it helps prepare someone for taking a leadership role.”

Your Dream Job
While an additional degree can improve your knowledge and skills, it’s no guarantee you’ll move to the top of a list for a promotion or new job.

“Not a given that it will necessarily help your career,” warns Dr. Gorman. “You need to first do an analysis about what you want to achieve, then work toward that goal. A lot of doctors don’t really realize that they need to think in terms of their total career plan.”

Dr. Saint agrees, saying of an MPH, “It may open the door, but you still have to walk through it. You still have to do the work yourself. You cannot hide behind the MPH. You have to be productive and even be an overperformer. But it does give you the tools you need, and it can help you get that first job.”

Dr. McCurdy believes a degree such as an MBA can be helpful for today’s hospitalists: “For a hospitalist with a strong interest in rising up through the hospital administrative ranks, having an MBA early in their career could definitely be beneficial,” speculates Dr. McCurdy. “Holding an MBA [in academia] is becoming the norm rather than the exception. There’s an increasing awareness in academics that this is a business.”

Does an advanced degree make a new hospitalist more hireable? “That depends,” says Dr. McCurdy. “For hospitalists working in a large hospital system, it becomes a matter of choice. I don’t think you’d be hired based on an advanced degree [such as a PhD] unless the job has something to do with a scholarly pursuit such as research or teaching. If you’re competing for a job in an academic health science center, a PhD degree can help if it has to do with scholarship.”

The Final Answer
Follow this sound advice: Chart your hospital medicine career path, and then work backward to see whether you’ll benefit from obtaining a specific degree.

“It has to do with what you intend to do in a five- or 10-year timeframe, with the course direction of your career,” says Dr. McCurdy. “If you plan to pursue academic scholarship, a PhD can be very helpful. If you aspire to become medical director at Maryland Shock Trauma, an MBA is the ticket you’re definitely going to need to punch.”

Jane Jerrard has been writing for The Hospitalist since 2002.
Is P4P Paying off?
Early research indicates modest benefits

Pay for performance (P4P) has been the hottest topic among physicians for quite a while. Perhaps the time has come to ask: Is it worth the hype?

“In terms of organized pay-for-performance programs, we’re at the very beginning of seeing pay for performance in action,” says Patrick J. Torcson, MD, MMM, FACP, member of SHM’s Public Policy Committee and director of hospital medicine at St. Tammany Parish Hospital in Covington, La.

Although P4P is still in its infancy, one major demonstration trial is complete, and researchers have begun to mine results for indications of success.

The largest national P4P trial to date is the Centers for Medicare and Medicaid (CMS)/Premier Hospital Quality Incentive Demonstration Project, which involved more than 260 hospitals reporting on 34 quality measures from October 2003 through September 2006. The measures were grouped in five clinical areas: acute myocardial infarction, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement.

Hospitals in the top 10% for each of the quality measures received a 2% bonus of their Medicare payments for the measured condition; hospitals in the top 20% received a 1% bonus; and hospitals in the bottom 20% returned 1% to 2% of their diagnosis-related group (DRG) payments.

CMS has paid $17.55 million in incentives to the top-tier, participating hospitals and reported savings of $1.4 billion in terms of avoidable deaths, complications and readmissions prevented, and shortened lengths of stay.

As for quality improvements, results from the first two years of the demonstration project show proven improvement across all five clinical focus areas. The average improvement of the composite quality scores (CQS), an aggregate of all quality measures within each clinical area, in the project’s second year was 6.7%, for total gains of 11.8% over the project’s first two years.

The CQS improved significantly between the start date and the end of the second year in all five clinical focus areas:
- From 87.5% to 94.4% for patients with acute myocardial infarction;
- From 64.5% to 82.4% for patients with heart failure;
- From 69.3% to 85.8% for patients with community acquired pneumonia;
- From 84.8% to 93.8% for patients with coronary artery bypass graft; and
- From 84.6% to 93.4% for patients with hip and knee replacement.

“The numbers are impressive,” says Dr. Torcson. “This is the true value of P4P.”

The Physician Quality Reporting Initiative (PQRI), now well under way, “is the first nationwide pay-for-performance program, and one of the first to include hospitalists,” says Dr. Torcson. “This is the first time we’re all having physician-level pay-for-performance since the PQRI started on July 1.”

The incentives for participating in the trial aren’t high. “Based on projections of PQRI reporting, hospitals can earn a bonus of $800,” says Dr. Torcson. “This may not be a strong motivator to participate in PQRI. However, it’s a beginning. If you’re going to fail [at reporting], this is the time to do it.”

The PQRI trial is short: it will end Dec. 31. And early next year, it’s guaranteed that all eyes will be on outcomes from this program. “Private payers are watching this very closely; they’re ready to jump into the game,” says Dr. Torcson. “Healthcare organizations and professionals should be ready to jump as well, because next steps for P4P and other payment factors are still unknown.”

“What happens after Dec. 31 is wide open,” Dr. Torcson says. “We don’t know what to expect from Congress. Right now we’re looking at a proposed 9.8% cut to physician fees. Will that cut be made up by pay-for-performance bonuses? Congress determines what will happen, and the [2008] election could change everything.”

To date, P4P has not lived up to its hype; however, the use of incentives to improve quality is in the early stages. Time will tell if P4P pays off in improved care—but CMS and many physicians seem committed to the idea.

“I think there’s a lot to be said for the concept of providing incentives that encourage hospitals to invest in quality of care,” says Dr. Lindenauer. “Our current system of healthcare hasn’t done that.”

Dr. Lindenauer’s advice for moving ahead with P4P: “We need to proceed cautiously and be mindful of some of the unintended consequences,” he concludes.

See Jane Jerrard’s rates at www.hospitalist.org. —JJ

POLICY POINTS

CUTS PROPOSED FOR CMS PHYSICIAN PAYMENTS
On July 2, CMS issued a proposed rule that would slash Medicare payments to physicians in 2008 by nearly 10%. CMS projects that it will pay $58.9 billion to 900,000 physicians and other healthcare professionals next year.

SHM is working to block this cut, as well as to urge CMS to replace the sustainable growth rate formula (SGR) with a stable, predictable annual update based on the Medicare economic index, which reflects inflation in the healthcare sector.

PQRI PARTICIPATION STILL OPEN
Although the Physician Quality Reporting Initiative (PQRI) is under way, organizations and professionals should be ready to jump in on this program. “Private payers are watching this very closely; they’re ready to jump into the game,” says Dr. Torcson. However, it’s a beginning.

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References
The Power of “Sorry”
Know how state statutes work before apologizing for an error

Like many people, we like to sing while driving. In the anonymity of our cars, this morning, one of us was wailing along with Elton John as he sang “Sorry Seems to Be the Hardest Word”:

> I said, “No I’m sorry, I can’t talk to you now.”
> Why can’t we talk it over?
> Oh, it seems to me
> That sorry seems to be the hardest word.

That verse frames a critical legal question: physicians regularly encounter: how to communicate with patients after an unexpected outcome. More precisely, should a physician apologize to a patient who suffers complications because of that physician’s treatment?

Traditionally, after a patient suffered a complication, defense lawyers were reluctant to allow the physician to express apologies or regret. The defense lawyer feared the apology would be treated as an “admission against interest.” In other words, the defense lawyer wanted to prevent a plaintiff’s lawyer from someday arguing that the physician’s apology was an admission of negligence or wrongdoing.

But the lawyer’s strategy fails. The patient wants the physician to apologize for an error. In fact, the patient distrusts a physician who does not admit errors.

> Although a physician may wish to tell a patient when he has made a mistake, lawyers often order doctors to say nothing,” wrote University of Florida law professor Jonathan R. Cohen in the Southern California Law Review: “The physician’s silence may then trigger the patient’s anger. This alienation may then prompt the patient to sue.”

The answers to these questions are consistent with studies demonstrating that patients are far less to sue when provided with a full explanation and apology.

Certainly no physician wants to make a statement that a plaintiff’s lawyer will use against him in court. But the same physicianrationally wants to take any steps that might prevent the patient from feeling as though he or she needs to consult with a lawyer.

Physicians rationally want to prevent patients from feeling as though they need to consult with a lawyer.

Dr. Smith is treating a 22-year-old patient, John Elway, for a fractured fibula. Dr. Smith sees no signs of neurological compromise while the patient is in a cast. After the cast is removed, it appears the patient has lost function in the leg because the cast was too tight. The patient was a star college athlete who was expected to be drafted into the NFL, but now likely won’t be drafted. Dr. Smith tells the patient: “It’s my fault this happened. I’m really sorry that I didn’t pick up on this sooner.”

Does Dr. Smith’s statement come into evidence in court? Does part of it? The answers probably depend upon which state’s apology statute is applied. Massachusetts was one of the first states to pass an apology statute. It reads:

> Statements, writings, or benvolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to the person or to the family of such a person shall be inadmissible as evidence of an admission of liability in a civil action.

Significantly, the Massachusetts statute applies to people “involved in an accident,” which might imply that it is limited to automobile accidents or workplace accidents. The Massachusetts statute prevents this limited construction by providing a broad definition of “accident,” including any “occurrence resulting in injury or death to one or more persons which is not the result of a willful action by a party.” This definition would encompass ordinary medical negligence.

It would seem clear that the statute would protect Dr. Smith if he simply stated: “I want you to know how sorry I am this happened. I feel awful that you experienced this complication.”

But if Dr. Smith said, “It’s my fault this happened,” would the Massachusetts statute protect Dr. Smith? That’s a much harder call. Saying “It’s my fault” is technically not an expression of sympathy or a general act of benevolence. There no clear answer under Massachusetts law. But we believe the result would probably depend on whether the judge hearing the case thought this statement occurred during an overall act of apology.

The answer is clearer in California. That state’s apology statute reads:

> The portion of statements, writings, or benvolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to the person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action.

A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section.

California draws a clear distinction between the “portion of statements … expressing sympathy or a general sense of benevolence” and “a statement of fault.”

In our scenario, the jury would almost certainly be able to hear Dr. Smith’s statement, “It’s my fault this happened.” Critics of California’s law believe it creates too narrow a window for physicians to believe that plaintiff’s lawyers will not use their apology against them in a lawsuit.1

While Dr. Smith’s statement is likely to come into evidence in California, it’s also clear the opposite would occur in Colorado, Colorado’s apology statute, which specifically applies to medical malpractice actions, reads:

> In any civil action brought by an alleged victim of an unanticipated outcome of medical care… any and all statements … expressing apologies, faults, sympathy, commiseration, condolence, compassion or a general sense of benevolence … shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

Because Colorado’s statute specifically renders statements of “fault” inadmissible, a jury would not be able to consider any of Dr. Smith’s statements made during the course of his apology. Colorado’s law provides the physician with the most protection. Critics of Colorado’s law believe it’s unfair for physicians to admit fault to their patients in the hospital, then deny liability after the patient files a lawsuit.

Twenty-six other states have passed apology statutes; each works a bit different. The choice of words matters. Legally, there is a big difference between a physician telling a patient, “I’m sorry about your pain” or saying, “It’s my fault you’re in pain.”

While apologies are valuable and important in relationships of trust—including the relationship between physicians and patients—we suggest you consult an experienced lawyer when crafting an apology to make sure it conveys your sympathies without opening a door to liability.

References
Families often note that after older relatives return home from the hospital, something is wrong with them. While the acute condition that brought a relative into the hospital has been remedied, major functional and cognitive deficits such as confusion, falls, and difficulty with basic activities of daily living remain.

This post-hospital decline may not be appreciated by hospital clinicians, perhaps because the problems do not become visible until the patient is home. However, these problems place significant burdens on patients and families. Following discharge for an acute hospitalization, about a third of older patients will have a major new disability that threatens their ability to live independently. Among community-dwelling elders, half of all new disability occurs within a month of hospitalization.

It isn’t surprising that nursing home placement has grown more common for medical hospitalizations, even for seemingly reversible medical problems. Older adults will make up an increasing number of the patients cared for by hospitalists. The Acute Care for Elders (ACE) unit model of care focuses on preventing functional decline and increasing discharges to home.

In 2005, leadership of the San Francisco General Hospital Medical Center (SFGHMC) committed to improving care for hospitalized elders by adopting the ACE model. The ACE model combats hospital-acquired disability by improving care processes for older patients.

Major motivating factors for the change included demographic and quality-of-care imperatives. After a nine-month planning process, the SFGHMC ACE unit opened in February.

Rationale

Largely driven by the baby boom, the number of California seniors older than 65 will double from 3.5 million to 7 million over the next 40 years,
and those older than 85 will triple from about 500,000 to 1.5 million. In San Francisco, changes will be even more dramatic as the number of residents over 65 increases from 14% of the population to 32%. (See Figure 1, right).

In California, people 65 to 84 are almost three times as likely to be hospitalized as those between 45 and 64. If rates of hospitalization do not change, an increase in hospitalized older adults will occur as the baby boom generation ages.

In addition, hospitalization can be hazardous for older adults, with increased risk for functional and cognitive disability and adverse events. As a result, hospitalization-associated disability represents a growing threat to the independence of the older population. A variety of changes to usual care have been adopted in an effort to reduce the hazards of hospitalization in the elderly.

ACE Model

The ACE unit model, proven to reduce the risk of hospital-acquired disability in the elderly, is based on the Model of Dysfunction for Hospitalized Elders. (See Figure 2, p. 23)

This model outlines how processes of hospital care for the elderly promote physical impairment and depressed mood, leading to dysfunction. Counterproductive factors in older adults include a hostile environment (lack of natural sunlight, high-glare floors, poor way-finding cues, high noise levels), depersonalization (lack of personal effects, clothing, and usual daily routines), bed rest through multiple tethers or inattention, medicines inappropriate in the elderly or given at inappropriate doses, procedures, and negative expectations (usually that the patient will require nursing home placement after admission).

These processes are the targets of the ACE intervention. The idea is to improve quality of care for the elderly by promoting rehabilitation and preventing disability.

The ACE unit addresses these issues through a “prehospitalization program.” The ACE unit is a physical location in the hospital with 10 beds. Care is redesigned by placing the patient at the center of restorative efforts of an interdisciplinary team consisting of an advanced practice nurse, a social worker, an occupational and a physical therapist, a nutritionist, a pharmacist, and a medical director. This ACE Unit team meets daily to review and plan care for all patients. Recommendations for nursing care and rehabilitation evaluation are implemented by the ACE team directly. Other recommendations, such as changing medications or considering alternative approaches to common geriatric syndromes are communicated to the primary team, which maintains overall responsibility for the care of the patient. Each patient’s assessment is multidimensional, with an emphasis on nonpharmacologic interventions where practical. For example, an emphasis is placed on after-dinner exercise such as walking and socializing to promote sleep and reduce medication use. Nursing-care plans were revised to promote mobility, discourage inappropriate Foley use, and encourage adequate hydration and nutrition. Recommendations are communicated to the primary team via a recommendation form placed in the physician-order section and text pages. The unit’s medical director and pharmacist

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review medications. Recommendations that involve medication changes are discussed with the primary team, which write all medication orders. Home planning begins on the day of admission.

Prior to opening the unit, the ACE unit social worker met with key city and county agencies including Aging and Adult Services, the Public Guardian, In-Home Supportive Services, and community nursing homes to introduce the unit and plan for an effective and safe transition.

All staff expect patients to maintain prehospital physical functioning. When possible, patients are expected to wear their own clothes, eat all their meals in a common dining room, and ambulate or exercise daily.

We considered establishing criteria for admission. We have not adopted formal criteria for patients 65 or older, presence of medical non-surgical condition(s) that require(s) acute hospitalization, and no need for telemetry or chemotherapy. As we learn how best to serve our hospitalized older adult population with the resources of the unit, we will re-evaluate targeting criteria. Most of our admissions are from the emergency department (ED), and the remainder are from other units in the hospital.

Challenges

Key challenges in opening the new service include securing commitment and resources from organizational leaders and key stakeholders; incorporation of the ACE unit concept in an academic training center; hiring key staff, especially the geriatric clinical nurse specialist and pharmacist positions; and completing the environmental rehabilitation on a limited budget.

While gaps in the care of the geriatric patient population were well identified at SFGHMC as far back as 1996 by a multidisciplinary task force, no actions on recommendations were taken, for several key reasons.

First, an executive level administrator or physician champion was not a member of the task force. Second, the organization did not have a department or regulatory mandate to address the gaps in the care of the elderly patients. Third, there was no link between the hospital strategic plan and the recommendations.

By 2004, these issues were largely addressed. A new chief nursing officer with a background in quality improvement understood the demographic and quality imperatives to improve care for hospitalized older adults.

That same year, the Hospital Executive Committee incorporated patient safety into the hospital strategic plan. This resulted in a successful business plan for an ACE Unit and geriatric consultation service linked to organizational strategy.

Funding was allocated for a medical director and a clinical nurse specialist in fiscal year 2005-2006. In addition, a grant was obtained from the SFGH Foundation to fund equipment, renovations, and staff education/training.

The original ACE unit concept involved expert, interdisciplinary geriatric assessment and communication of suggestions via a paper-based chart.

Initially, we felt the primary medical team should round with the ACE team, preferably at the bedside. However, informal focus groups held with the residents suggested this would happen infrequently.

The demands on the medical teams of completing patient rounds before morning attending rounds were cited as the main reason that model wouldn’t work.

We have implemented the following methods to promote communication between the ACE unit team and the primary medical team:

- Medical teams are encouraged to attend ACE unit rounds while on bedside rounds. This provides an opportunity to model the team-delivered care for house staff and medical students, an ACGME requirement;
- Suggestions to change medications are directly text-paged to the house staff; and
- Recommendations are summarized in a communication sheet left in the chart (this not a permanent part of the medical record).

We plan on using the text-paging system.
The ACE unit concept. Department leaders Readiness for Change in geriatrics.14-16 The advanced practice of a recommendation or new emphasis are occasions where a team is not aware computer capability. Despite this, there approaches to agitation. chairs, handrails, unit-based physical required to create a more welcoming, are limited for the rehabilitation with many competing demands, monies national search. This prompted us to This position remained unfilled for almost a year despite an intensive national search. This prompted us to incorporate the geriatric resource nurse model into our unit while we continued our recruitment. Although we have successfully concluded our search for a nursing leader for the ACE unit, we have yet to hire a clinical pharmacist. The rehabilitation of the unit would not have been possible without foundation support. As a public hospital with many competing demands, monies are limited for the rehabilitation required to create a more welcoming, safer environment for the older patient. In this case, the hospital foundation and a local foundation made grants to the ACE unit to allow us to change the environment. These grants have allowed for significant changes to the unit, including elevated toilet seats, high-backed chairs, handrails, unit-based physical therapy equipment, and activities to promote non-pharmacological approaches to agitation.

Readiness for Change
All levels of hospital staff embraced the ACE unit concept. Department leaders three days of training. This provided baseline knowledge of common geriatric syndromes in hospitalized older patients for all team members. This been helpful during ACE unit team discussions.

Although medical residents felt they could not consistently attend ACE rounds, they appreciated potential benefits of the unit:

Different perspectives could provide a wider range of evaluation and treatment recommendations for their patients;

The co-location of key disciplines could result in overall time savings in calling for and ordering evaluations;

The reduced likelihood that key interventions such as mobilization, feeding, catheter removal, and medication review would be missed; and

The opportunity to learn principles of geriatric care through attending ACE rounds (when possible).

Medical staff in other departments immediately accepted the rationale for the unit.

Many expressed interest in expanding the concept to their departments, specially orthopedics, general surgery, and the ED. Although unfamiliar with specific interventions to improve care for hospitalized elders, the underlying concepts of patient-centered, team-delivered care with a focus on function resonated with most medical staff.

Next Steps
The unit is still in startup mode. Our major areas of focus are:

- Evaluating and improving team dynamics: We have engaged with researchers to evaluate our team dynamics and intervene where necessary to promote a high-functioning team.

- Developing a culture of performance improvement: One of the hallmarks of high-functioning teams are measures of performance that are team-derived and reflect work product that the team can control.

- We are putting into place processes to measure key quality parameters including length of stay; nursing home placement; readmission rate, inappropriate catheter use; inappropriate medication prescribing; incidence of delirium, falls, and pressure ulcers; functional and cognitive status at admission and discharge; and patient satisfaction.

Care is redesigned by placing the patient at the center of restorative efforts of an interdisciplinary team consisting of an advanced practice nurse, a social worker, an occupational and a physical therapist, a nutritionist, a pharmacist, and a medical director.

The orders set used by admittance residents are the standard general medical ward admission set and need revision for the ACE unit.

- Developing a research program: Our goal is to develop a research program evaluating interventions to prevent post-hospital degeneration of elders’ health. There is a dearth of research on improving hospital care for older, vulnerable adults.

- Expanding philanthropy support: The unit has benefited tremendously from philanthropy. In a relatively resource-constrained setting, this allowed for rapid engagement with designees and vendors to remake the environment. We plan to expand our outreach efforts to interested philanthropists.

Summary
The ACE unit model can improve care for hospitalized older adults. It requires a sustained level of commitment from hospital leaders, a focus on patient-centered, team-delivered care, sensitivity to communication modalities with primary caregivers, an awareness of the market for key professionals required, and flexibility to respond effectively to the many challenges that will emerge in implementing this model locally.

Dr. Piloozian is medical director of the ACE unit at the San Francisco General Hospital. Susan Cornyn is the hospital’s chief nursing officer.

References
Hospital medicine groups depend on camaraderie and expertise to carry them through long days and heavy workloads. Group cohesiveness—often fragile—depends on recruiting and keeping hard-working doctors who pull their weight professionally and boost the group’s chemistry.

In a field with five job openings for every qualified candidate, and average annual turnover at 12%, hospital medicine groups can ill afford a bad hire. Whether that person is a practice killer, a cipher who blends into the wallpaper while collecting a paycheck, or a doctor marking time until a fellowship or something better comes along, the group leader must quickly limit a bad hire’s negative impact.

Recognizing that competition to hire hospitalists is fierce, it may seem that avoiding or axing a bad hire—the physician who either doesn’t mesh with your team, is a professional and/or personal train wreck, or has a blue-ribbon pedigree, but performs poorly—is a luxury hospitalist groups can’t afford.

But as Per Danielsson, MD, medical director of Seattle-based Swedish Medical Center's adult hospitalist program has learned the hard way: "No doctor is better than the wrong doctor. I don’t sugarcoat the demands of our program with prospects. We’re a seasoned hospitalist program, we work hard, and, if we have a position vacant, we’ll work even harder for short periods of time until..."
Some hospitalist groups would rather pull a bigger load temporarily than tolerate a laggard; others stomach imperfection.

TIPS FROM THE TRENCHES

- Budget adequate time for recruiting and interviewing;
- Conduct part of the interview over a meal with the candidate and spouse/significant other. Observe how the candidate treats servers, a tip-off for how he’ll treat nurses and other perceived underlings. Alcohol loosens tongues and may give a revealing look at what your candidate would like to keep hidden;
- Be explicit about your group’s work load, schedules, and culture;
- Check references thoroughly. Get a signed release from the candidate permitting you to call a number of professional, personal references;
- Build group consensus to work harder temporarily rather than fill a vacancy with the wrong person;
- Optimize a questionable fit (e.g., offer a permanent part-time position; give no committee or administrative assignments to a good clinician not suited for those tasks; promptly mentor an “iffy” hire);
- Cut your losses. Get rid of an organizational disrupter as quickly as possible. Severance pay is money well spent; and
- Don’t pass along a bad hire to other programs without cutting your losses. Get rid of an organizational disrupter as soon as you find one.

Probing Personality
To weed out potential bad hires, employers long have used personality tests. Such tests also help job candidates focus on what they want from a hospital group, and that physician was fired on the spot.

Another organizational disrupter, briefly employed by IPC—the Hospital Company (North Hollywood, Calif.)—made inflammatory remarks about a hospital’s pre-eminent specialist and other referring physicians. He was fired.

Several hospitalist leaders report hiring physicians with stellar pedigrees whose hands consistently strayed to nurses’ derriers. Such callous behavior would send shock waves through any group, and that physician is gone, they say.

Robin Ryan, a career coach from Newcastle, Wash., who has prepared office-based physicians for professional moves to hospitalist careers, says the new career path can be confusing. When a physician and a hospitalist group have made a mistake, Ryan says most groups cut their losses by terminating someone who doesn’t fit.

“Contrast often require a hefty severance fee, but it’s often the road that groups take,” she says.

Marlene Pflurro is a frequent contributor to The Hospitalist.
Lone hospitalist. It sounds adventurous. It might mean having the chance to set the stage for a hospital medicine program—working exactly the way one wants to and enjoying the feeling of indispensability.

But it’s not for the faint of heart, as those who’ve done it attest. There’s the potential for having no starting patient base, or being overwhelmed because there are few to no physicians to share coverage. Having the chance to educate the hospital and its staff about hospital medicine can be a blessing—and a curse.

An example of a lone hospitalist who has experienced the joys and pains of her position is Patricia M. Hopkins-Braddock, MD, an assistant professor of pediatrics at Albany Medical College in N.Y. She was hired as the only pediatric hospitalist in the pediatrics intensive care unit (PICU) at Albany Medical Center. This is her fourth year in that position. Having become the residency program director at her institution in January, she works every day plus one weekend a month, alternating weekly between a pediatrics floor and a long-term care facility and sedation service for children.

“I like the fact that I have turned into the go-to person for problems within the hospital continuum,” Dr. Hopkins-Braddock says. “I also have to say that that is probably one of the things I like least. I have that presence in the hospital and the understanding of the way the floor works. I also do pediatrics sedation. Somehow I become the solution for every problem. It’s good in its own sense, but it can also become very overwhelming.”

A Perfect World?

“If we could figure out a way for one person to function productively and efficiently by themselves, it would be wonderful,” says Cary Ward, MD, who works with hospitalist programs that are part of Catholic Health Initiatives, based in Denver, and is the chief medical officer at St. Elizabeth Regional Medicine Center in Lincoln, Neb. “There is a large group of hospitals that wants to have a hospitalist program, and those are the critical access hospitals. These hospitals are often clamoring for someone to be in the hospital the majority of the day,” he says.

“You’ve heard the saying, ‘You’ve seen one hospitalist program, you’ve seen one hospitalist program,’” continues Dr. Ward. “I’ve been amazed at all the hybrid programs out there. At most small hospitalist groups, even those programs under the smallest census of 12 or 13 patients, hospitals still often bring in two doctors with alternate week rotations. “Many consider this the most feasible way to try to cover one hospital census at all times; however, some worry that this ‘feast or
famine’ schedule may lead to burnout and this can be expensive for the hospital. To get only one physician to cover that kind of responsibility is a real challenge.”

And yet, some hospitals and hospitalists manage to do it. Of the 362 hospitalist groups that responded to SHM’s 2005-2006 survey “Bi-Annual Survey on the State of the Hospital Medicine Movement,” only nine groups (2.5%) consisted of one physician. Joseph A. Miller, MD, who staffs SHM’s Benchmarks Task Force and has been helping SHM build a national hospitalist database, estimates that of the 2,500 hospitalist groups in the U.S., 62 groups might have just one hospitalist.

Pluses and Minuses

Martin C. Johns, MD, a rural internal medicine and pediatrics hospitalist at Gifford Medical Center in Randolph, Vt., sees some definite advantages to being a lone hospitalist, a post he has held for the 1 1/2 years. “It allowed me the time to interact with all the other modalities and to establish with physician therapy, occupational therapy, care management, pharmacy, what was lacking in the previous model with a variety of docs covering,” Dr. Johns says. “I was trying to create standards that made sense for everyone. The establishment of my being the only hospitalist was determinant primarily on my ability to create those relationships and ensure that they were solid, and also to have the support of all the primary care doctors.”

Gifford’s administration was also supportive. “Because we are a critical access hospital, there are certain restrictions and requirements that we have to take into consideration with Medicare and Medicaid,” Dr. Johns says. “Being the sole hospitalist as we’re expanding...”

Christopher Farrar, MD, lead hospitalist at Anderson Hospital in Maryville, Ill., began the program there. His employer, the hospitalist company Inpatient Management Inc., based in St. Louis, Mo., manages 18 hospitalist programs in 12 states. “As I was ending my primary care role,” says Dr. Farrar, “this opportunity came available. I think that they weren’t expecting someone to jump in so quickly. They didn’t have the luxury of time to find another physician right away.”

There are now two physicians in the program there, and they are on the verge of getting a third. Dr. Farrar said he doesn’t think there are a lot of pluses to being the lone hospitalist. The most difficult part is avoiding burnout, he warns. Although there were plenty of patients and work for him when he first started at his institution, he wasn’t overwhelmed. But he was relieved when the company brought in a second physician with whom to share call. “I could have easily become overwhelmed quickly had it gone down that road,” he says.

Finding a patient base and physician call backup were not issues for J. Stewart Fulton, DO, medical director of the hospitalist program at Southern New Hampshire Medical Center in Nashua, when he began five years ago as the lone hospitalist. Foundation Medical Partners, a multispecialty group of 27 doctors directly affiliated with the hospital, recruited Dr. Fulton to start a hospitalist program. “I walked into an ideal situation,” he says. “I stepped into a group that had a patient base, that knew they needed hospital coverage, and were willing to support me as I grew to provide 24/7 coverage for myself.”

Continued on page 28

THE HOSPITALIST | OCTOBER 2007 27

HOW TO GO IT ALONE

Hospitalists from a variety of settings and programs shared the following tips for their colleagues who will step into the shoes of the lone hospitalist.

1. Remain flexible and malleable. Expect the unpredictable.
2. Know what you’re getting into in terms of structure, responsibilities, and policies. Question administrators about rapid response, night and weekend coverage, working with the ED, the ratio of patient volume to current staff, and plans for hospitalist coverage as volumes increase.
3. Start plans for recruitment of a second hospitalist quickly if this has not been done when you become the lone hospitalist. Within a year, that is likely to become imperative—not optional.
4. Make yourself indispensable. It’s helpful if there are no plans to grow the hospitalist program.
5. Know your limitations and set your boundaries.
6. Find mentors. Mentors can answer questions from everything to contract negotiations, conflict resolution, clinical questions, or someone to bounce ideas off of. SHM has resources for mentoring options—if you are not a lone hospitalist, sign up to mentor one.
7. Track and trend from the beginning. Follow volumes for the doctor...
referred to as a hospitalist—but nobody really understood what that meant,” says Dr. Li. “Looking back now, I didn’t even really understand what that meant.”

Tin M. Oo, MD, medical director for the hospitalist program at St. Mary’s Health Center in Jefferson City, Mo., practiced for seven months as a lone hospitalist but was hardly a new physician. He has been practicing medicine for 34 years in the U.S. and four other countries: Burma (now Myanmar, his native country), Sri Lanka, Malaysia, and Brunei Darussalam. Since he emigrated to the U.S. 15 years ago, he has served as an epidemiologist with the state Department of Health in Minnesota, matriculated into a three-year internal medicine residency program in New York and practiced there, and was in private practice in Chattanooga, Tenn.

When Dr. Oo first came to St. Mary’s, he taught his co-workers, the patients, and their families. “The hospital [and nurses] didn’t have any experience with hospitalists so they didn’t know when to call me and when not to call me,” he says. Dr. Oo got his first hospitalist experience in Chattanooga, Tenn., when he worked with outpatients and some inpatients. His prior experience moonlighting as a hospitalist as well as an emergency physician has helped him greatly as a lone hospitalist. “It was a good thing that I wasn’t just a hospitalist; that I had been in private practice and worked in the ER and as a hospitalist. I knew what the private doctors were facing, and what was coming across from the ER.”

For those who have not yet practiced medicine, Dr. Oo would dissuade them from taking a position as a lone hospitalist. “You have to have a feel for what the ER physicians or what the family practice/internists, and what the specialists do,” he says. “You also have to be in the hospitalist’s shoes, at least from time to time.”

Be Flexible

While all hospitalists need to be flexible, this may be particularly true for the lone hospitalist. Dr. Johns finds his dual internal medicine/pediatrics training serves him well. “I assist with patients, especially pedi-

Dr. Johns, whose title is associate medical director in charge of hospitalist services, finds the biggest challenge has been attaining and maintaining a commitment to quality on opposite shifts. Sharing coverage with several primary care physicians, he says, means there are differences in concepts of protocols for admissions, commitment to caring for the extra patients, and the physician’s comfort in his or her inpatient knowledge base.

Taking over after a previous night’s coverage, Dr. Johns is unsure which orders were carried out and which patients received what therapy, for instance. “The covering providers take care and make sure patients make it through to next day but often hesitate to alter the plan too much because they are not covering the following day as the inpatient provider.” A newly instituted Thursday-through-Monday hospitalist service schedule has helped improve continuity of care and transfer of information through the weekend. But it is still not a perfect situation.

After 15 months as the lone hospitalist, Dr. Johns’ position has changed. He cares for patients during the day and dur-
ing the opposite shift takes on administrative responsibilities, such as deciding on protocols and expanding services. That kind of juggling—without hospitalist colleagues—has required flexibility as well.

**Plan and Set Boundaries**

Educating the hospital taught Dr. Fulton a good deal as well, especially about his and their expectations. “The group that grasps the whole concept the quickest is the ancillary services (case management) and the nursing staff,” he says. He likens their receptivity to having a hospitalist to the workings of a pendulum: “There is nothing before this better way, and then they want more of it and they want it all the time. It really means needing to create boundaries.”

Dr. Oo agrees that as a lone hospitalist it is important to set boundaries for your accountabilities. The administration of his hospital asked him whether he would take charge of rapid response calls. He declined, leaving that traditional role to the ED.

The year Dr. Fulton practiced as a lone hospitalist gave him a window of time to plan. “It really allowed me to hit the bumps in the road and figure things out so when I added partners, I was able to get them up to speed more quickly,” he says. “Hospitals continue to get busier and busier and that requires planning. I was tracking and trending the volume [of patients that] these 27 doctors were generating in the hospital so that I could anticipate how many doctors I needed. Hospitals continue to increase in volume. The intensity of medicine continues to increase. You always need to plan for one or two more docs than you think you need.”

**Coverage**

For many lone hospitalists, sharing schedule coverage is a dilemma. Dr. Li, an assistant professor of medicine at Harvard Medical School in Boston and a board member of SHM, spent one year as a lone hospitalist before another full-timer joined him. “Everybody understands that as sole physician you really can’t be expected to see patients 24/7/365,” says Dr. Li.

Dr. Li’s recommendation for any hospitalist group of any size—but particularly early on when the hospitalist is alone or in a small group—is to match volume with staffing. “With every program that I have seen or been involved with, early on there is always a massive shift of primary care providers who want to refer patients to you after the program is up and run—Continued on page 30
Another recommendation Dr. Li has for the lone hospitalist is to identify how you will quickly get help in urgent circumstances. “There is a real benefit to the whole service for having more than one physician on any given day,” he says. It takes only one critically ill patient to cause an upheaval in the schedule.

Committee Work
As recent SHM data show, a large proportion of hospitalists serve on hospital committees. But during his year as a lone hospitalist, Dr. Li focused on taking care of patients, relying upon consultants, and getting through the day.

“I certainly had very little insight at that point of the hospitalist model in terms of communications and leading a team and being the leader of quality in the institution,” he says. “Those were the furthest things from my mind.”

Dr. Fulton participated on committees even though he was a lone hospitalist. “I was involved because I was willing to do the extra work and to use that opportunity to educate and establish who we were in the hospital,” he says. When he was joined by his first two partners, he protected them from committee work because that wasn’t their initial responsibility,” he says.

For lone hospitalists, “you either need to anticipate being on committees and protecting time for it, or you need to anticipate protecting yourself from the committees in order to provide your service,” says Dr. Fulton. “That’s sort of a slippery slope because if you lose the opportunity to become involved in committees, someone else will do it and then they’re making decisions for you that affect your practice of medicine in the hospital.”

Because Dr. Fulton would not sit in hourlong meetings, he took an indirect route—discussing issues with case managers on the floors in between patients or when they shared a patient.

Dr. Fulton advises the lone hospitalist to consider “who is boss” when he or she considers allocating time for committee involvement. Employment by a hospital versus a multispecialty group versus going out as a solo practitioner or working in a private group will determine whose agenda you have to fulfill. “If you are owned by the hospital, the hospital calls the shots; and you have to negotiate … where you put your efforts and your service. If they want you to be on committees, you need to negotiate less patient interaction. You can’t do both; you’ll begin to lose your mind.”

Andrea Suttinger is a frequent contributor to The Hospitalist.
When attendings at Denver Health Medical Center (DHMC) were asked to be available to help supervise the teams of residents and interns with the hand-off process, Eugene Chu, MD, director of the hospital medicine program, quickly knew there was a problem.

“They didn’t really know what they were teaching,” says Dr. Chu. “They had an idea of how to do a hand-off, but they had never explicitly learned what a good hand-off was because it had never been described before. Some of our attendings fell back on what they did best—teach medicine. But that was not necessarily what the house staff wanted at that time of day.”

The house staff did want to learn to give safe, effective, and efficient hand-offs. “Giving a lecture on renal failure was not really the point of the hand-off,” says Dr. Chu.

Time for Training

“Sign outs serve a lot of purposes, not just information [transfer],” says Leora Horwitz, MD, an assistant professor in the division of general internal medicine at Yale School of Medicine, New Haven, Conn. “Signout is also a time for training. It is a time for socialization in terms of how we talk about patients and what is expected. And it is a time for catching errors and for rethinking plans and diagnoses because as you are describing something to someone, they might pick up on gaps or inconsistencies or things that should be done differently.”

Dr. Horwitz, who is also associate medical director of the Center for Outcomes Research and Evaluation at Yale-New Haven Hospital, has researched training for transfer of care over the past three years.1

“Make sure trainees get the know-how they need to do hand-offs right” I By Andrea M. Sattinger

“Sign outs serve a lot of purposes, not just information [transfer],” says Leora Horwitz, MD, an assistant professor in the division of general internal medicine at Yale School of Medicine, New Haven, Conn. “Signout is also a time for training. It is a time for socialization in terms of how we talk about patients and what is expected. And it is a time for catching errors and for rethinking plans and diagnoses because as you are describing something to someone, they might pick up on gaps or inconsistencies or things that should be done differently.”

Dr. Horwitz, who is also associate medical director of the Center for Outcomes Research and Evaluation at Yale-New Haven Hospital, has researched training for transfer of care over the past three years.1

“The most important thing is that hospitalists should not assume that residents have any skills [pertaining to transfer of care],” says Dr. Horwitz. “In medical schools, students are taught over and over how to present a patient for the first time. There’s a rigid order in which the information is supposed to flow, and there is a rigid list of categories of information that should be conveyed. People are taught that same order and that same flow and that same list of categories at all medical schools. Consequently, as residents, everybody has the same sense of how to represent an initial history and physical. There is no such thing for hand-offs.”

Resident duty-hour limitations have increased the number of hand-offs, which creates greater risks for discontinuity of care and patient safety.1 “Hand-offs occur two or three times a day and a patient presentation only occurs once—when the patient shows up,” says Dr. Horwitz. On top of that, when residents appear in their clinical duties, the attendings tend to forget residents don’t have the skills to execute a comprehensive and well-communicated hand-off. “The first thing to remember is that people need to be trained,” she says.

In a study in the Archives of Internal Medicine in 2006 (for which Dr. Horwitz is first author), the investigators asked internal medicine chief residents whether their program provides direct training in how to perform sign outs. Sign-out training varied considerably, and fewer than half the 202 programs that responded (62% of all U.S. residency programs) provided formal sign-out skill training: 40% of the programs taught sign-out skills through a lecture or workshop, 45% supervised oral sign outs, and 38% reviewed written

Continued on page 32
teaching trainees to communicate to provide anticipatory guidance, residents need to recognize the problem and address it in some way,” Dr. Horwitz says.

Be Explicit, Create a Model
“Many residency programs have a standardized form that residents use to sign out to the cross-covering physician,” says Sunil Kripalani, MD, MSc, director of the Section of Hospital Medicine at Vanderbilt University in Nashville, Tenn. “However, there is often not much attention given to the actual process of transferring patient information to another physician.”

For example, residents may tack the form up to a wall or leave it on a computer, he says, because this may be more convenient than meeting for a verbal, face-to-face sign out. “It is important that residents receive training about how to best sign out patients, so it is viewed as a priority area,” he says.

The initial training should cover best practices for hand-offs, says Dr. Kripalani. “It may not be intuitive, especially to new residents, that poorly executed hand-offs can be perilous,” he says.

It is also important to teach trainees how to best convey that information. “Sometimes you’ll think more is better,” says Dr. Horwitz, “but that’s not the case; people turn off or get distracted. There is a tension between providing enough information to take care of the person overnight versus providing too much information.”

Modeling best behaviors is also an important part of training, says Jay Routson, MD, a teaching hospitalist and clinical assistant professor of medicine in the Idaho State University Department of Family Medicine in Pocatello, Idaho. Dr. Routson, trained in internal medicine, thinks opportunities to train residents and students in transfer of care are also a chance to model what you expect of them. “This is particularly important in Dr. Routson’s circumstances because of the nature of his university’s family medicine residency: It is conducted at a number of locations. At morning report on the first day of a block, residents who have been on the previous rotation are to transfer patient care to the incoming residents. But they may have already left for their new pediatrics or NICU assignments, for instance, not only elsewhere in Pocatello but perhaps in Boise or Logan.

Another problem in his program’s training is that experienced residents are not always aware of the important things to check. What one resident thinks is important to follow up on the next resident may put at the bottom of his or her list.

“That is why you have to model the importance you place on [hand-offs],” says Dr. Routson. “You have to set aside time during the day and make it a priority. Model the behavior when you’re checking out a new attending, make sure the residents and interns know it’s a priority, especially early in the academic year.”

Supervision and Feedback
Supervised evaluation of performance and feedback are key aspects of training for transfer of care. “Training residents means supervising them,” says Dr. Horwitz. “Are they getting the concepts? Are they incorporating the key points into everyday communication and actions?”

Routson, who thinks opportunities to train residents and students in transfer of care are also a chance to model what you expect of them.

FIVE-POINT TRAINING

1. Give the subject importance and emphasize that it is a priority;
2. Recognize and teach what information to convey. The first step is recognizing which information is not important to mention;
3. Teach trainees what being explicit means. Teach them to use concrete language rather than vague generalities: “The patient is breathing 98% on 2 liters of oxygen” versus “The patient’s fine”;
4. Teach trainees to communicate to provide anticipatory guidance/contingency planning. What you think is going to happen with this patient in the next hours and how the new provider should respond to that; and
5. Provide ongoing evaluation and feedback of residents’ performance.

Two-Way Street
Just as the DHMC team recognized that...
communication for hand-offs is a two-way street, the same is true for performing a discharge communication exchange. Are primary care providers considering best practices to train themselves in this integral aspect of patient care and safety?1,4

“I don’t think the primary care community has gotten together and come up with a consensus of what they want to know and how much interaction they want,” Dr. Horwitz says. “There should be a standard for that.” That is a first step to encourage greater training all around. She urges collaboration between SHM and a national organization, such as the American Academy on Family Practice, and hopes SHM will open that dialogue.

In that regard, some steps have been taken. Dr. Kripalani is a member of the SHM Hand-off and Communication Standards Task Force, which is developing national standards (The Hospitalist, August 2007, p. 17). There is a working list of nine best practices for hand-offs at shift changes or rotation ends, and the group plans to publish a final list in the upcoming year. The list is designed primarily for practicing hospitalists but will also be suitable for residents. The task force hopes other groups, such as internal medicine program directors and chief residents, will disseminate the best practices to trainees. National best practices are also likely to affect providers in the community. “My suspicion is that a lot of community-based programs are interested in improving hand-offs, but each program may develop a different set of procedures,” says Dr. Kripalani. “One of the main reasons for developing national standards is so that both academic and community groups can refer to a list of evidence-based best practices.”

Evolution of Training

“Training for transfer of care and transfer of care are very different things,” says Dr. Chu, “but they’re interrelated.” He and his colleague Gregory Misky, MD, a hospitalist and instructor with the University of Colorado Health Sciences Center (UCHSC), have been disseminating that training program throughout the UCHSC internal medicine residency program for the past three years.

In order to develop a structured, standard method for patient hand-offs, they took on teaching and supervising interns during their internal medicine ward rotations. Although much of the literature advocates the SBAR (situation, background, assessment, and recommendation) communication technique, the UCHSC team has developed a verbal structure specifically for hand-offs that differs from the SBAR model.

Having learned many lessons their first year of training the trainers and the trainees, the Colorado hospitalists regrouped the next year. Because there were two interns coming on duty each evening, both taking cross covers, one attending could supervise only one of the interns. And, those hospitalists were getting called away to handle their clinical responsibilities.

“We felt it was important that attendings were available to guide the

process safely,” says Dr. Chu. Therefore, because the evening hand-offs were conducted at 6 p.m., and a hospitalist was in house daily at that time, they began having the evening person, who was on each night until about 11, supervise the interns. To improve the quality and consistency of the teaching, only four of the Division of Hospital Medicine’s eight attendings focused on supervising intern hand-offs. Also, in a series of focus-group meetings with attendings and house staff, they discussed supervision and identified several structures and standards for teaching hand-offs.

In addition to determining a consistent time and place for hand-off exchanges, they developed a consistent written template and a standard for verbal communication that provides an order of thinking and presenting, just as they use watch for and a clear-cut means by which to supervise. In the third year of training at UCHSC, the hospitalist attendings provided training and feedback on the first night of call for the first four months beginning in July and in small-group sessions during the first week of the ward month.

The Reviews Are In

In response to a survey, the vast majority of UCHSC internal medicine residents said the new protocols were useful or extremely useful. Responses also revealed that training increased interns’ self-perceived hand-off skills and knowledge. The common denominator of a same time and place for hand-off was judged the most useful element of the program; lectures were considered the least useful.

Andrea Satterfield is a frequent contributor to The Hospitalist.

References

Table 1. SIGNOUT Mnemonic for Oral Communication

<table>
<thead>
<tr>
<th>Description</th>
<th>Sample Sign Out</th>
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<tbody>
<tr>
<td>S</td>
<td>Sick or DNR? (highlight sick or unstable patients, identify DNR/DNI patients)</td>
</tr>
<tr>
<td>I</td>
<td>Identifying data (name, age, gender, diagnosis)</td>
</tr>
<tr>
<td>G</td>
<td>General hospital course</td>
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<tr>
<td>N</td>
<td>New events of day</td>
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<tr>
<td>O</td>
<td>Overall health status/ clinical condition</td>
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<tr>
<td>U</td>
<td>Upcoming possibilities with plan, rationale</td>
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<tr>
<td>T</td>
<td>Tasks to complete overnight with plan, rationale</td>
</tr>
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? Any questions?

? Any questions?

SUCCESS: Eviva Aagaard, MD, associate chair for education in the department of medicine, approved hospitalists to incorporate the program into the medical school’s interclinical curriculum, given to students between the third and fourth years as additional skills they would need in their sub-internships. Originally offered as an electives, the course exceeded the class limit. Plans are under way to make this course mandatory.

“This past year, for the first time, we specifically taught our medical students hand-offs,” says Dr. Chu. He and his colleagues presented an abstract at SHM’s annual meeting in Dallas and are preparing a manuscript for publication.

Until now, all physicians have managed to do hand-off without formal training. “Most residents figure out their own way of doing things after a while, but what we’re trying to do is not let it be a random evolution of learning,” says Dr. Chu. “It’s like learning to drive or ski with no lesson at all. If you point your skis downhill, eventually you’ll learn how to ski, but you’ll have a lot of crashes. In hand-offs, the same is true for performing communication failures, and a patient may suffer morbidity. We want to teach and supervise [residents] so they learn in a progressive fashion and have fewer crashes.”

What is the best medical therapy for the secondary prevention of stroke?

Antiplatelet agents, statins are among the best treatments

KEY POINTS
1. Warfarin is the most effective therapy for secondary prevention of cardioembolic stroke but is not better than antiplatelet agents for non-cardioembolic events.

2. Both combination aspirin/dipyridamole and clopidogrel are superior to aspirin for non-cardioembolic stroke secondary prevention.

3. Treatment of hypertension, hyperlipidemia, and carotid stenosis have been demonstrated to significantly reduce risk of second strokes and over time may have as much of an effect as anti thrombotic therapy.

4. Lifestyle risk factors such as tobacco abuse, obesity, inactivity, and alcohol abuse are appropriate targets for counseling.

THE BOTTOM LINE
Following non-cardioembolic stroke, antiplatelet therapy such as combination dipyridamole/aspirin and aggressive reduction of risk factors is necessary and effective in preventing disabling or fatal cerebrovascular events.

ADDITIONAL READING

By Ethan Cumbler, MD

The Case
A 62-year-old obese woman with prior history of type 2 diabetes, hypertension, and a pack-a-day smoking habit presented to the emergency department (ED) for acute onset of right-side weakness and sensory loss noted on awakening from sleep.

She reports taking a baby aspirin daily to “prevent heart attacks” prior to her stroke. Her electrocardiogram demonstrates a left bundle branch block and frequent premature atrial contractions. She recovers with mild hemiparesis and is ready for discharge. What is the best medical therapy for secondary prevention of stroke?

Overview
Cerebrovascular accident (CVA) represents an important diagnosis for the hospitalist, with 700,000 people suffering a stroke in the U.S. each year. This translates to a stroke every 45 seconds. About 200,000 of these strokes are recurrent events.

Cardioembolism is the largest cause of ischemic strokes, representing 29% of all infarcts.1 Stasis from impaired contractile function, atrial fibrillation, or mechanical valves are significant risk factors. More rarely, a paradoxical embolus arising in the venous system may pass through a patent foramen ovale.

Large-artery atherosclerotic and lacunar infarcts each account for 16% of strokes. Risk factors for these forms of strokes are the same as those for atherosclerosis and include hypertension and diabetes. Rarer causes such as vasculitis, dissection, hypercoagulability, or hematological disorders account for 3% of strokes. Work-up for these should be driven by historical and atypical features such as young age, family history, or unusual distribution of ischemic zones. Despite appropriate work-up, the mechanism remains uncertain in 36% of strokes.

Regardless of the manifestation and residual of the index event, the hospitalist must initiate appropriate therapy to prevent a disabling CVA. While antithrombotic drugs are the mainstay of secondary prevention, it is a mistake to miss other opportunities for risk modification. Optimal management requires a tailored evaluation for etiology, identification of modifiable risk factors, and initiation of antplatelet or anticoagulant therapy.

Cardioembolic Stroke
Treatment of stroke depends on the etiology of the original infarct. Evidence is strong that the optimal therapy for cardioembolic stroke is anticoagulation with warfarin.

The European Atrial Fibrillation Trial found that warfarin reduces the risk for second strokes in patients with atrial fibrillation by two-thirds and is superior to antiplatelet agents for preventing cardioembolic strokes.2 Warfarin increases the risk of extracranial bleeding, but not severely enough to negate the benefit of reducing stroke death and disability. The target international normalized ratio (INR) for non-valvular atrial fibrillation is generally two to three, although this may be higher for certain prosthetic valves.

Noncardioembolic Stroke
For large-vessel atherosclerotic and lacunar cerebral ischemia, the oldest—and still effective—therapy for recurrent stroke is aspirin. The use of low-dose aspirin after transient ischemic attack (TIA) or stroke reduces second strokes or death by approximately 15%-18%.3,4 Larger doses do not appear to be more effective, although the rate of gastrointestinal complaints is greater with increased dosage. The use of either 325 mg or 1,200 mg of aspirin produced the same 15% reduction in second ischemic events. Similar efficacy has been seen in comparisons between 30 mg and 283 mg dosing.3

While a subset of patients may experience aspirin resistance, reliable assays in clinical practice are not commonly available to guide management. Current recommendations suggest that use of between 50 mg and 325 mg of aspirin is appropriate for secondary prevention.5 Clopidogrel is another antiplatelet agent that can be given daily at 75 mg as alternate therapy for secondary prevention of non-cardioembolic stroke. The Clopidogrel versus Aspirin in Patients at Risk of Ischemic Events trial comparing clopidogrel with aspirin in patients at risk of ischemic events demonstrated significant reduction in the annual rate of combined endpoint of stroke, myocardial infarct, or disabling TIA.9

Table 1. Medication Options for Secondary Prevention of Ischemic Stroke

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warfarin</td>
<td>5 mg oral daily</td>
<td>For atrial fibrillation titrate INR to 2-3.</td>
</tr>
<tr>
<td>Aspirin</td>
<td>325 mg oral daily</td>
<td>Only appropriate if warfarin contraindicated.</td>
</tr>
<tr>
<td>Clopidogrel</td>
<td>75 mg oral daily</td>
<td>Preferred agent for aspirin allergy. Rare incidence of thrombotic thrombocytopenic purpura.</td>
</tr>
<tr>
<td>Aspirin/ER dipyridamole</td>
<td>25 mg/200mg oral daily</td>
<td>Headache is common.</td>
</tr>
<tr>
<td>Aspirin</td>
<td>50 mg to 325 mg oral daily</td>
<td>Least expensive antiplatelet agent, but less effective than other antiplatelet choices.</td>
</tr>
</tbody>
</table>

* All antiplatelet agents are acceptable options for initial therapy and choice may be individualized

Source: TeamHealth, December 2006
infarction, and vascular death—from 5.83% with aspirin to 5.32% with clopido- 
grel.1 This study’s applicability to sec- 
ondary prevention of stroke is limited by 
the fact that only 19% of the patients in 
this trial were included because of prior 
stroke, and the results were not significant 
for reduction of stroke as a lone endpoint. 
Clopidogrel is recommended as an accept-
able agent for CVA secondary prevention 
and is preferred for patients with stroke 
and an acute allergic or with recent coro-
nary stent.

The combination of a low-dose aspirin 
and extended-release dipyridamole has 
proved superior to aspirin monother-
apy in multiple trials. Over two years, the 
European Stroke Prevention 2 trial found 
an 18% reduction with aspirin alone com-
pared with 37% reduction with the combi-
nation therapy, and the Euro-
penean/Australasian Stroke Prevention in 
Reversible Ischaemia trial confirmed that 
the combination reduced the absolute rate 
of secondary ischemic events by 1% annual-
ly.11 Headache is a common side effect 
of dipyridamole and may limit use. 
Dipyridamole/aspirin is recommended as 
another acceptable option for secondary 
prevention of non-cardioembolic stroke.

Evidence suggests that aspirin/ 
dipyridamole and clopidogrel—which are 
both significantly more expensive—are more 
effective than aspirin monotherapy for 
preventing second ischemic events. Direct 
comparison between aspirin/dipyridamole 
and clopidogrel is ongoing in the Prevention 
Regimen for Effectively Avoiding Second Stroke trial, 
with results anticipated in 2008.

Things That Don’t Work

The Warfarin-Aspirin Recurrent Stroke 
Study trial demonstrated that warfarin was 
not better than aspirin for prevention of 
non-cardioembolic stroke, and the 
Warfarin–Aspirin Symptomatic Intra-
cranial Disease trial found the same result for 
patients with intracranial stenosis.12

There is little evidence that warfarin 
should have a role in the treatment of most 
non-cardioembolic strokes. The 
MATCH trial failed to show benefit to 
adding aspirin to clopidogrel over clopido-
grel monotherapy for secondary preven-
tions of non-cardioembolic cerebral ischemia.13 
Despite efficacy following coronary stenting, 
the combination of clopidogrel and aspirin can not be recom-

mended for stroke prevention.

What To Do

Aggressive risk factor modification is key in 
the prevention of second ischemic events. One of the most promising thera-
pies is the use of statins following a CVA. 
Maintaining low-density lipoprotein (LDL) at less than 100 mg/dL (or less 
than 70 mg/dL in the highest-risk 
patients) is recommended despite a rela-
tively weak association between stroke and 
hyperlipidemia.

This stands in contrast to the strong 
relationship between elevated LDL and 
coronary disease. However, the Stroke 
Prevention by Aggressive Reduction in 
Cholesterol Levels trial utilized high-dose 
atorvastatin after acute CVA and was able 
to create an absolute risk reduction for sec-
ond stroke of 2.2% over the next five years.14 It is possible that the findings of 
this trial may reflect actions of statin ther-
apy on the endothelium independent of 
the lipid lowering effect.

Blood pressure commonly has a tran-
sient elevation following cerebral ischemia. This is managed permissively 
to preserve perfusion to the ischemic penum-
bra. Once the hyperacute period is over, 
reduction of blood pressure to less than 
140/90 mm/Hg (130/80 mm/Hg for dia-
betics) is recommended.

Interventions to treat chronic hyper-
tension have been demonstrated to reduce 
the rate of strokes by approximately 30% 
to 40% over four to five years.15,16 An opti-
mal agent has not been determined, but 
therapy with angiotensin converting 
enzyme inhibitor (ACE-I) or angiotensin 
II receptor blockers (ARB), possibly in 
combination with a diuretic—would be 
effective. Close follow-up for titration to 
goal in the outpatient setting should be 
arranged. Diabetics should have optimiza-
tion of glycemic control, and lifestyle 
counseling should occur regarding recog-
nized risk factors for stroke such as smok-
ing, inactivity, and alcohol abuse.

While antithrombotic therapy is the 
mainstay of what we think of in secondary 
prevention of stroke, treatment of these 
other modifiable risk factors have been 
shown to affect mortality and second 
strokes of a similar magnitude and should 
not be neglected.

How to Treat This Case

The patient described should undergo an 
MRI with diffusion (to define the area 
of ischemia) and targeted evaluation for 
etiology with cardiac monitoring, echocar-
diogram, and carotid ultrasound.

Assuming arterial fibrillation or intracra-
nal thrombus is ruled out, this likely 
represents atherosclerotic disease. MRI 
will help distinguish between large-vessel 
thrombotic etiology and lacunar infarct. 
If carotid stenosis of greater than 70% is 
found in the setting of large vessel atherosclerotic stroke, then she should 
be referred for carotid endarterectomy. At 
50% to 69% stenosis, carotid endarterectomy would still be a consid-
eration. Antithrombotic agent of choice 
for non-cardioembolic CVA is an anti-
platelet agent. With a stroke occurring 
on a reasonable dose of aspirin, I would 
not recommend increasing the dose as 
there is little evidence that 325 mg is more 
effective than 81 mg. The most appropri-
ate step would be to change to an alternate 
anti-platelet agent such as combination 
dipyridamole/aspirin or clopidogrel.

In the absence of a direct comparison 
trial, either choice is acceptable. The 
evidence supporting dipyridamole/aspirin 
is stronger for secondary stroke prevention.

A torvastatin 80 mg daily is an evidence-
based therapy after acute stroke and can 
be started immediately. Her hypertension 
should be managed permissively for 
the first few days after the acute event, 
but then an ACE-I or ARB—possibly in 
combination with a diuretic—would be 
appropriate. This patient’s goal blood 
pressure as a diabetic would be at least 
130/80 mm/Hg.

Finally we would be remiss if we did 
not stress the importance of smoking 
cessation, exercise, and weight loss.

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3. European Atrial Fibrillation Trial Study Group. Secondary prevention in non-mechanical atrial fibrillation after tran-
vention of stroke in patients with ischemic stroke or tran-
8. CAPRIE Steering Committee. A randomised, blinded, 
trial of clopidogrel versus aspirin in patients at risk of 
and dipyridamole compared with clopidogrel alone after recent ischemic stroke or transient ischemic attack in 
Diagnose Misdiagnosis

I By Andrea M. Sattinger

This is the first of a two-part series examining medical errors. This article addresses thought processes hospitalists use that may lead to mistaken diagnoses. Part 2 will look at what healthcare corporations are doing to improve diagnoses and reduce errors.

Hospitalists’ thought patterns can be a roadblock to making the right calls

When talking about tough diagnoses, academic hospitalist David Feinbloom, MD, recalls the story of a female patient seen by his hospitalist group whose diagnosis took some time to nail down.

This woman had been in and out of the hospital for several years with nonspecific abdominal pain and intermittent diarrhea. She had been seen by numerous doctors and tested extensively. Increasingly her doctors concluded that there was some psychiatric overlay—she was depressed or somatic.

“Patients like these are very common and often end up on the hospitalist service,” says Dr. Feinbloom, who works at Beth Israel Deaconess Medical Center in Boston.

But to Joseph Li, MD, director of the hospital medicine program at Beth Israel, this patient seemed normal. There was something about the symptoms she described that reminded him of a patient he had seen who had been diagnosed with a metastatic neuroendocrine tumor.

Although this patient’s past MRI had been negative, Dr. Li remembered that if you don’t perform the right MRI protocol, you’ll miss something. He asked the team to obtain a panel looking for specific markers and to repeat the MRI with the correct protocol. It
Cognitive errors involve instances where knowledge, data gathering, data processing, or verification (such as by lab testing) are faulty. Improving diagnostics will require better accountability by institutions and individuals. To do the latter, experts say, physicians would do well to familiarize themselves with their diagnostic weaknesses.

Thinking about thinking is the science of cognitive psychology and addresses the cognitive aspects of clinical reasoning underlying underlying diagnostic decision-making. It is an area of study in which few medical professionals are versed. "Except for a few of these guys who trained in psych or were voices in the wilderness that have been largely ignored," most physicians are unaware of the cognitive psychology literature, Dr. Groopman says.

Common biases and errors in clinical reasoning are presented in Table 1 (right). These are largely individual mistakes for which physicians traditionally have been accountable.

Patterns and Heuristics

The following factors contribute to how shortcuts are used: the pressures of working in medicine, the degree of uncertainty a physician may feel, and the fact that hospitals rarely have all the information they need about a patient. "That's just the nature of medicine," says Dr. Groopman. "These shortcuts are natural ways of thinking under those conditions. They succeed about 85% of the time; they fail up to 10-20% of the time. The first thing we need to educate ourselves about is that this is how our minds work as doctors."

Dr. Groopman and those he interviewed had rigorous training in clinical medicine, or later through academic centers, community centers, affiliated areas, suburbs, inner cities, and Native American reservations. But except for Pat Croskery, MD, PhD, in the department of emergency medicine at Dalhouse University's Queen Elizabeth II Health Sciences Center in Halifax, Nova Scotia, none of the experts he interviewed had rigorous training in cognitive science.

Although how to think is a priority in physicians' training, how to think about one's thinking is not. "We are not given a vocabulary during medical training, or later through CME courses, in this emerging science—and yet this science involves how our minds work successfully and when we make mistakes," Dr. Groopman says. "The data back this assertion. In a study of 100 cases of diagnostic error, 90 involved injury; including 33 deaths; 74% were attributed to errors in cognitive reasoning (see Figure 1, right). Failure to consider reasonable alternatives after an initial diagnosis was the most common cause. Other common causes included faulty context generation, misjudging the salience of findings, faulty perception, and errors connected with the use of heuristics. In this study, faulty or inadequate knowledge was uncommon. Underlying contributions to error fell into three categories: "no fault," system-related, and cognitive. Only seven cases reflected no-fault errors alone. In the remaining 93 cases, 548 errors were identified as system-related or cognitive factors (5.9 per case). System-related factors contributed to the diagnostic error in 65% of the cases and cognitive factors in 74%. The most common system-related factors involved problems with policies and procedures, inefficient processes, teamwork, and communication. The most common cognitive problems involved faulty synthesis. Dr. Groopman believes it is important for physicians to be more introspective about the thinking patterns they employ and learn the traps to which they are susceptible. He also feels it is imper-
can be used to reduce error rates. Because the names for these traps can vary, the development of a universal and comprehensive taxonomy for classifying diagnostic errors is also needed.

“It’s impossible to be perfect; we’re never going to be 100%,” Dr. Groopman says. “But I deeply believe that it is quite feasible to think about your thinking and to assess how your mind came to a conclusion about a diagnosis and treatment plan.”

When physicians think about errors in cognitive reasoning, they often focus on the “don’t-miss diagnoses” or the uncommon variant missed by recall or anchoring errors.

Medical researchers conclude that the majority of diagnostic errors arise from flaws in physician thinking, not technical mistakes.

“When I reflect on the errors I have made, they mostly fall into the categories that Dr. Groopman describes in his book,” Dr. Feinbloom says. “Interestingly, the errors that I see most often stem from the fear of making an error of omission.”

It is paradoxical, but in order to ensure that no possible diagnosis is missed, doctors often feel the need to rule out all possible diagnoses.

“While it makes us feel that we are doing the best for our patients, this approach leads to an inordinate amount of unnecessary testing and potentially harmful interventions,” says Dr. Feinbloom. “Understanding how cognitive errors occur should allow us to be judicious in our approach, with the confidence to hold back when the diagnosis is clear, and push harder when we know that something does not fit.”

Emotional Dimension

Although many diagnostic errors are attributable to mistakes in thinking, emotions, and feelings—which may not be easy to detect or admit—also contribute to decision-making.

As hypothesized by noted neurologist and author Antonio Damasio in Descartes’ Error: Emotion, Reason, and the Human Brain, some feelings—visceral signals he calls somatic markers—deter us from or attract us to certain images and decisions. Remaining cognizant of those feelings helps clarify how they may inform a medical decision—for good and bad.
BETTER DIAGNOSTIC THINKING

- Become aware of your thought processes and how your emotions and feelings inform them;
- Be mindful of how your emotional reaction to each patient may inform your clinical decision-making;
- Be skeptical of everything—even yourself;
- Explain everything. Use every clue you have;
- Resist relying too much on testing, especially if the results are discordant with your intuition;
- Remember that Bayesian assessment has its limitations but is useful in appropriate circumstances: with a sufficient clinical history and for a singular clinical problem;
- Understand if patients act annoyed when the clinical history is asked for repeated times. Reassure them that it is to their benefit to supply their story to a new listener;
- Remember that you can’t know what you don’t know: Keep up on the literature, keep your ears open; ask to be informed about misdiagnosis and solutions for similar faulty thinking; and
- Encourage in staff, trainees, and colleagues openness to admitting misdiagnoses to the group. Put everyone’s thinking under the microscope.
The emotional dimension of decision-making cannot be disregarded, says Dr. Groopman. “We need to take our emotional temperature; there are patients we like more and patients we like less,” he says. “There are times when we are tremendously motivated to succeed with a very complicated and daunting patient in the hospital, and there are times when we retreat from that for whatever psychological reason. Sometimes it’s fear of failure, sometimes it’s stereotyping. Regardless, we need to have a level of self-awareness.”

The stressful atmosphere of hospital-based medicine contributes to a high level of anxiety. “Physicians use a telegraphic language full of sound bytes with each other that may contribute to the way heuristics are passed from one generation of doctors to the next,” Dr. Groopman says. “That language is enormously powerful in guiding our thinking and the kinds of shortcuts that we use.”

**Pitfalls in Reasoning**

Of all the bias errors in clinical reasoning, two of the most influential on physicians are anchoring and attribution. Bounded rationality—the failure to continue considering reasonable alternatives after an initial diagnosis is reached—is also a pitfall. The difference between the latter and anchoring is whether the clinician adjusts the diagnosis when new data emerge.

Anchoring errors may arise from seizing the first bits of data and allowing them to guide all future questioning. “It happens every day,” says Dr. Feinbloom. “The diagnosis kind of feels right. There is something about the speed with which it comes to mind, the familiarity with the diagnosis in question, [that] reinforces your confidence.”

Dr. Feinbloom teaches his young trainees to trust no one. “I mean that in a good-hearted way,” he says. “Never assume what you’re told is accurate. You have to review everything yourself, interview the patient again; skepticism is a powerful tool.”

With the woman who was ultimately diagnosed with Zollinger-Ellison syndrome, Dr. Li’s skepticism paid off—and the hospitalist team benefited from deconstructing its clinical thinking to see where it went awry.

“If someone had gotten the gastrin level earlier,” says Dr. Feinbloom, “they would have caught it, but it was not on anyone’s radar. When imaging was negative, the team assumed it wasn’t a tumor.”

**Lessons Learned**

There are lots of lessons here, says Dr. Feinbloom. “You could spin it any one of five different ways with heuristic lessons,
but what jumped out at me was that if you don’t know it, you don’t know it, and you can’t diagnose it,” he says. “And that gives you a sense of confidence that you’ve covered everything.”

No one had a familiarity with the subtle manifestations of that diagnosis until Dr. Li stepped in. “One lesson is that if you think the patient is on the up and up, and you haven’t yet made a diagnosis,” says Dr. Feinbloom, “it doesn’t mean there’s no diagnosis to be made.”

Dr. Li gives this lesson to his students this way: You may not have seen diagnosis X, but has diagnosis X seen you? Andrea Sattinger is a frequent contributor to The Hospitalist.

References

PERSONAL GUIDELINES

Drs. Feinbloom and Krakow tend to ask themselves these questions to guide their own diagnostics:

- What do I think it is and what can’t I miss today?
- Which data fit and which don’t fit?
- How come the test does not show what I expected? Is that because it’s wrong or I’m wrong?
- What are the worst things this could be?
- What are the most likely things this is?
- What are the highly unusual things it could be, especially considering the inclusion of an item of data that does not fit into any known categories? and
- What causes of an item of data that doesn’t fit, would be catastrophic if missed? For example, unexplained thrombocytopenia has two causes that could be catastrophic if not correctly diagnosed the same day as noted: heparin-induced thrombocytopenia with thrombosis and thrombotic thrombocytopoenic purpura.
The average young or middle-age person probably finds a hospital stay stressful, uncomfortable, and inconvenient. The experience can be strikingly more disruptive for a geriatric patient. A frail elderly person can easily succumb to delirium, a fall, dehydration, polypharmacy, and deterioration in basic life skills, quickly turning even a routine hospitalization into a catastrophic downhill slide. But if a patient is lucky, she will be treated by a geriatric hospitalist—a physician who by training and temperament is uniquely suited to care for her.

Geriatric hospitalists bring heightened sensitivity and experience to treating and preventing the common syndromes that can overwhelm the elderly during hospitalizations. Fredrick Sherman, MD, FACP, medical director of Senior Health Partners and professor of geriatrics at the Mount Sinai School of Medicine in Manhattan, has been a geriatrician since the 1980s. He sees a great opportunity for hospitalist geriatricians to improve the metrics by which hospitalist programs are judged: reduced length of stay, bounceback, and morbidity. They do this, he says, with a unique blend of skills, mindset, and temperament.

“In one or two minutes at the bedside, a geriatric hospitalist can do a basic functional assessment of an elderly patient,” he says. “We can understand their ADL [activities of daily living] skills, mental status, and what resources we have to mobilize during the hospital stay and for a safe discharge plan. We don’t want to turn hospitalists into social workers, but geriatricians can teach them a body of knowledge to help them better understand and develop a holistic approach to elderly patients.”

How geriatricians work best, though, can be somewhat out of synch with hospital medicine’s fast pace. “Many hospitalists are younger and have been trained very recently,” Dr. Sherman says. “They quickly learn to take care of a 55-year-old with a [myocardial infarction], but they sometimes lack a global view of geriatric patients that is more a frame of mind than about the physician’s technical skills.”

Challenges Ahead

As hospital medicine groups integrate geriatricians into their ranks, they will have recruited major players invested in improving the care of hospitalized elderly patients. There’s a lot at stake in caring for them.

The Healthcare Cost and Utilization Project’s (HCUP) most recent figures of what hospitalizations of the elderly cost is staggering. Medicare patients account for 76% of public spending on hospital care. The costliest diagnoses for Medicare-paid hospitalizations are coronary arteriosclerosis ($44 billion), acute myocardial infarction ($31 billion), and heart failure ($29 billion). Further, 90% of elderly patients with osteoarthritis are hospitalized for elective hip or knee joint replacement therapy.

The expertise of board-certified hospitalist geriatricians will be hard to disseminate throughout the corps of hospitalists. Only a tiny fraction of the nation’s hospitalist programs claim special expertise in geriatrics. Researchers from the University of Colorado Health Sciences Center and the Mayo Clinic College of Medicine conducted a cross-sectional survey of the hospitalist community in 2003-2004 to determine the impact of the hospitalist movement on acute care geriatrics. They found:

Out of 1,415 hospitalist pro-
ACES FOR OLDER PATIENTS

Acute Care of Elders (ACE) units are designed to treat the elderly hospitalized with acute medical conditions. Generally consisting of fewer than 30 beds, they are designed to resemble home more than a hospital. Activity rooms for congregate meals, kitchens, recliners, low beds, carpeting, art, and music areas are common features. Geriatricians, advanced practice nurses, physical and occupational therapists, and social workers work together create a kinder, gentler approach to care.

Based on a model developed at University Hospitals of Cleveland in conjunction with the Case Western Reserve University's School of Nursing, the physical and psychological hospital environment has been adapted by ACE unit clinicians to prevent the functional decline observed in about 35% of hospitalized geriatric patients. Simple things—taking before diagnostic procedures, unfamiliar routines, medication changes, and enforced bed rest—can throw a senior into decline. ACEs get patients up and moving, keep them oriented through home-like environments, and connect them through congregate meals and activities. —MP

A GOOD CAREER

Despite the difficulty of persuading family practice and internal medicine residents to consider a career in geriatrics, these doctors consistently report the highest career satisfaction of any sub-specialists.

A snapshot of 68 physicians with formal geriatric training showed:

- 89.5% planned to pursue recertification;
- 95% felt that a geriatric fellowship had a positive career impact;
- 87% recommended pursuing geriatric fellowship training;
- 75% devoted at least half of their practice to caring for the elderly;
- 64% had yearly incomes between $100,000 and $200,000; and
- 25.6% had incomes greater than $200,000.

That essentially describes Purnima Joshi, chief of medicine, at Kaiser-Permanente Mid-Atlantic States at Washington Hospital Center in Washington, D.C. She directs a group of 12 hospitalists, the group’s only training ground for geriatricians.

A snapshot of 88 physicians with formal geriatric training showed:

- Four developed core clinical activities, four used geriatric QI measures, three used comprehensive geriatric assessments, and two had specific protocols for elderly patients discharged to nursing facilities; and
- In terms of staffing, four had hospitalists with no special geriatric training, four employed fellowship-trained geriatricians, two had general hospitalists and geriatricians, and four used advanced practice nurses with and without geriatric training.1

Four developed core clinical activities, four used geriatric QI measures, three used comprehensive geriatric assessments, and two had specific protocols for elderly patients discharged to nursing facilities; and

In terms of staffing, four had hospitalists with no special geriatric training, four employed fellowship-trained geriatricians, two had general hospitalists and geriatricians, and four used advanced practice nurses with and without geriatric training.1

Adding to the difficulty of building a cadre of geriatric hospitalists is the national paucity of geriatricians. According to the American Geriatrics Society (AGS), there were 9,000 board-certified geriatricians in 1998. A decade later there are 7,600—and the pipeline is narrow. Of 9,780 medical school graduates in 2004, only 321 were geriatricians. The AGS estimates that the United States needs 14,000 geriatricians now and 36,000 in 2030, when there will be an estimated 70 million adults 65 years and older.

But there’s hope. Hospital medicine programs, growing by leaps and bounds, offer a new career path for physicians interested in geriatrics. As the number of hospitalists continues to grow, there’s room for physicians to have an impact by staying tuned in to the special clinical, psychosocial, emotional, spiritual, and environmental needs of elderly patients.

The Breed

According to Leslie Libow, MD, distinguished clinical professor at the Jewish Home and Hospital of New York in Manhattan, physicians who pursue a career in geriatrics do so because they have the right psychological make-up to work with elderly people.

He should know. In 1968, Dr. Libow petitioned the American Board of Internal Medicine (ABIM) to recognize geriatrics as a sub-specialty of internal medicine. Shortly after ABIM recognition, Dr. Libow established a geriatric residency/fellowship at Mount Sinai—still a national leader in geriatric education.

Being a geriatric hospitalist allows physicians with a simpatico set of personality traits to thrive. One study of geriatricians who had been practicing for up to 25 years found that they shared these traits:

- Highly value enduring relationships;
- Enjoy making small but potent changes in their patients’ lives;
- Like to make a difference personally and for society;
- Prefer working in a multidisciplinary team;
- Prefer democratic, not autocratic, decision-making;
- Desire the intellectual challenges of geriatric medicine and like to teach; and
- Perceive that they have a distinct and different career path than other physicians.2

That essentially describes Purnima Joshi, chief of medicine, at Kaiser-Permanente Mid-Atlantic States at Washington Hospital Center in Washington, D.C. She directs a group of 12 hospitalists, the group’s only training ground for geriatricians.

*continued on page 44

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We don't want to turn hospitalists into social workers, but geriatricians can teach them a body of knowledge to help them better understand and develop a holistic approach to elderly patients.—Fredrick Sherman, MD, FACP, medical director of Senior Health Partners and professor of geriatrics at the Mount Sinai School of Medicine in Manhattan

geriatrician at the 800-bed tertiary care facility, and enjoys teaching residents about geriatric medicine. A family physician by trade, she was grandfa-


“I love working with the frail elderly and practicing Kaiser’s brand of med-
icine because I don’t do billing—I just treat patients,” Dr. Joshi says. Additionally, Kaiser simplifies recordkeeping on inpatient and outpatient treatments and makes communicating with Kaiser’s outpatient doctors about post-discharge care smooth and effi-
cient.

Dr. Joshi explains that being a geri-

atric hospitalist is different than special-

izing in general internal medicine because she customizes the approach for each patient—including tailoring therapi-

es to life expectancy. “Guidelines and evidence-based medicine are fine and very important, and we use geriatric guidelines on our teaching service,” she says. “But geriatrics liberates your thinking as a doctor. You treat the whole person—a diabetic with three days to live, and a 90-year-old with delirium and decubitus ulcers.”

She calls herself a surrogate primary care physician, seeing 12 patients most days. She consults frequently with other hospitalists on their toughest geriatric issues and makes daily multidisci-

pinary rounds—with discharge planner, pharmacist, physical therapist, palliative care specialist, nurses, and resi-
dent in tow.

“We keep length of stay and guide-

delines in mind, but the patient is the cen-
ter of my universe,” Dr. Joshi asserts. “I deliver holistic, patient-centered care and use gentle teaching tools for our res-
idents. I have the luxury of taking time to see the patient and talk to them and their families. It’s wonderful.”

Dr. Joshi’s attitude toward her pro-

fession reflects a consistent national finding: Geriatricians rank No. 1 in nearly every study of physician career satisfaction, from the American Medical Association to the American Geriatrics Society.

Across the country, Alpesh Amin, MD, MBA, FACP, professor and chief of general internal medicine and execu-
tive director of the University of California at Irvine’s School of Medicine Hospitalist Service, is making the most of the two geriatricians on his 15-hospo-
talist team. Starting about eight years ago, Dr. Amin—also a member of SHM’s board of directors—turned to his hospitalist geriatricians for a host of services: geriatric assessments, co-man-

agement of psychiatric problems, peri-

operative consults, critical care, and pal-

liative care consults.

“Geriatricians have such knowl-

edge and insight into elderly patients to share with the other hospitalists,” says Dr. Amin. “That’s why they work well side by side with internal medicine and family medicine hospitalists. They keep us aware of issues in geriatrics and the literature on what works best with these patients.”

Knowing that geriatricians are scarce, Dr. Amin accesses their expertise by using a system that focuses team members’ attention on their knowledge. There are journal clubs, frequent con-

sults, monthly meetings, teaching rounds, geriatric fellowships, and other opportunities that keep the geriatrician’s unique perspective front and center for other team members. “They are so in tune with issues related to delirium, polypharmacy, falls risk, etc.,” he says.

“Our model incorporates that expertise, and it works very well. We truly work as a multidisciplinary team with ownership and accountability of the special needs of our geriatric patients.”

A New Generation

The rapid growth of hospital medicine has encouraged new physicians to choose this career path.

Claudene George, MD, recently completed a two-year geriatric fellow-

ship at Mount Sinai Hospital in New York City and is starting as a geriatric hospitalist at Montefiore Hospital in the Bronx. “Becoming a geriatrician sort of surprised me because I thought I’d go into internal medicine,” she says. “But I love the approach to caring for the whole person and communicating with their families.”

As part of her contract at Montefiore, she negotiated a half-day-

per-week rotation at the hospital’s out-
patient clinic—part of her commitment to being a well-rounded physician. “The geriatric assessment up front is essential to find out what the patient’s and family’s goals of care are,” says Dr. George. “If they’re 80 years old and want to stay at home, we need to help them do that safely. That may mean linking them to the [visiting nurse serv-

ice], a home aide, or adult day care.”

She points out that an inpatient stay also offers seniors the opportunity to be seen by subspecialists and do a lot in a short period of time. “As a hospital-

ist geriatrician you can see change almost immediately; you can have an impact,” she concludes.

As the hospitalist movement affords career opportunities to geriatric-

ians, young physicians can obtain financial incentives to pursue a career in geriatrics. For instance, in 2006 South Carolina enacted a Geriatrician Loan Forgiveness program, helping physicians to repay up to $35,000 of medical school loans if they complete a geriatrics fellowship and practice in South Carolina for five years after completing medical training.

Victor Hirth, MD, medical direc-
tor for the Division of Geriatric Services of Palmetto Health of Columbia, S.C., has recruited eight geriatric fellows, two of whom will be hospitalists. A recent recruit, Andres Leone, MD, went to medical school in Ecuador, recently completed a geriatric fellowship in South Carolina, and works as a hospital-

list half time and at a free clinic for Hispanics half time. “The flexibility to work as a hospitalist and in an outpa-
tient clinic feels right to me,” says Dr. Leone.

While the number of geriatric hos-

pitalists today is small, some predict their growing presence is inevitable.

“The baby boomers will deluge us, and they will demand so much more of hospitalists in the near future,” Dr. Sherman says. “They will have complicat-

ed issues and be very inquisitive geriatric patients.”

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atrician in the house? Geriatric care approaches in hospi-


Malene Phane is a frequent contributor to The Hospitalist.
“Hospital medicine, more than many other specialties, tends to attract people who care a lot about lifestyle,” says Leslie Flores, MHA, Nelson/Flores Associates. “A practice that isn’t willing to be flexible and consider part-time is sort of shooting itself in the foot.”

Before deciding whether to hire part-time or job-sharing hospitalists, there are many factors to consider, such as how to handle benefits and malpractice insurance and how to make sure a part-timer with a private practice doesn’t draw patients away from the hospital’s crew of referring doctors—intentionally or not.

There are benefits to the hospital: It’s easier to provide vacation and gap coverage, it’s less likely the full-time hospitalists will burn out, and in some cases, a part-time specialist can provide services the hospital didn’t offer.

“We’re real advocates of part-time hospitalists,” Flores says. “I think the benefits really outweigh the risks.”

A part-time hospitalist can be anyone from a physician who cuts back to 75% of her hours so she can spend more time with her kids, to a resident or fellow who signs up for a few shifts a month. A job-sharer splits a full-time job with another physician, sometimes sharing office space and even a malpractice insurance policy.

“Also, they’re extremely helpful when the practice is in an expansion mode,” Dr. Simone says. “If they want to bring in two or three more referring providers’ practices, you
can utilize the part-timers to help with the extra work so you don’t overwork your staff. The same is true of the other side: a new hospitalist program may meet with resistance from local doctors. Offering those doctors part-time shifts can help ease the transition. They’re worried about what’s going to happen to their inpatient skills, what their patients may think, and their income,” says Steven Nahm, vice president of the Camden Group, a hospitalist consultancy and management company with offices in Chicago and El Segundo, Calif. As with the part-timers, these doctors keep current with inpatient care and can gauge the impact of the program on their practices. A respected local physician who comes in part-time also lends credibility and gives medical staff a greater sense of confidence in the program, Nahm says. Dr. Simone calls these part-timers ambassadors.

One Example

The hospitalist program at Hudson Valley Hospital Center in Cortlandt Manor, N.Y., began in July 2007 at the request of local doctors. The program, Hospital Medicine Associates, contracts with the hospital and has its own billing system. It has eight full-time hospitalists, and as of about six months ago, four hospitalists sharing two full-time positions. They even share malpractice insurance because New York state law allows for half-policies. The part-timers work under pro-rated policies because they work fewer hours. Allowing doctors to job-share seemed like common sense, says Richard Becker, MD, who leads the program.

“If you have good physicians, you want to keep them,” he says. “Having two doctors share shifts gives you flexibility. If one sticks to his last day on vacation, the other can come in and take care of it. You never have to worry about that position.”

While most programs have a few part-time physicians, it’s rare to see a program fully staffed by part-timers or job-sharers, Nahm says.

“Generally, they’re transition steps toward a program staffed by full-time hospitalists,” he says.

It can take more than a year to staff a program, especially for medical centers that aren’t in a city with a medical school. Now that more hospitals want to start hospitalist programs—and quickly—it helps to bring in part-timers to support an incomplete team, says Betty Abbott, chief operating officer of Eagle Hospital Physicians in Atlanta. A hospitalist consultancy that serves the southeast and Atlantic states.

“It used to be you had three to nine months to start a program, and now many people are saying, ‘We’d like to have it next Monday,’” Abbott says.

Some smaller or rural hospitals run part-time-only hospitalist programs because it’s the only option that makes economic sense, or because they have trouble recruiting full-time hospitalists. In these cases, part-timers can give a much-needed boost.

“The doctors typically in the community don’t want to work on weekends,” says Alan Himmelstein, FACMPE, president of Hospital Care Consultants Inc. (HCC) in San Antonio, Texas. “So if you’re a part of your staff, they come in on a Thursday that has previously been a washout, they will opt to either transfer to a bigger city, or treat the patient in an outpatient setting which is not optimal. With the hospitalist there, the hospital can take that patient.”

**Competition, Commitment**

Two of the major concerns about part-time and job-sharing hospitalists are that they won’t be as committed to the program as other hospitalists, or that they’ll attract patients to their own private practice away from referring physicians.

“This is a big factor,” Nahm says. “You should have a policy that a part-timer who group meetings, Nahm says.

“One of the benefits of the hospitalist is that they know the ins and outs, the ups and downs of the hospital,” Dr. Simone says. “If I’m not going to the medical staff meetings and to my committee meetings, I’m not going to have adequate information—and that may make me less effective as a hospitalist.”

**Continuity of Care**

Job-sharing works well for Hudson Valley Hospital Center, but allowing physicians to come in for just a few shifts a month doesn’t sound as appealing, Dr. Becker says.

“If a hospital uses part-timers only sporadically, ‘that opens the chances for errors and for patient dissatisfaction,’” he says.

To counter this, a hospital might hire only part-timers who can work consecutive shifts. Or it might use doctors who are available sporadically to support the program other ways.

“Dr. A is willing to provide 12 shifts per month but only wants to work two or three days a week,” Dr. Simone says. “You probably want to utilize him or her as an admitting doctor or a float, not a rounder, since patient continuity may be negatively affected.”

“Dr. B is willing to provide 12 shifts per month and doesn’t mind working several days in a row; for example, six or 10 or 12 consecutive days. That schedule offers wonderful continuity, and this provider can be utilized as arounder, following patients from admission until discharge. Even physicians who fill in only when volume is high—perhaps in four- or six-hour shifts in the evenings or on week ends—can benefit some hospitals, Abbott says; that support might make it easier to recruit full-timers.”

Johns Hopkins Medicine in Baltimore supplements its nine full-time hospitalists with part-timers.

“The nature of our job is such that it’s fairly easy to coordinate that,” says Daniel J. Bromman, MD, FACP, director of the hospitalist program there. “It creates sort of auxiliary staffing.”

**Other Issues**

There are other factors to consider before bringing in full-time hospitalists or job-shares, such as billing.

“They’re working as a hospitalist for a week, and one of their private patients comes in to be admitted.” Nahm says. “Are they seeing that patient as a hospitalist or are they seeing that patient outside of the program, as their own patient?”

The same issue can come up with a pulmonary or infectious disease specialist, for example. If she consults on other patients during her shift, is she doing so as a hospitalist or in her private practice?

“I find it best if you just take the philosophy that you’re buying this physician’s time, and anything this physician does on the clock for you is considered a service of the hospitalist group—and all billing and collection and revenue, in other words, go back to the hospitalist group,” Nahm says.

Also, a part-time hospitalist may face competing demands for his or her time.

“Sometimes they come in and they’re lacking focus because they’re tired—they’ve been up all night moon-lighting in the ED,” Dr. Simone says. “Or they pace themselves because they know tomorrow and for the next four days, you’re on call for their private practice.”

Despite the practical issues parttimers bring, Dr. Simone points out, they tend to increase a program’s flexibility and efficiency, allow the hospital to offer more value, lower burnout, and increase job satisfaction.

Dr. Gupte wants more programs to start hiring part-time hospitalists—especially to help families like hers, where both parents are busy physicians.

“We may have to make a big difference in family care,” she says. “People sometimes think that we won’t be as intense or as focused when you’re doing the part-time thing, I don’t think that’s true.”

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HYPHENATE

hospitalists

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The pros and cons of subspecialization in hospital medicine

By Gretchen Henkel

chairman, department of medicine, chief of the medical service at the University of California San Francisco (UCSF), and author of the upcoming blog “Wachter’s World.” “They’re always done medical consultations and helped to take care of sick patients with surgical, gynecological, and psychiatric issues.” But now, he says, “The demand for hospitalist services is almost limitless.”

At UCSF, he reports, hospitalists now manage the medical problems of patients on the complex heart failure service, the bone marrow transplant service, and the neuropsychiatric and orthopedic services. Dr. Wachter views the trend of using hospitalists in a variety of subspecialty services as “one of the most exciting developments for the field”—it is taking the field to a whole new level of importance and growth.” That’s because it signals recognition that the concept of hospital medicine has value “for virtually every patient sick enough to be in the building,” he says.

Ambiguity of Terms

Not only are hospitalists increasingly present in subspecialty services, but some specialists services are reorganizing according to the hospitalist model. This may create complexities regarding hospital medicine’s core identity, according to Dr. Wachter.

For instance, at UCSF, there are generalist surgeons who have organized a hospitalist service, providing on-call responsibility, triage for specialized surgical problems, and a breadth of care and coordination typical of the hospital medicine model. Separately, there are also internal medicine hospitalists who serve on the surgery service. “I think there is going to be some ambiguity about roles until we clean up the language,” remarks Dr. Wachter.

For instance, “Is the hospitalist on the surgery service still a generalist who takes on the role of subspecialist by caring for a more specialized population? And, what do you call the specialist surgeon who takes on a more hospitalist role?”

Shaun Frost, MD, FACP, chair of SHM’s Membership Committee and regional medical director for Cogent Healthcare in St. Paul, Minn., considers whether the inclusion of various subspecialists fits with the SHM’s definition of hospitalists. “If you’re looking strictly at definition,” SHM considers a hospitalist to be a physician whose primary professional focus is the general medical care of hospitalized patients,” he says. “As hospitalist subspecialists are likely engaging in the management of hypertension, diabetes, chronic lung and cardiac disease, etc., I see no reason to believe that they would not fit the definition of a hospitalist.”

Best Use of Skills?

Although Drs. Wachter and Frost see inclusion of hospitalists on subspecialty services as a positive trend, others warn that hospitalists should be wary about the reasons for their enlistment.

Lauren M. Friedly, MD, a hospitalist at Marin General Hospital in Greenbrae, Calif., believes subspecialty hospitalist jobs are “ultimately untenable for solid, well-trained, dedicated hospitalists.” She developed this view after a frustrating two years on a liver transplant service—where she found she “wasn’t able to practice medicine in a way that was comfortable.”

Dr. Friedly explains that she chose to be a hospitalist because of her experience as a medical student at UCSF and as a resident at California Pacific Medical Center—watching and learning from the originators of the movement, such as Dr. Wachter and Masa Yukimoto, MD, former chief resident.

All the reasons she chose hospital medicine—the pace, acuity of patients, ability to revisit patients and ruminate about their problems, and the opportunity to improve the quality of a patient’s in-hospital care by adhering to a “first do no harm” philosophy—were stymied when she became a hepatologist.

“The problems that can potentially exist in any subspecialty hospitalist group are magnified a hundredfold in a liver transplant service,” she explains. “There were philosophical differences in our approach to medical care of inpatients, and the hospitalists were, in some ways, considered the bottom of the food chain.”

“Because of our position relative to the hepatologists and transplant surgeons, we were not provided the autonomy nor the resources with which to accomplish any of these things. For example, decreasing length of stay by discharging patients efficiently, which to a well-trained hospitalist may mean less risk of exposure to nosocomial infections and iatrogenic complications, was not necessarily valued by the transplant surgeons and hepatologists. Less is often more for a well-trained hospitalist, but this sentiment is in direct conflict with the maximalist approach used in transplant medicine.”

Satisfying in the Long Run?

Perhaps the most important question about subspecialization for the hospitalist is whether joining a subspecialist service is a good fit. Dr. Frost believes it’s important to consider whether a career in a subspecialty service would be satisfying in the long run. “For many of us,” he explains, “one main reason we chose to pursue careers in general internal medicine, general pediatrics, or family practice is that we enjoy variety. Personally, for example, I know that I would quickly become bored with solely focusing on one organ system or one special patient population. Therefore, I believe that there is probably a limited group of folks who would enjoy exclusively restricting the scope of their hospital medicine practice to a specific subspecialty area.”

Still, Dr. Friedly admits she will miss the challenges of dealing with complex pathology. On the liver transplant service, for instance, she cared for patients with complex gastrointestinal issues, including cancers. But, due to her time on that specialized service, she now finds herself having to refresh her more general internal medicine skills.

The Pediatrics Picture

The hospitalist model is increasingly common in pediatrics, where costs per patient and length of stay have been lowered when using the hospital medicine model to restructure academic pediatric inpatient services, and hospitalists have contributed to improved survival in pediatric intensive care units.

In part because of lower patient volumes on pediatric hospitalist services, the trend toward subspecialization is not as evident in pediatric hospital medicine as it is in adult hospital medicine, according to Sanford M. Melzer, MD, senior vice president of strategic planning and business development at Seattle Children’s Hospital and Regional Medical Center, and a member of the American Academy of Pediatrics’ Committee for Hospital Care. “Pediatrics overall is more general in nature,” he explains, “except for subspecialty services.”

Although the subspecialization rate is rising in key specialty areas, that may be changing.

Dr. Melzer, who has been a clinical pediatric hospitalist for 20 years and has published research on the financial aspects of pediatric hospitalist programs, reports that his service is beginning to field requests for hospitalists from specialty programs to provide

Continued on page 48

continued from page 1
Pediatric hospitalists, as generalists, typically provide care for many different types of illnesses and conditions. "This is one of the attractive features of the job for pediatricians choosing this career track," Dr. Melzer says. "An increasing degree of specialization may make these positions somewhat less interesting, and may highlight discrepancies between hospitalist and specialist salaries." On the other hand, he says, "Continued shortages in specialty areas in pediatrics will continue to drive the trends toward increased deployment of generalists in the subspecialty." One model employed in children’s hospitals is to utilize more physician extenders, such as nurse practitioners and physician assistants, to provide the needed coverage. How pediatric hospitalists will fit into this evolving care model is not clear, notes Dr. Melzer.

The other area in which pediatric hospitalists may provide "specialty" care in is neonatology, where shortages of specialists or costs of coverage result in hospitalists covering the delivery room or the neonatal intensive care unit (NICU). Pediatricians staffing—just as adult hospital medicine programs have noticed. For example, the oncology service at Seattle Children’s Hospital has started to explore using pediatric hospitalists to help manage its pediatric cancer unit, which treats 225 new diagnoses of childhood cancer annually. In part because oncology treatment at Seattle Children’s tends to be "heavily protocolized," Dr. Melzer believes pediatric hospitalists can provide quality patient care as inpatient generalists, in terms of palliative care and symptom management, if included on that service.

Future Configurations

To avoid the possible pitfalls hospitalists can encounter with subspecialist services will require innovative solutions, Dr. Friedly believes. "Ultimately, I think the only way that it will be sustainable [as a long-term career choice] for any individual hospitalist to take a position within a subspecialty program will be to help create or to be part of the initial vision," Dr. Friedly says. "Or, an already-established hospitalist group could approach the subspecialist and ask, 'How can we help you deliver the highest quality standard of care to your patients while they’re here in the hospital?’" As of July 1, the UCSF neurosurgery service has embraced the addition of core internal medicine hospitalists who help to manage the medical problems of the [typical census of] 60 neurosurgery patients. So far, Dr. Wachter reports, the hospitalists are enjoying their stint on the neurosurgery service. "They’re learning a lot because these patients have very unusual and specialized problems," he says. "It only took three minutes for them to realize that they were making a difference because some of the patients are very sick and have many medical problems. The surgeons don’t focus on or keep up with medical management, and even if they did, they are in the OR all day long."

Rotating hospitalists to specialty and subspecialty services for 25% of their time in the hospital, as the UCSF Neurosurgery hospitalists do, might be one way to preserve the traditional general medical model to which many internal medicine hospitalists still gravitate. "This could be an interesting, specialized niche practice, but would not be the bulk of what they do," says Dr. Wachter.

Dr. Frost agrees that the key to addressing the challenge of subspecialization lies in building this type of work into the context of a larger hospital medicine program. "Rotating all members of a hospital medicine group through a subspecialty experience for a portion of their overall time may be the way to go," he notes. Dr. Friedly cautions that certain subspecialist services, such as liver transplant, may not embrace the multidisciplinary hospital medicine model, so it remains to be seen if the effort can evolve to be truly collaborative. Her advice to younger residents just entering hospital medicine? “Hospitalist medicine has unlimited possibilities as a career choice, especially if you enjoyed being an internal medicine resident. Be careful, however, to avoid a setting where you risk losing your hard-earned skills while also being treated like a ‘perma-resident.’ Starting out in a more traditional hospitalist program to learn solid hospitalist ‘tricks of the trade,’ then transitioning to a subspecialty program where you can offer your skills, rather than the other way around, may be the more sustainable, long-term option.”

Gretchen Henkel is a frequent contributor to The Hospitalist.

References

I "If there is one thing most everyone in healthcare can agree on, it is that too often the information we need is not readily available." 

Primary care physicians (PCP) complain that when recently hospitalized patients show up in their office—or, heaven forbid, call the first day after their hospital discharge—they don’t have their discharge information. We often hear that when hospitalists are called to admit an acutely ill patient information is sketchy or incomplete. We hear most hospitalized patients present not only as diagnostic Web database with the patient as the focal point. When a patient has a test, sees a physician, visits an ED, or is hospitalized, that information would flow into an updated record accessible by the patient or physician virtually anywhere, any time.

For hospitalists, this could be a source of complete, up-to-date medical information. This tool doesn’t require that every physician have an electronic medical record (EMR) and isn’t limited by interoperability issues.

Other strategies are gaining traction. At a recent conference on care coordination sponsored by the American Board of Internal Medicine Foundation (ABIM) in Montreal, Quebec, Canada, Chuck Kilo, MD, MPH, CEO of GreenField Health and The GreenField Group in Portland, Ore., showed how e-mail smooths transitions and improves information flow.

Those in Dr. Kilo’s practice recognize that, while some professionals may have reservations about e-mails between patients and physicians, there seems less resistance to physicians and hospitals using e-mail to exchange information. With minimal expense and startup costs, PCPs can e-mail patients’ medical records, recent charts, and test results to a specialist for referral or a hospitalist for admission.

When the consultant or hospitalist is ready to provide information in the transition back to the PCP e-mail is a quick solution. It’s not perfect, but it’s immediate. Certainly there are barriers to overcome. HIPAA issues are always important to resolve, and documents converted to PDFs don’t flow into an EMR. But this is a step forward.

These solutions get information to the point of decision when the patient is there and the acute need must be met. For those in the trenches this is good news—a great improvement on the hunt-and-peck paradigm.

In a broader strategic approach, SHM has advocated giving hospitals a role in defining the standards and measures to be used in assessing performance in transitions of care. In July, SHM worked with the ABIM, the American College of Physicians, the Society of General Internal Medicine, the American Geriatrics Society, and the Agency for Healthcare Research and Quality to develop consensus on transitions-of-care standards. This group included most of the big players in the house of internal medicine as well as representatives from nursing, pharmacy, case management, home health, patients, and families. The American College of Emergency Physicians (ACEP) joined the discourse in August.

At the same time, SHM has been working with the American Medical Association’s Physician Consortium and the National Quality Forum to use standards conceived in consensus to develop measures for transitions of care. The measures would mark either stand-alone performance or performance with specific disease states (e.g., management of diabetes or acute heart failure).

Hospitalists will need resources and tools to give patients the best care and smoothest transitions (and score well on these measures). SHM has developed a Web-based quality-improvement resource room on transitions and continues to work with a broad coalition to improve the discharge process under our Hartford grant.

We add real value for our patients. But our job doesn’t end at the hospital door. Hospitalists recognize their obligation to patients as well those who will assume their care outside the hospital. Whether working on tools with Intel or RevolutionHealth or working with professional societies and organizations charged with developing performance standards and measures, hospitalists and SHM must take an active leadership role.

This is not easy stuff and can’t be solved in one meeting—or even one year. A few years ago no one was talking much about patient safety, notes past SHM President Bob Wachter, MD, professor of medicine at the University of California, San Francisco, associate chairman of UCSF’s Department of Medicine, and chief of the Medical Service at UCSF Medical Center. That is, until the Institute of Medicine’s 2000 report “To Err Is Human: Building a Safer Health System” and some disastrous medical errors.

Transitions aren’t happening well, and care is sporadic and isolated. This is high on our agenda; SHM and hospitalists are willing to work with any group that will help all of us get closer to a solution. TM

Dr. Wellikson is the CEO of SHM.
End-of-Life Predictions
Why we have a lot to learn from Oscar the cat

The July 26 New England Journal of Medicine contained several articles of interest for hospitalists: A trial of steroids for bronchiditis, mortality associated with type B aortic dissections, cardiovascular outcomes in patients using rofecoxib, implications of our social network on obesity, and a terrific review of methicillin-resistant Staph aureus in soft-tissue infections.

But all these were trumped in the media by Oscar the cat.

National Public Radio, CNN, Fox, and the BBC all covered the story about the cantankerous cat that could predict death in a community nursing home’s third-floor dementia unit with Grim Reaper-like proficiency. The 2-year-old cat was adopted and raised from kittenhood by staff members at the Steere House Nursing and Rehabilitation Center in Providence, R.I.

Nursing staff began noticing that Oscar would curl up in bed next to patients who had only hours to live. Oscar was so adept at predicting death that the nursing staff began using his prophesies to alert family members of an impending demise. Oscar observed daily, waiting for closed doors to open when necessary and employing somewhat less-sophisticated methods than his human colleagues—namely observing and sniffing. However, this “cat scan” appears to serve as an unprecedented augur, accurately predicting the death of 25 nursing home residents.

Why all the fuss about this predictive puss in boots? To be sure it’s an intriguing story. But why does the public care so much that Oscar the cat can now be found in Wikipedia—and why should the average hospitalist care about a prognosticating cat?

The answer lies in the medical profession’s dreadful lack of ability to predict patients’ survival at the end of life. Multiple studies have shown physicians are terrible at predicting survival, most often in an overly optimistic manner. A paper in the British Medical Journal examined the ability of 343 doctors to estimate the survival of 468 patients at the time of referral to hospice. Only 20% of physicians were able to accurately prognosticate the time of death within 33% of the actual survival. While median survival was 24 days, doctors, on average, predicted patients would live 5.3 times longer than they did. Interestingly, the longer the doctor knew the patient the more likely they were to predict wrongly.

Most seriously ill patients value prognostic information more than they do information about therapeutic options. It is a central determinant in how patients and families make end-of-life decisions. The fact that we seem to systematically provide overly optimistic predictions has several important downstream effects.

Unduly optimistic predictions likely delay referral to palliative care providers and hospice. Doctors generally believe patients should receive hospice care for several months before death. However, patients typically receive this care for less than a month and in many cases only a few hours. Our inability to realistically predict survival most likely plays into this discrepancy and negatively affects our patients’ quality of life.

Second, we consistently overestimated predictions likely translate to patients making inappropriate or counterproductive end-of-life decisions. We’ve all experienced the patient who continues to push for obviously futile care despite our attempts to nudge them toward a palliative approach. Yet it’s easy to see why patients who believe they have six months to live would push for more aggressive treatments. If they knew they had six weeks to live, they might choose more palliative options.

Finally, hospitalists are increasingly under the gun to decrease length of stay (LOS) and contain costs. It is estimated that more than 25% of Medicare costs (approximately $88 billion a year) are associated with care in the last year of life, much of it in the hospital. While several studies have shown that early palliative care intervention reduces LOS and cost of care, overly optimistic predictions might make it less likely these timely referrals will be made.

The development of the hospitalist model, with its fractured approach to care, might provide an opportunity to improve end-of-life prognostication. Having a strong, long-lasting relationship with a patient appears to be an important predictor of inaccurate prognosis. It isn’t hard to imagine that a provider with a long relationship with a patient might have a more difficult time acknowledging a patient’s poor outcome or unwittingly be less likely to squelch a patient’s hope with a poor prognosis.

We can take advantage of the inherent discontinuities of the hospitalist model as well as the severity and immediacy of the patient’s acute illness to not only proffer an end-of-life prediction but contextualize it for the patient. This, of course, needs to be done in a sensitive manner that recognizes our brief role in their care and, as such, is most often best managed in concert with the patient’s primary care provider.

The promise of the hospital medicine movement is that we can do it better and cheaper. This is a tall order indeed. While the hospitalist model has improved efficiency and quality, future improvements will require us to adopt and develop new efficiencies and better systems of care.

It is in this vein that I believe we can and should be able to improve end-of-life care. An early salvo in this front can be a dedicated and systematic push to improve end-of-life prognostication and its myriad downstream effects. This will require a conscientious effort, more formal education, and better predictive tools. As hospitalists, we are perfectly positioned to lead these efforts. The other alternative may be to adopt more cats into our multidisciplinary team. TM

Dr. Glasheen is associate professor of medicine at the University of Colorado at Denver and Health Sciences Center, where he serves as director of the Hospital Medicine Program. An expert in Clinical Services in the Department of Medicine and the Hospitalist Training Program, and an associate program director of the Internal Medicine Residency Program.

References

Contribute to The Hospitalist

Have a legal problem, a pharmaceutical question, or a billing conundrum? We’d like to hear about it and have an opportunity to address it in our departments and columns: “Legal Eagle.” “The Hospital Pharmacy,” and “Billing & Coding.” Send your questions and story ideas to Geoff Giordano, editor, ggiordan@wiley.com, (201) 748-8339, or to Physician Editor Jeff Glasheen, MD, jeffrey.glasheen@uchsc.edu.
By John Nelson, MD, FACP

OCTOBER 2007   85
PRACTICE MANAGEMENT

How to negotiate for more financial support

Most hospital executives care about performance on quality measures and will pay to improve it.

Negotiating support from the hospital where you practice is one of the most critical skills you can learn. I am often asked, “How can our group prove our value to the hospital so we can get the support we need?” The best approach is the same whether you are a practice employed by the hospital or a separate legal entity that contracts with the hospital.

There are many valuable sources of guidance regarding the best way to negotiate any important agreement, including a book I recommend, Getting to Yes. I suggest you read such a book if you want to be a better negotiator. But here I want to highlight some features of negotiations between a hospital and hospitalist practice and a hospital that such sources won’t specifically address.

Clearly this is complicated, and different situations call for different strategies. These are generalizations worth thinking about in any situation.

Know what is important to the hospital. I often hear hospitalists say, “We want to attend to the things that are important to the hospital, but we don’t know what those things are.” If that is really the case, the communication between the hospital and hospitalists must be awfully poor—and there is an opportunity for the hospitalists to improve it. It is worth the time and energy required to know what is on the mind of the hospital’s leadership. It may be as simple as having a person-to-person conversation with one or more hospital leaders about what they see as the institution’s most important goals—and how your practice could help achieve them. You need to be sure and understand the particulars at your hospital, but the topics below are on the mind of most executives.

Propose using additional funding to ensure adequate staffing, not raises for existing doctors. In the current environment of difficult recruiting, hospital executives are usually far more inclined to pay for increased staffing than worry about whether you need a raise just because you deserve it. So it is usually much more effective to tell the hospital, “Our practice needs more money so we can add doctors and more fully meet the demand for our services.” Much less effective is saying, “We (existing hospitalists) are working hard and don’t get more money we’re going to quit.”

While the latter may be true, a hospital executive is much more likely to respond positively to paying for increased manpower so the existing doctors won’t have to continue working at unreasonably high workloads, rather than to providing money to support a raise for doctors already working unreasonably hard.

Propose additional resources to support quality improvement, and consider sharing some financial risk. Most hospital executives care about their hospital’s performance on quality measures and are willing to provide money to improve it. You might win more financial support if it is contingent on your group improving performance on quality measures.

You could propose that the hospital make additional money available to encourage and reward improved performance. You could even put existing financial support at risk and ask the hospital to match it. In other words, you could say you will contribute $5,000 or $10,000 of the money currently provided annually by the hospital per full-time equivalent hospitalist into a pool matched dollar for dollar (or some other ratio) by the hospital. Your group would get less total financial support (i.e., lose the funds put at risk) if quality doesn’t improve, but get more support if performance improved by an agreed-upon amount. A willingness to share financial risk demonstrates your commitment to success and can be compelling to the hospital.

Know your data. Hard data are far more effective than anecdotes when trying to convince the hospital of your practice’s value. Trumpet your successes, but remember that same executive will probably hear from 10 others in the same week that spending huge sums of money on their product or service will dramatically improve the hospital’s bottom line. If you’re trying to convince the hospital that every dollar spent to support your practice will provide an attractive return on investment, you need hard data to prove it.

It would be best if you could independently collect this data. But in most cases, you will have to rely on data the hospital has collected. It’s worthwhile to insist on routine reports (e.g., monthly, or no less than quarterly) from the hospital summarizing your group’s performance on quality and financial metrics (CMS core measures, patient satisfaction, cost per case). This data will be critical to you when you negotiate financial support from the hospital.

You should also have data about other hospitalist practices, such as results from the 2005-06 “SHM Survey of Hospitalist Productivity and Compensation” and other sources I discussed in a recent column (July 2007, p. 73). And if you’re able to get reliable data about other practices in your local marketplace (i.e., something more significant than just what you heard through the grapevine), be sure to share that information as well.

Agree to conditions carefully. Don’t agree to do things you would be unhappy doing just because it might help get more financial support from the hospital. Executives know it is bad business to pay people more money to get them to keep doing something they don’t want to do. Such an agreement usually leads to the hospitalists asking for more money each year to continue providing the service—and the quality of the service is often sub par if it’s something the hospitalists really don’t want to do (even if paid well to do it).

Stay focused on hospital performance—even in areas not specifically governed by your contractual relationship. Many or most hospitals that employ hospitalists assume all the financial risk for the practice. That is, the hospital agrees to make up the difference between collected professional fee revenue and the cost of operating the practice.

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Dr. Hospitalist responds: Boutique or specialty hospitals have been hotly debated among healthcare policymakers over the past few years. Compared with the number of general hospitals, the numbers of specialty hospitals—typically those that focus on cardiac, orthopedic, surgical, and women’s procedures—are small. A Government Accounting Office (GAO) report in 2003 identified 100 such hospitals in the country. More than two-thirds of the hospitals are in seven states (Arizona, California, Kansas, Oklahoma, Louisiana, South Dakota, and Texas).

The GAO found that compared with general hospitals, specialty hospitals are “much less likely to have emergency departments, treated smaller percentages of Medicaid patients and derived a smaller share of their revenues from inpatient services.” Although small, this is a growing segment of the healthcare industry. Specialty hospitals are controversial because many are for-profit and often owned by some of the physicians who work at the hospital. Specialty hospital supporters believe competition between specialty and general hospitals for services can lower costs and improve care.

A 2005 Medicare Payment Advisory Commission study found that physician-owned specialty hospitals decreased lengths of stay but didn’t lower costs for Medicare patients.

In general, specialty hospitals treated less-severe cases and tended to have lower numbers of Medicaid patients than community hospitals.

Specialty care hospital critics are concerned that specialty hospitals take care of the most profitable patients (those who are less ill) and leave the general hospital with the sicker patients who incur higher costs.

They fear growing numbers of specialty hospitals will make it financially difficult for general hospitals to meet all of a community’s needs, including charity care and emergency services.

Critics are also concerned that physician ownership of specialty hospitals could affect physicians’ clinical behavior by driving inappropriate referrals.

You may remember that the federal Stark law (named after Rep. Peter Stark, D-Calif.) generally prohibits physicians from referring Medicare patients for healthcare services to facilities where they have financial interests.

This law was enacted after several studies demonstrated that physicians with ownership interest in clinical laboratories, diagnostic imaging centers, and physical therapy providers made more referrals to these centers and ordered more services at higher costs.

The Stark law lets physicians who have an ownership interest in an entire hospital and are authorized to perform services there to refer patients to that hospital.

As you consider this opportunity, further investigate the risks, benefits, and potential effect of the specialty hospital on your community and our healthcare system.

Holiday Dilemma

Question: I just took over scheduling for our hospitalist group. I’ve been practicing nearly two years and am wondering how to staff holidays. I’m finding it difficult handling the multiple requests for Thanksgiving, Christmas, and New Year’s Eve. Do you know of any innovative scheduling techniques?

Dr. Hospitalist responds: Congratulations on your new responsibility! I write this with my tongue firmly planted in my cheek. As you now realize, completing the schedule is not easy.

Unfortunately, most hospitalists don’t recognize the enormous challenge one faces in filling the schedule until they are given the task. Unless you were a chief medical resident, you probably didn’t learn or practice scheduling in the course of your medical training. Inevitably, everyone wants and expects to get their choice of days off. Of course, that is rarely possible.

How do you make everyone happy? It is important to recognize that making everyone happy every time is not possible. But it is possible and important to be fair to everyone all the time. There are some steps you can take to ensure the scheduling process is fair.

The first step is to set appropriate expectations. It is critical for the group leader and the staff member making the schedule to help each group member understand the enormous challenges that come with scheduling.

Providers who understand the difficulties of scheduling will be more understanding and accommodating in their requests.

The second step is to establish and clearly state the rules of engagement. For example, be explicit in explaining the rules for submitting requests and the deadline for requests. Avoid misconceptions by setting the final schedule to help each group member understand the enormous challenges that come with scheduling.

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Foreign Medical Graduates

Question: What’s your opinion on the effect of foreign medical graduates in the U.S.? Dr. Hospitalist responds: The U.S. healthcare system would be quite different without foreign (aka international) medical graduates (IMGs), who play important clinical, educational, administrative, and research roles.

Some physicians and patients believe medical education outside this country is inferior. In some cases, they are correct—in others, they could not be more wrong. Medical education outside this country varies in standards and curricula.

Many people are not aware that IMGs who wish to enter an Accreditation Council for Graduate Medical Education residency program in the United States must have Educational Commission for Foreign Medical Graduates (ECFMG) certification. ECFMG certification requires the applicant to pass a series of examinations, including United States Medical Licensing Examination (USMLE) Steps 1 and 2.

ECFMG certification is also required before an applicant can take Step 3 of the USMLE and is required before a physician can obtain an unrestricted license to practice medicine in the United States.

I suspect some IMGs face discrimination in this country because some may speak with an accent. But truth be told, the United States healthcare system could not exist without the contributions made by IMGs. 
CASE STUDIES OF FAULTY THINKING

Dr. Groopman’s book arose partly from his making rounds and co-attending with Dr. Feinbloom and David Krakow, MD, now a hospitalist at Emory University Hospital in Atlanta.

“With all the pressure and all the stress and night call,” says Dr. Groopman, “what impressed me was that they were constantly on guard against making snap judgments. They weren’t educated about cognitive science … but they forced themselves.”

Dr. Feinbloom and Krakow recalled examples of misdiagnoses or delays to diagnosis that they, their colleagues, or their trainees had made. They and Dr. Groopman deconstructed these real-life cases:

**Case 1:** Your community is experiencing a flu epidemic. Over the course of two weeks you’ve admitted eight patients from the ED with influenza pneumonia. An older woman presents with a low-grade fever and says she is breathing quickly. She tells you she took a few aspirin at home, and someone else in the house has been sick. You examine her and immediately anchor on influenza pneumonia.

“For two reasons, it seems to be the most likely diagnosis based on her symptoms,” says Dr. Groopman “and these [modes of thinking] work as cascades; they congregate, basically. Usually the errors are multiple. One leads to the next.”

The physician admits the elderly patient with a diagnosis of influenza pneumonia. “What he doesn’t do is think about all the information that has been presented to him,” says Dr. Groopman. “He anchors on the fact that she had fever and that she is breathing quickly. He ignores the fact that she said she took a few aspirin. He doesn’t ask, ‘What is a few?’”

Then he rationalizes the fact that her chest X-ray is clear and that there are some changes in her electrolytes.

It was eventually determined that rather than taking “a few aspirin,” this patient had taken a fistful over two days and had aspirin poisoning.

**Case 2:** A classic example of anchoring surrounds diagnosing chest pain. A patient with known coronary artery disease, ventricular tachycardia, and an implantable cardiac defibrillator, presents to the ED with three days of left-sided substernal chest pain.

“If you stop there, most doctors would say, ‘My biggest concern is that he has coronary ischemia,’” says Dr. Feinbloom.

The patient is admitted to rule out myocardial infarction, and the overnight doctor schedules him for a stress test in the morning. When the patient is interviewed again, it becomes apparent his pain is non-anginal and pleuritic.

While no one would fault a physician for obtaining a stress test in a patient with coronary disease and left-sided chest pain, this test would only confirm the established diagnosis of coronary disease, which is unrelated to his chest pain syndrome. As it turns out, this patient had an acute pulmonary embolism.

**Case 3:** Attribution errors are possible when patient signs and symptoms conjure stereotypes and feelings in the physician that affect clinical thinking. For instance, if a medical student says disparagingly: “This is the third time this woman has been admitted with abdominal pain. She’s seen by a psychiatrist and has irritable bowel syndrome.”

It takes something amid all your busyness not to corner yourself into that route of thinking, says Dr. Groopman. “You have to be the doubling Thomas. You have to be the skeptic when you hear the words, ‘I’ve got a patient with a case of . . . ,’ you have to say, ‘OK, maybe, but what else could it be?’”

**Case 4:** An elderly man presents with anginal chest pain. He initially is evaluated by a resident, who schedules him for a pharmacologic stress test with nuclear imaging that is interpreted as normal.

“A trainee might think: ‘If the test is normal, then this is not angina,’” says Dr. Feinbloom.

Bayesian reasoning, a way to express uncertainty as a probability for each decision point, provides a language and logic for considering potential diagnoses. Its primary limitation is that physicians largely lack reliable data to characterize unique patients.

Even when those data are available, physicians are relatively unfamiliar with the complex process of interpreting their own sub-test interactions.

“Thinking based on probabilities is far afield from the real needs for making better diagnoses,” Dr. Groopman says. “The problem is that we don’t have databases to calculate these probabilities. But in appropriate circumstances, Bayes’ thinking can be helpful.”

This case exemplifies an instance of those circumstances. From the standpoint of pretest probability, an elderly male with classic angina has a high likelihood of having flow-limiting coronary disease. While a stress test is a reasonably accurate diagnostic study, in this instance, a “normal” result should not be reassuring.

This gentleman ultimately went for angiography and was found to have three-vessel coronary artery disease. This explained why he had “balanced” myocardial perfusion leading to a false negative test result.

“People often give more weight to tests than they do to clinical history,” says Dr. Feinbloom. “Given that no test is perfect, the physician should have a sense of how likely they think the diagnosis is before a test is ordered as the result depends not only on the properties of the test, but on the pretest probability as well.”