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Associate Professor

Updates in Hospital Medicine

Disclosures

- ◆ I have no financial disclosures.
- ◆ I am the Grand Rounds and Journal Club director for my division.
- ◆ My 9 year old son is a huge fan of Jurassic Park and challenged me to include some Jurassic Park in my talk.



Objectives

- ◇ This is NOT a comprehensive list nor a deep dive- just some updates about things you may or may not have heard about... that you may or may not consider incorporating into your practice.
- ◇ My goal is to point you at things that I think are most useful for hospital medicine since the literature is SO voluminous at this point, and our time to read is not increasing in proportion.
- ◇ Also to have a little fun 😊



Where I found these...

Journals I searched Jan-July

- ◇ Chest
- ◇ JHM
- ◇ JAMA Int Med
- ◇ Annals/ACP journal club
- ◇ BMJ
- ◇ NEJM
- ◇ Clinical Infectious Diseases
- ◇ Journal of American College of Cardiology



- ◇ Multicenter (single system) cohort
- ◇ Primary outpoint- 90d mortality vs steroid cumulative dose.
- ◇ N=375 nonHIV immunocompromised adults w/ proven or probable PJP on supplemental oxygen.

Results:

-Steroid exposure was consistently associated with increased 90d mortality.

-Each additional 100mg = 2% higher hazard for death HR 1.02 (95%CI 1-1.02, p=0.006)

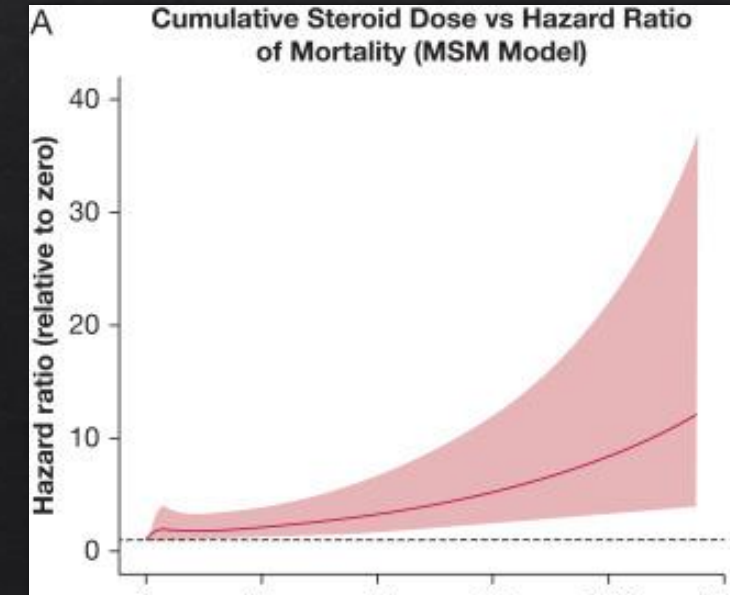
-analyzed pts alive and event free at 7d to rule out early death as a sole driver, effect persisted.

HR 1.03 (95% CI, 1.00-1.07 p=.049)

Take home: We might need to abandon the longstanding one-size-fits all steroid plan for PJP and consider HIV-related cases to be different. Need more study. Stay tuned but perhaps be cautious.

Adjunctive Corticosteroid Use and Clinical Outcomes in Non-HIV *Pneumocystis jirovecii* Pneumonia

Aaron M. Pulsipher MD^a, Holenarasipur R. Vikram MD^b, Michael B. Gotway MD^c, Rodrigo Cartin-Ceba MD^a, Emily R. Thompson MS^d, Andrew H. Limper MD^e, Ayan Sen MD^a, Augustine Lee MD^f, Kealy Ham MD^a



Retrospective cohort single “center” Atrium health Charlotte, HaH vs BaM. EHR review

N=297 eligible for HaH, 178 HaH 119 remained BaM

HaH higher

- Supplemental oxygen [RR]: 1.04, 95% [CI]: 1.01–1.09)
- bronchodilators (RR: 1.12, 95% CI: 1.04–1.20)
- mean 30-day acute care-free days alive (mean ratio [MR]: 1.04, 1.01–1.08).

Take home: HaH might be just as good as inpt care, at least in a system built to support it. We need larger studies

Outcome	Summary statistics ^a		Adjusted treatment effect of HaH versus BaM, estimate (95% CI)
	BaM inpatient care (n = 119)	HaH care (n = 178)	
Oxygen therapy	114 (95.8)	178 (100.0)	RR: 1.04 (1.01–1.09)
Bronchodilators therapy	104 (87.4)	174 (97.8)	RR: 1.12 (1.04–1.20)
Corticosteroids therapy	74 (62.2)	125 (70.2)	RR: 1.07 (0.90–1.26)
Antibiotics therapy	91 (76.5)	141 (79.2)	RR: 1.00 (0.88–1.14)
30-day hospital readmission	17 (14.3)	15 (8.4)	RR: 0.68 (0.35–1.34)
30-day ED readmission	13 (10.9)	16 (9.0)	RR: 1.03 (0.51–2.07)
7-day ED readmission	4 (3.4)	5 (2.8)	RR: 1.30 (0.33–5.01)
30-day mortality	4 (3.4)	2 (1.1)	RR: 0.27 (0.04–1.79)
Length of stay (days)	5.0 (5.0)	5.3 (2.2)	MR: 1.08 (0.91–1.27)
30-day acute care-free days alive	28.0 (5.4)	29.2 (3.2)	MR: 1.04 (1.01–1.08)

ORIGINAL ARTICLE

High-Flow or Standard Oxygen in Acute Hypoxemic Respiratory Failure

J.-P. Frat,^{1,2} J.-P. Quenot,³ C. Guitton,⁴ R. Coudroy,¹ A. Gacouin,⁵ J. Badie,⁶
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A. Ferré,²⁴ C. Daubin,²⁵ A. Bourreau,²⁶ A. Delbove,²⁷ G. Pradel,²⁸ A. Fatah,²⁹
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E. Turbil,⁴³ F. Reynaud,⁴⁴ L. Chamblet,^{45,46} S. Ragot,^{45,46} and A.W. Thille,¹
for the SOHO Trial Group and the REVA Network*

Randomized, open-label, 42 ICUs in France

Inclusion: $p\text{AO}_2:\text{FiO}_2 < 200$, $\text{RR} > 25$, infiltrate

N=1110 556 HFNC

Primary: d28 mortality

Secondary: need for intubation, Median time to intubation, Vent free at 28d, Death, LOS

No difference in mortality

HFNC appeared to reduce the incidence of intubation, and improved dyspnea, RR but had higher discontinuation rates due to discomfort.

Take home: consider HFNC, might be helpful.

Patients

- 1110 adults
- Median age, 62 to 63 years
- Male sex: 74% (high-flow group); 66% (standard group)

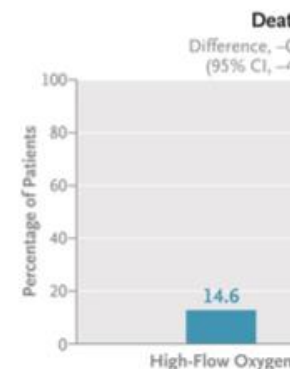


High-Flow Oxygen

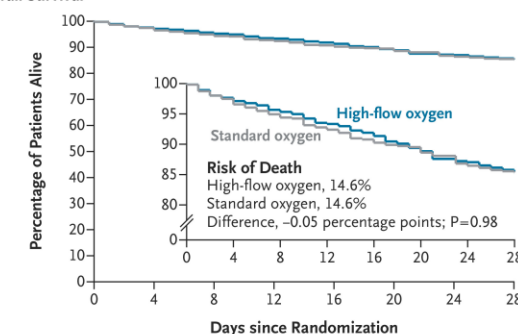


N=556

Standard Oxygen



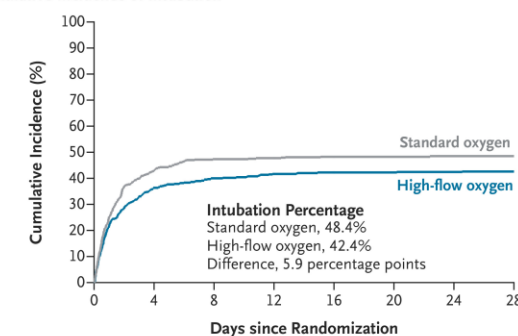
A Overall Survival



No. at Risk

High-flow oxygen	556	543	532	520	511	497	485	475
Standard oxygen	554	540	526	514	503	496	481	473

B Cumulative Incidence of Intubation



No. at Risk

High-flow oxygen	556	350	327	316	313	311	309	308
Standard oxygen	554	314	286	280	276	274	272	272

Exacerbation Risk by Chronic Proton Pump Inhibitor Use in Obstructive Lung Diseases

Valerie Dehondt PharmD ^a, Frauke Van Vaerenbergh PharmD ^a, Katia Verhamme MD, PhD ^{a,b}, Lies Lahousse PharmD, PhD ^{a,c}  

-Retrospective using Belgian claims data, long term Chronic obstructive airway diseases (COAD) meds and PPI use

N=932135 w COAD

-44.1% PPI users, Looked at defined daily doses (DDD)

Results:

-Increased risk of exacerbations AHR 1.18 (95%CI 1.17-1.19)

risk of exacerbations increased with cumulative DDDs

≤ 28 DDDs: HR, 1.09 [95% CI, 1.07-1.10];

≤ 180 DDDs: HR, 1.15 [95% CI, 1.14-1.16];

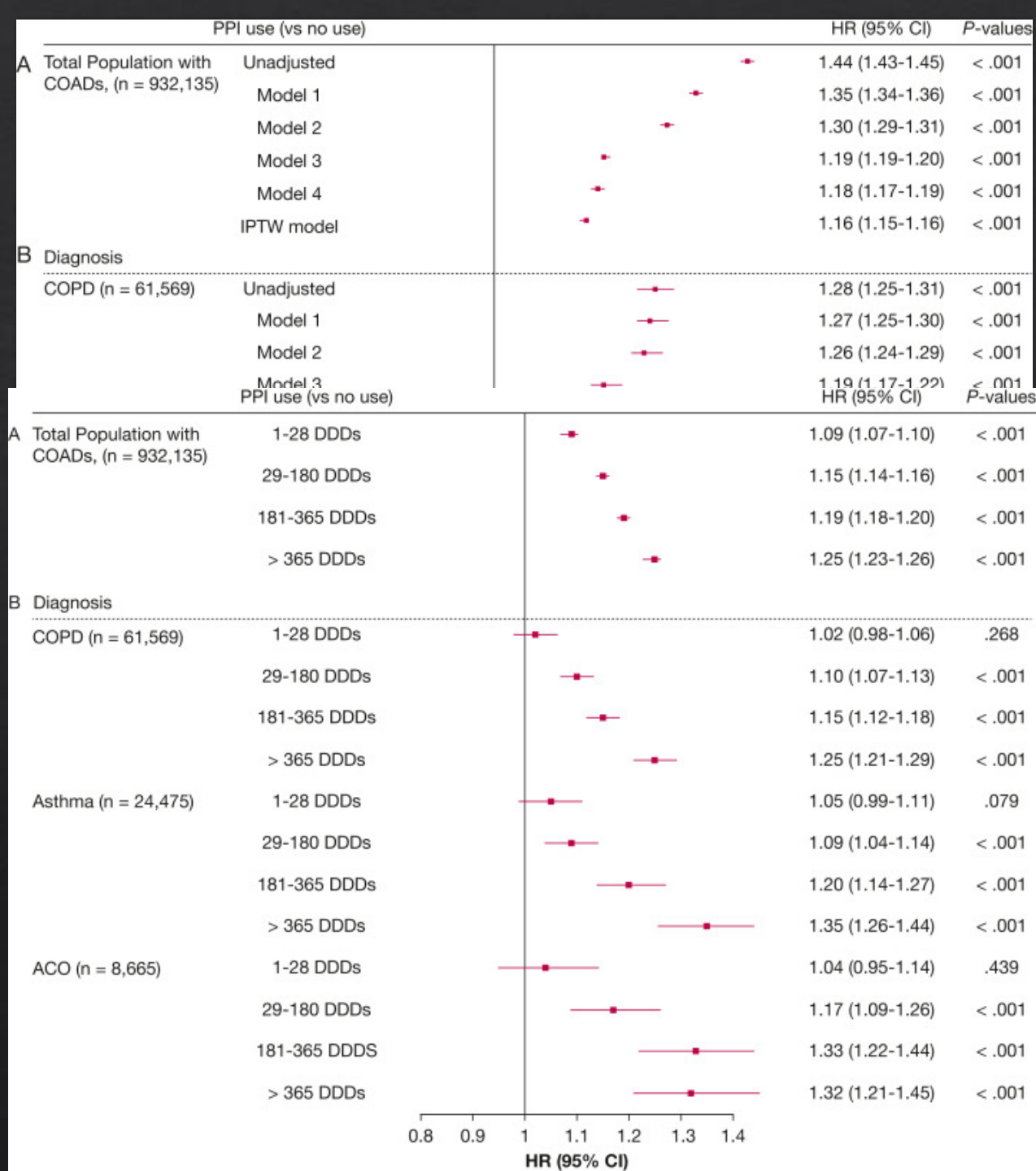
≤ 365 DDDs: HR, 1.19 [95% CI, 1.18-1.20];

> 365 DDDs: HR, 1.25 [95% CI, 1.23-1.26])

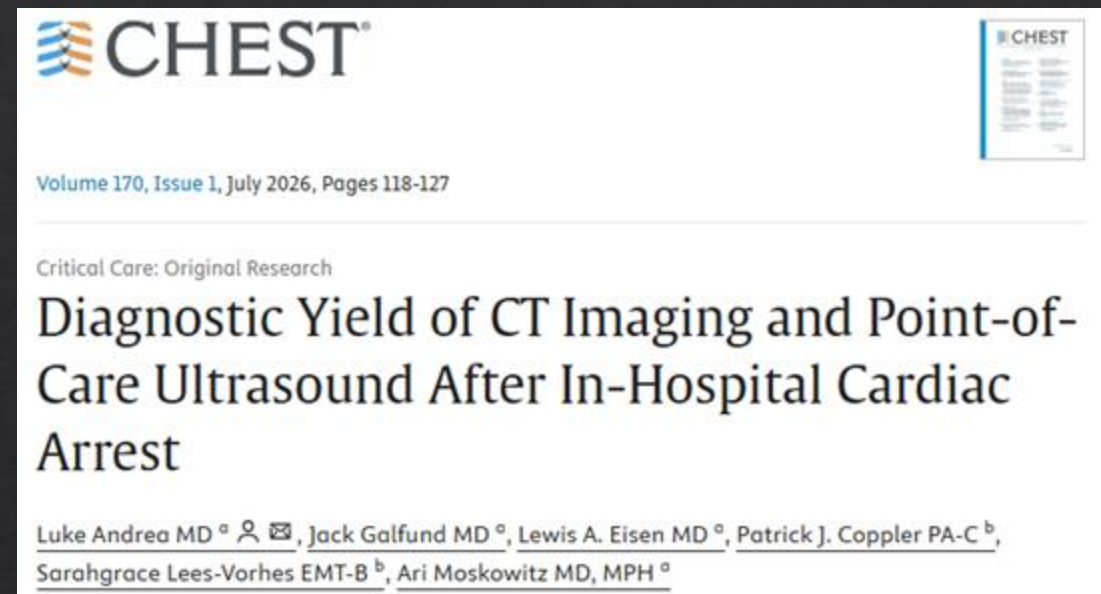
-not significant w short term use.

-more pronounced in young non-frail patients.

Take home- deprescribe PPIs IN COAD pts asap.



- ◇ Retrospective observational study
- ◇ 4 hospitals
- ◇ Adults with In Hospital Cardiac Arrest (IHCA) and ROSC, all with CT or US within 48h of event. Excluded those who died in first 24h
- ◇ N=345
- ◇ CT imaging overall
 - ◇ identified new findings 65.2%
 - ◇ Led to management changes 65.8%
 - ◇ Suspected cause in 20.5
 - ◇ One adverse event- IHCA during scan.
 - ◇ Chest CT most useful
 - ◇ identified new findings 92.2%
 - ◇ Led to management changes 64.1%
- ◇ Take home: consider imaging post-CA to identify cause. US vs. CT



- ◇ POCUS
 - ◇ identified new findings 57.6
 - ◇ Led to management changes 41.3%
 - ◇ Suspected cause 19.3%

Why you think it helps

Neurohormonal activation in
HF → sodium & fluid
retention

Guidelines & tradition
Widely recommended practice

Outpatient data →
symptom improvement

Why low salt may NOT help



No benefit in acute HF trials
No difference in weight,
congestion, or readmissions

No improvement in outcomes

May worsen patient experience

What you should do instead



Use regular diet
for most hospitalized patients

Avoid extreme restriction

Individualize in select patients

Address nutrition and
malnutrition

Variation in effectiveness of blood transfusion by hospital day: A multicenter retrospective study

Nicholas A. Bosch MD, MSc^{1,2} | Anica C. Law MD, MS¹ |
Nareg H. Roubinian MD^{3,4} | S. Reza Jafarzadeh DVM, MPVM, PhD⁵ |
Allan J. Walkey MD, MSc^{6,7}

TABLE 2 Primary analysis associations between packed red blood cell transfusion and hospital mortality or discharge to hospice by cohort.

Index day cohort	pRBC transfusion use percent difference (95% CI) from above to below 7.0 g/dL	Hospital mortality or discharge to hospice absolute percent difference (95% CI) from above to below 7.0 g/dL	Association between pRBC transfusion (vs. no transfusion) and hospital mortality or discharge to hospice—absolute percent difference (95% CI) ^a	p Value
1	24.6 (21.3, 27.9)	−0.7 (−1.4, −0.02)	−2.9 (−5.9, −0.04)	.047
2	36.0 (32.5, 39.5)	−0.3 (−1.0, 0.4)	−0.8 (−2.6, 1.1)	.43
3	42.2 (38.4, 46.0)	0.4 (−0.4, 1.2)	0.9 (−1.0, 2.8)	.34
4	43.5 (39.4, 47.5)	1.3 (0.5, 2.2)	3.1 (1.1, 5.0)	.002
5	45.5 (42.2, 48.7)	0.8 (−0.4, 2.0)	1.7 (−0.9, 4.3)	.20
6	46.4 (43.1, 49.8)	1.5 (0.2, 2.9)	3.3 (0.4, 6.1)	.03
7	46.7 (43.0, 50.5)	1.9 (0.4, 3.4)	4.1 (0.8, 7.3)	.01

Abbreviation: CI, confidence interval; pRBC: packed red blood cell.

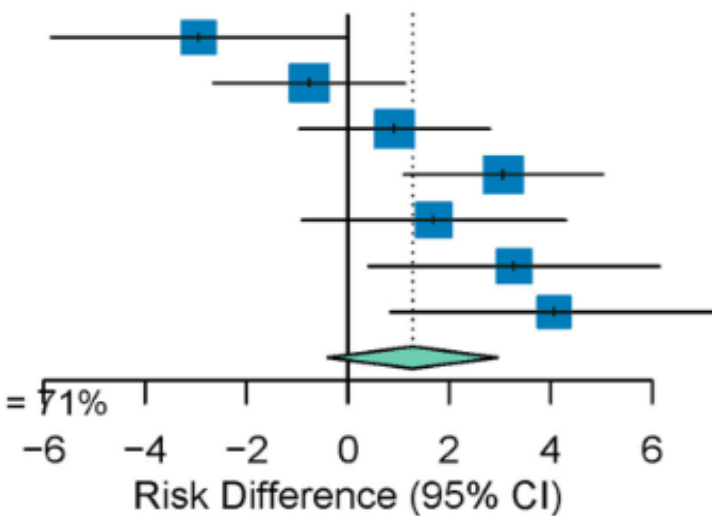
^aComplier average treatment effect: Effect of transfusion on hospital mortality or discharge to hospice among those who would be transfused for a hemoglobin concentration below 7.0 g/dL versus those who would not be transfused for a hemoglobin concentration above 7.0 g/dL.

- ❖ Multicenter retrospective cohort
- ❖ 1 hgb day 1-7, lowest hgb
- ❖ 2,293,021 index days
- ❖ Association between PRBC transfusion and hospital mortality or discharge to hospice differed based on days from admission.
 - ❖ Benefit Day 1 (RD: −2.9 [95% CI: −5.9, −0.04] %)
 - ❖ Harm
 - ❖ Days 6 (RD: 3.3 [95% CI: 0.4, 6.1] %)
 - ❖ Day 7, RD: 4.1 [95% CI: 0.8, 7.3] %, p-interaction < .0001)

Index Day RD (95% CI)

Day 1 cohort −2.95 [−5.85; −0.04]
Day 2 cohort −0.76 [−2.65; 1.13]
Day 3 cohort 0.92 [−0.96; 2.80]
Day 4 cohort 3.07 [1.10; 5.03]
Day 5 cohort 1.70 [−0.91; 4.30]
Day 6 cohort 3.28 [0.40; 6.15]
Day 7 cohort 4.07 [0.84; 7.31]
Total 1.27 [−0.40; 2.95]

Heterogeneity: $\chi^2_6 = 20.69$ ($P = .002$), $I^2 = 71\%$



Routine Serial Follow-up Blood Cultures After a Negative Result Within 48 Hours of Methicillin-susceptible *Staphylococcus aureus* Bacteremia: Low Yield, High Cost

Marianne M. C. Hendriks,^{1†,●} Eline H. H. M. Kamps,^{1,†,●} Cairo Norberhuis,² Mihai G. Netea,^{1,3} Matthijs S. Berends,^{4,5,●} Ianthe Maat,⁶ Sander van Assen,² Jaap ten Oever,^{1,4,●} and Ilse J. E. Kooijzer^{1,4,●}

- ◇ Follow-Up Blood Cultures (FUBC) are used often in management of Staph aureus bacteremia SAB
 - ◇ Skip phenomenon = intermittent negative cultures despite ongoing bacteremia 4-13%
 - ◇ Retrospective Cohort , 2 Hospitals in Netherlands.
 - ◇ Early Clearance (EC)
 - ◇ Persistent Bacteremia (PB)
 - ◇ SP
 - ◇ Primary outcome- SP
 - ◇ Secondary-
 - ◇ possible missed PB w 1 negative FUBC in 48h
 - ◇ Cost of unnecessary FUBC
- ◇ N=1005 3.1% SP, in 27/31 had clinical condition prompting repeat cultures.
 - ◇ 4 pts would have been misclassified as EC (1%)
 - ◇ Cost \$13,513 USD/100 pts
 - ◇ Authors recommend blood cultures 48h after initial negative.

Fosfomycin as Oral Transition Therapy Versus Continued Intravenous β -Lactams for Complicated Urinary Tract Infections Caused by Extended-Spectrum β -Lactamase–Producing *Enterobacterales*: A Multicenter, Open-Label, Randomized Controlled Trial

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[Jun-Won Seo](#), [Da Young Kim](#), [Youngmin Yoon](#), [Young Sang Lyu](#), [Yong Sub Na](#), [Do Sik Moon](#), [Na Ra Yun](#), [Min Seok Kim](#), [Jeong-Han Kim](#), [Sang Woon Bae](#) ... [Show more](#)

Clinical Infectious Diseases, ciag345, <https://doi.org/10.1093/cid/ciag345>

- ◇ Multicenter, open labe randomized noninferiority 4 Hospitals in Skorea
- ◇ Adults, ESBL *Enterobacterales* improved w 3-7d IV abx
 - ◇ Continue IV Carbapenem/B lactam
 - ◇ Fosfomycin 3g PO daily
- ◇ Primary outcome: clinical cure
- ◇ Secondary: Microbiological cure, readm, adv events, 30 recurrence

- ◇ N=299
- ◇ Clinical cure 92.8 fos, 95.2 IV abx. (risk difference, -2.47% ; 95% CI -7.84 to 2.89), confirming noninferiority.
- ◇ Microbiological cure, and all other secondary endpoints were similar.
- ◇ Take home: fosfomycin noninferior as oral transition therapy for complicated UTI even in ESBL.

Table 2 Outcomes among immune compromised patients randomized to 7 or 14 days of antibiotics.

Outcome	7 days (n = 530)	14 days (n = 507)	Risk difference, 95% CI
Mortality 90 days (ITT population)	106/528 (20.1)	120/507 (23.7)	-3.6 (-8.6-1.4)
Mortality 90 days – (mITT population)	104/526 (19.8)	117/504 (23.2)	-3.4 (-8.5-1.6)
Hospital mortality	54/529 (10.2)	62/507 (12.2)	-2.0 (-5.9-1.8)
ICU mortality	29/269 (10.8)	26/247 (10.5)	0.25 (-5.1-5.6)
Relapsed bacteraemia (%)	23 (4.3)	13 (2.6)	1.8 (-0.44-4.0)
Length of hospital stay (days) (median, IQR)	9 (6-18)	10 (6-20)	-1 (-2.7-0.7)
Antibiotic-free days (day 28) (median, IQR)	19 (9-21)	14 (10-14)	5.0 (4.1-5.9)
Colonization/infection with antimicrobial resistant organisms	42 (7.9)	42 (8.3)	-0.36 (-3.7-3.0)
Adverse events			
Allergy	4 (0.75)	7 (1.4)	-0.63 (-1.9-0.63)
Anaphylaxis	0 (0)	0 (0)	NA
Acute kidney injury	6 (1.1)	5 (1.0)	0.15 (-1.1-1.4)
Acute hepatitis	0 (0)	2 (0.39)	-0.39 (-0.94-0.15)
<i>Clostridioides difficile</i>	12 (2.3)	8 (1.6)	0.69 (-0.98-2.4)

mITT, modified intention-to-treat; IQR, interquartile range;

- ❖ Post-hoc analysis of immunocompromised
- ❖ Primary: 90d mort
- ❖ Secondary: Hosp mort, LOS, relapse, adv events, vent duration, Abx free days, sec infection.

- ❖ 7d was noninferior for 90d mortality, not enough data to get info on relapse.
- ❖ Take home: shorter course of abx likely safe in those with some forms of immunosuppression.



WHEN DINOSAURS

RULED

THE

EARTH

Things We Do for No Reason™: Routinely maintaining intravenous access in hospitalized patients

Brent Kennis MD  | John P. Gerstenberger MD | Lara Hayes MD

Why you might think this is good.

PIV ubiquitous

Commonly placed preemptively

Maintenance offers convenient and rapid ability to administer meds.

Why it is NOT necessary

1/3 placed in ER are never used.

1/4 in inpts are maintained but never used

Increased risk of infection: 65/100,00 catheter days. (4.4ep BSI: 1/3rd of catheter-related *S. aureus* bacteremia)

Noninfectious complications (phlebitis 10-20%)

Burdensome monitoring

Pain and distress

False security: 1/3 fail even in Cardiac arrest

When they ARE useful

Acutely ill, iso Cardiac arrest, anticipated diagnostic procedures with contrast or sedation, inability to tolerate/absorb oral meds.

What you SHOULD do.

Use them short term, selectively, and monitor regularly. Remove asap.

Resource management and clinical outcomes during a national intravenous fluid shortage

[Stacy A. Johnson MD, MS](#) ✉ [Erin R. Fox PharmD, MHA](#), [Smitha Warriar MD](#), [Russell Vinik MD](#)

First published: 15 May 2026 | <https://doi.org/10.1002/jhm.70352> | [VIEW METRICS](#)

Hurricane Helene damaged production facility 60% IVF

Retrospective quasi-experimental. Interrupted time series, multivariable regression.

1 academic hospital. Med/surg and OB/Gyn admits

Intervention: system wide communications, HER changes, monitoring

Primary: outcome: utilization.

Secondary: LOS, diuretics, AKI, RRT, ICU tx, Hypotension, inpt and 30d mortality

N=15847 (8164 pre, 7683 post)

Results: sig decreases in utilization, LOS, loop administration, but no increase in hypotension, ICU transfer or mortality.

Outcomes	Preintervention period (n = 8164)	Postintervention period (n = 7683)	p value
Resource utilization			
Bags of IV fluid dispensed, mean (95% CI)	5.5 (5.3–5.7)	3.5 (3.4–3.6)	<.001
Clinical outcomes			
Length of stay in days, mean (95% CI)	5.5 (5.4–5.6)	4.9 (4.8–5.0)	<.001
Loop diuretic administered, OR (95% CI)	ref	0.87 (0.79–0.95)	.001
Days of diuretic administration, mean (95% CI)	0.57 (0.52–0.62)	0.50 (0.45–0.55)	.053
Total dose of diuretic administered in oral furosemide equivalents, mean (95% CI)	60.9 (53.0–68.7)	53.5 (45.2–61.9)	.207
Average daily dose of diuretic, mean (95% CI)	12.2 (11.2–13.3)	10.8 (9.8–11.8)	.057
Acute kidney injury, OR (95% CI)	ref	1.1 (1.0–1.3)	.024
Severe acute kidney injury, OR (95% CI)	ref	0.91 (0.77–1.08)	.299
Renal Replacement Therapy, OR (95% CI)	ref	0.92 (0.66–1.28)	.625
Hypotension, OR (95% CI)	ref	1.0 (0.9–1.1)	.983

Take home: restrictive fluid might actually be safer.

Low-Volume Polyethylene Glycol for Bowel Preparation in Hospitalized Adults

A Multicenter Randomized Trial

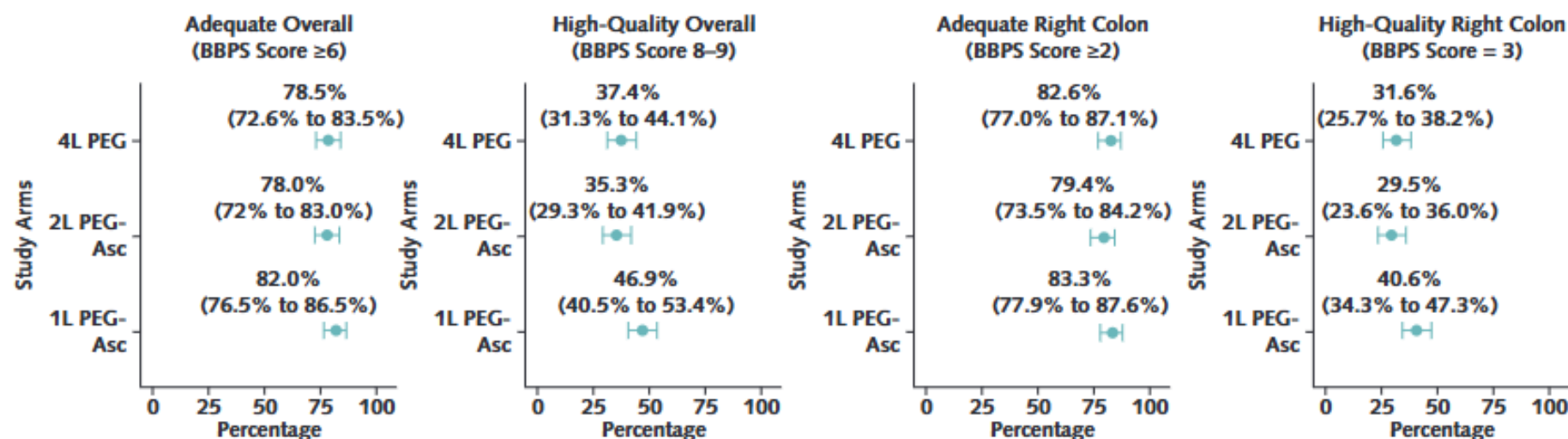
Leonardo Frazzoni, MD; Paola Cesaro, MD; Franco Radaelli, MD; Carlo Fabbri, MD; Simona Guglielmo, MD; Alessandro Mussetto, MD; Mauro Manno, MD; Cecilia Lina Pugliano, MD; Francesco Segatta, MD; Edoardo Pezzuto, MD; Emanuel Raschi, MD; Antonio Facciorusso, MD; Cesare Hassan, MD; Cristiano Spada, MD*; and Lorenzo Fuccio, MD*; for the INTERPRET Study Group†



- ◇ Multicenter, randomized, controlled endoscopist blinded. Italy
- ◇ Randomly assigned 1L or 2L PEG-ascorbate or 4L PEG
- ◇ Primary: adequate bowel prep (Boston Bowel Prep score 6 or greater, no seg below 2)
- ◇ Secondary: high quality cleansing 8-9, high R colon 3, willingness to repeat.
- ◇ N=665 (excludes urgent for GI bleeding)

Results

Bowel-Cleansing Quality and Absolute Differences (FAS)



Take home: Less prep, same results

Variation in initiation of medications for alcohol use disorder during alcohol withdrawal hospitalizations in a large health system: A retrospective cohort study

Eden Y. Bernstein MD, MPH ✉, Jacob A. Lebin MD, Jason Hoppe DO, Izzie Clinton BA, R. Mark Gritz PhD, Gina R. Kruse MD, MS, MPH, E. Jennifer Edelman MD, MHS

First published: 08 October 2025 | <https://doi.org/10.1002/jhm.70201> | [VIEW METRICS](#)

- Retrospective cohort
- AWD adm
- Outcome MAUD-
 - IM naltrexone,
 - PO naltrexone
 - acamprosate
 - disulfiram
 - topiramate
 - baclofen
- excluded recent Ppx in 90d

Original Research

Medications for Alcohol Use Disorder (MAUD) Initiation During Alcohol Withdrawal Hospitalizations

Alcohol withdrawal hospitalizations = opportunity to start treatment

- 5,993 hospitalizations
- 4,989 patients

Only 19.8% initiated MAUD

Most common MAUD:
Oral naltrexone 66.9%

Journal of
Hospital Medicine

Wide variation across hospitals

43.2%

5.1%



MAUD is underutilized and inconsistent

More likely to receive MAUD:

Addiction/psychiatry consult

'Other' insurance (VA)

Less likely to receive MAUD:

Age ≥ 65
eGFR ≤ 30

Liver enzyme elevation

Opioid use disorder
Surgical service

Bernstein et al., May 2026
#Visual Abstract by @kovalenkojul

Prescribing Gabapentinoids for Pain

Why you think it helps



Widely used

Opioid alternative

Multiple Indications

Why gabapentinoids may
NOT help



Limited data

Minimal benefit for off-label use

May worsen adverse effects

What you should do instead



Reassess indication

Deprescribe

Avoid routine substitution

Nonpharmacologic strategies

Sleep friendly order set-

-decreased interruptions

-No neuro checks/vs overnight, retimed meds/labs

Sleep menu

- “ear plugs, eye masks, links to meditation videos, television channels with relaxing content, journals, and books”

Primary outcome- sleep duration

Secondary- awakenings, Richards-Campbell sleep questionnaire

Safety- delirium rate, ICU transfer, 30d Readm

N=66 pre/61 post

DID NOT improve sleep duration, only mildly improved awakenings. No change in safety metrics.

Take home: maybe safe to decrease overnight interventions but it probably won't help sleep.

Improving sleep on the inpatient general, non-stroke neurology service: A quasi-experimental interventional trial

Noor F. Shaik MD, PhD, Lydia Denison MD, G. M. Anya Venezia MD, Lovisa Ljungberg MD, Alexa Lebrón-Cruz BA, David Resnick MEd, MPH, Colleen Peachey MSN, RN ... [See all authors](#) ▾

First published: 09 February 2026 | <https://doi.org/10.1002/jhm.70223> | [VIEW METRICS](#)

Original Research

Improving Sleep on the Inpatient Neurology Service

THE PROBLEM



Hospital sleep is
poor

~ **5.5** hours/night
Frequent disruptions

THE INTERVENTION



Sleep-friendly care

Fewer overnight interruptions

THE RESULTS



No improvement in sleep
duration

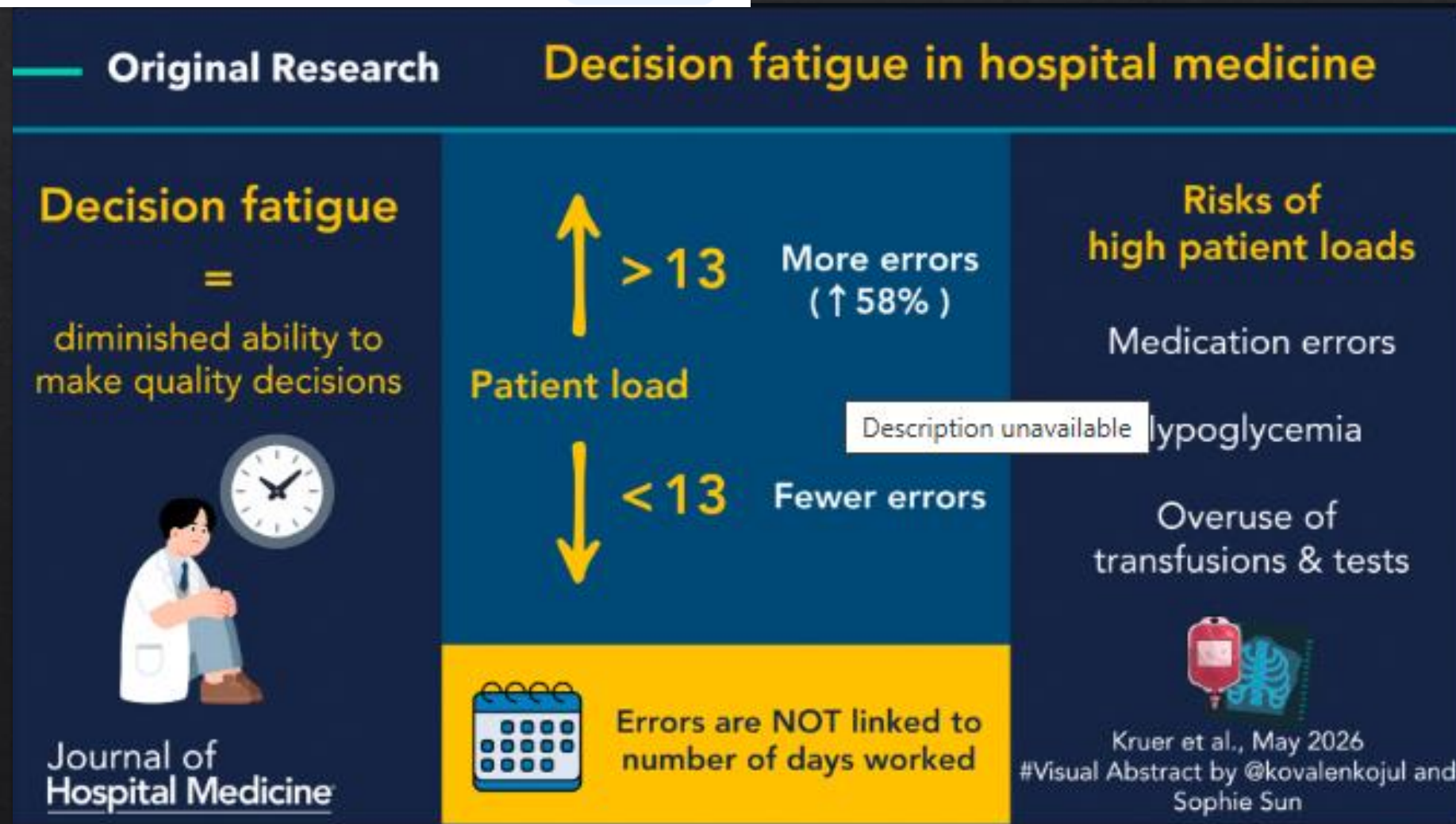
No safety concerns

**TAKEAWAY: Reducing interruptions
alone is NOT enough
Sleep is multifactorial**

Decision fatigue in hospital medicine: A retrospective exploratory evaluation

Rachel M. Kruer PharmD, MPH, BCCCP, FCCM, LaKeisha Boyd MS, Lauren Czosnowski PharmD, Sarah Jones PA-C, Kelsey Perry MD, Thomas J. Streepey BS, Areeba Kara MD, MS 

First published: 29 October 2025 | <https://doi.org/10.1002/jhm.70216> |  VIEW METRICS



Decision fatigue- Impaired ability to make decision and control behavior as a consequence of repeated acts of decision making

Retrospective, 2 hospitals
43 hospitalists
median census 13, median workdays 7 (6-8)

Take homes part 2: Less and more

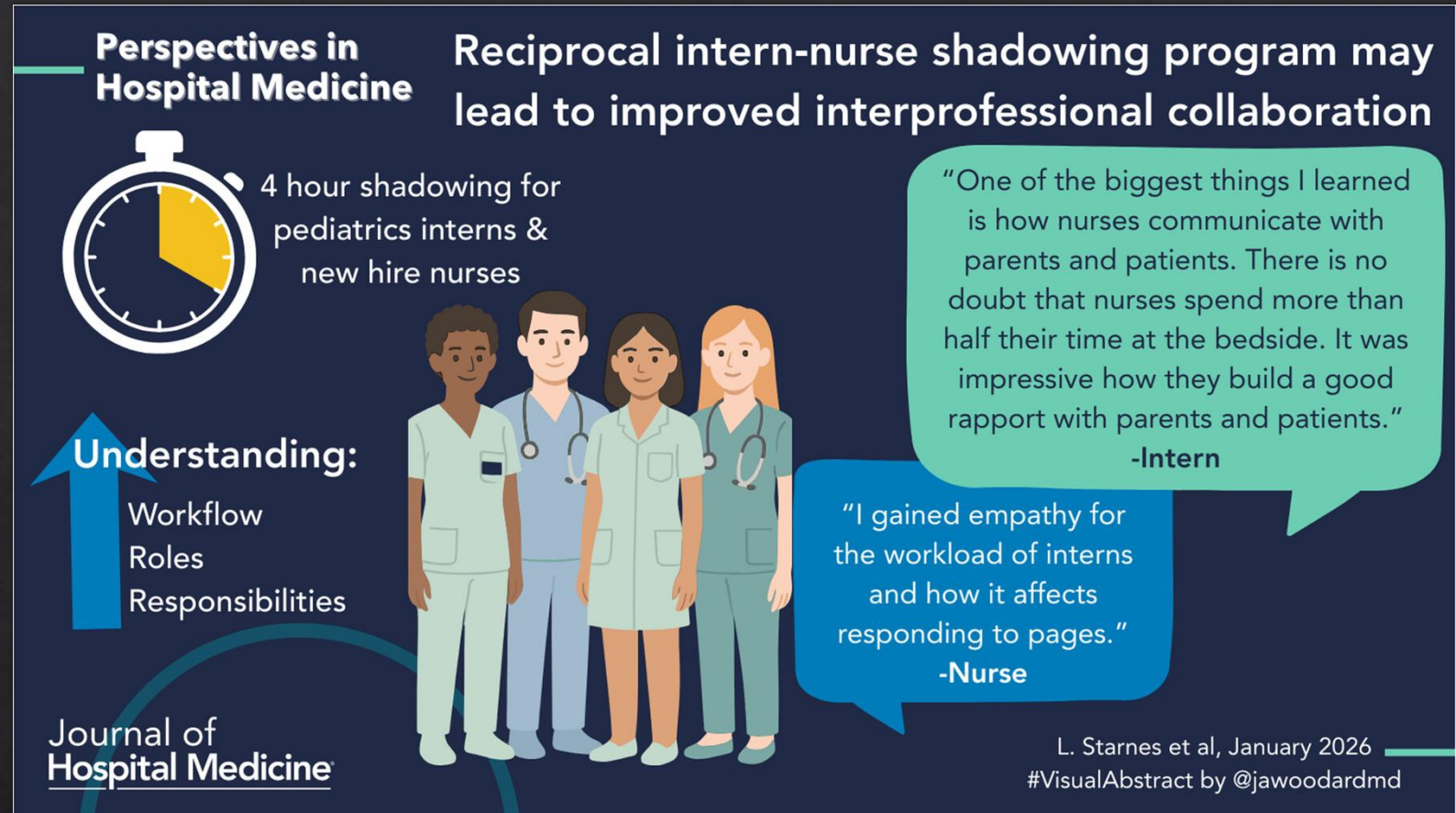


LOS, diuretic

o less

d

- ◇ 1. M
- ◇ 2. T
- use
- ◇ 3. 1
- ◇ 4. M
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Mixed methods study

4h shadowing – Interns shadowed RNs w 6+m experience/Newly hired RNs shadowed interns.

343 bed tertiary care

Redcap surveys

N=34 RN, 28 intern finished

Interns –better understood:

- daily workflow ($p < .001$)

- responsibilities of nurses ($p = .0568$) but

- not nursing training ($p = .9909$).

Nurses reported better understanding:

- interns' responsibilities, workflow, and training (all $p < .001$).

interns (25, 89.2%) and nurses (31, 91.2%) agreed/strongly agreed that the program changed their daily practice.

Take home: shadowing other roles can be beneficial.
Consider implementing.

GoComm, 4h serious illness communication training.

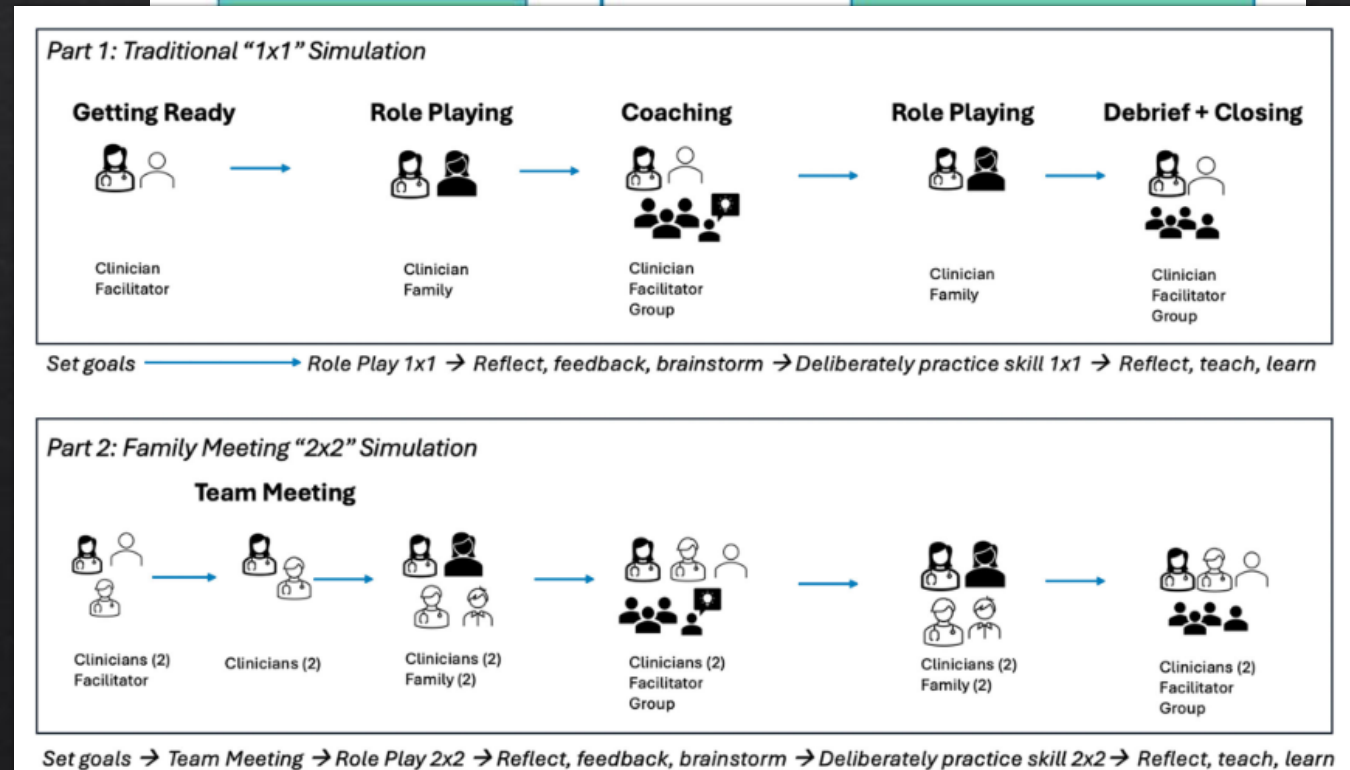
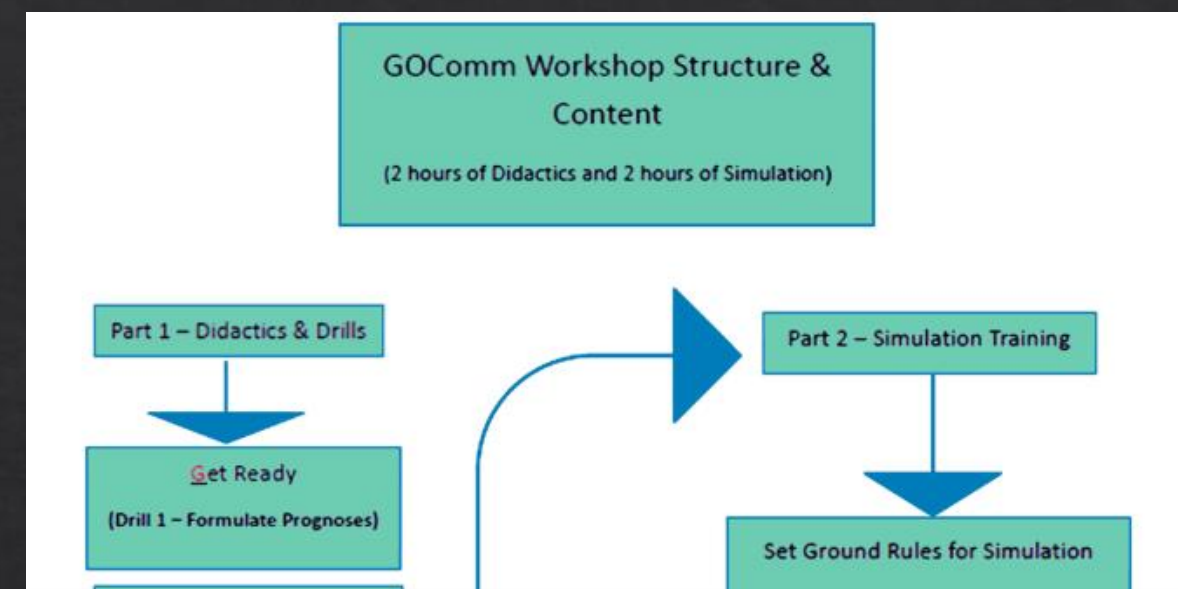
8 campuses of large health system

Train the trainer

N=390 Hospitalists/intensivists/Pas/Trainees

- Prognosticating
- Conveying serious news
- Managing emotions
- Creating values-informed medical recommendations
- Discussing hospice

Role play



The “5L” framework of diagnostic reasoning: A stepwise scaffold to support clinician educators

[Olivia Brumfield MD](#), [Amal Mohamed MBBCH](#), [Shuhan He MD](#), [Cory Rohlfen MD](#) 

First published: 03 April 2026 | <https://doi.org/10.1002/jhm.70312> | [VIEW METRICS](#)

◆ Lethal

◆ Likely

◆ Logical

◆ Lurking

◆ Linger

Care Team Model and Diagnostic Error Risk in Medical Patients Who Transferred to the ICU or Died

Original Research | Published: 26 January 2026

- ◇ How does team composition effect errors/safety?
- ◇ Retrospective observational
- ◇ 1544 GIM Inpatients transferred to ICU or died
- ◇ Attending, APP, Resident
- ◇ Primary: diagnostic error, Harmful DE
- ◇ 63% teaching, 29% direct, 9% APP teams
- ◇ Direct care higher risk of ANY diagnostic error (mRR, 1.36; 95% CI, 1.04–1.68)
- ◇ APP trended towards lowest harmful DE but it was not statistically significant

Take home: more eyes on a case or more discussion about decisions or distributed workload may avoid some diagnostic errors.

Take home: Life long learning.
There are teachable moments.



Universal

The impact of shifting hospitalist switch days from Monday to Tuesday

Larry Nguyen MD , Lauren Messing MHA, Katherine A. Hochman MD, MBA, Adriana Quiñones-Camacho MD, Jesse Burk-Rafel MD, Benjamin Verplanke MD, FACP, FHM

First published: 04 November 2025 | <https://doi.org/10.1002/jhm.70176> |  VIEW METRICS

- Single center, M-> T 7on/7off model urban academic quaternary care 16802 discharges
- Compared Pre/post intervention.

The Impact of Shifting Hospitalist Switch Days from Monday to Tuesday

L Nguyen et al., 2025

Changing the hospitalist switch day from Monday to Tuesday enhanced continuity at the start of the week and was associated with more Monday discharges and fewer 30-day readmissions.

Problem



The day of the week when hospitalists switch providers can significantly impact hospital throughput. While schedule restructuring has been linked to admission wait times, average length of stay (ALOS), and discharge rates, limited data exist on which switch day is optimal.

Innovation



Hospitalist 7-day rounding blocks rescheduled to switch on Tuesday instead of Monday

- reduce disruptions in continuity at start of work week
- overlapped provider schedule with social workers and case managers to prevent whole-team turnover on Mondays

Takeaways



- Aligning schedules improved continuity within the multidisciplinary team
- Small yet strategic operational changes can yield meaningful clinical and quality benefits



Key tools



Operational alignment
Schedule restructuring to coordinate intentional continuity with discharge planning

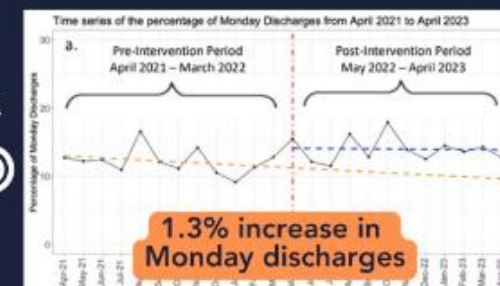


Accelerate Change



Engage hospitalists early
Involve hospitalists in discussions about preferred switch day before initiating scheduling changes for operational purposes

Impact



1.5% decrease
in 30-day
unplanned
readmission
rates



Elevation in white blood cell count after corticosteroid use in noninfected hospitalized patients

Erin Sullivan BS, Rebecca Schulte MPH, Michael B. Rothberg MD, MPH 

First published: 11 February 2025 | <https://doi.org/10.1002/jhm.70008> |  VIEW METRICS

Retrospective cohort study, single health system. Cleveland Clinic

WBC trajectory stratified by steroid dose

Nonsurgical patients only, 2+ wbc
n=28425

Excluded immunosuppression, known infection, malignancy or steroids in prior 2 weeks

1608 rec'd steroids.

Main outcome- WBC by day after steroids.

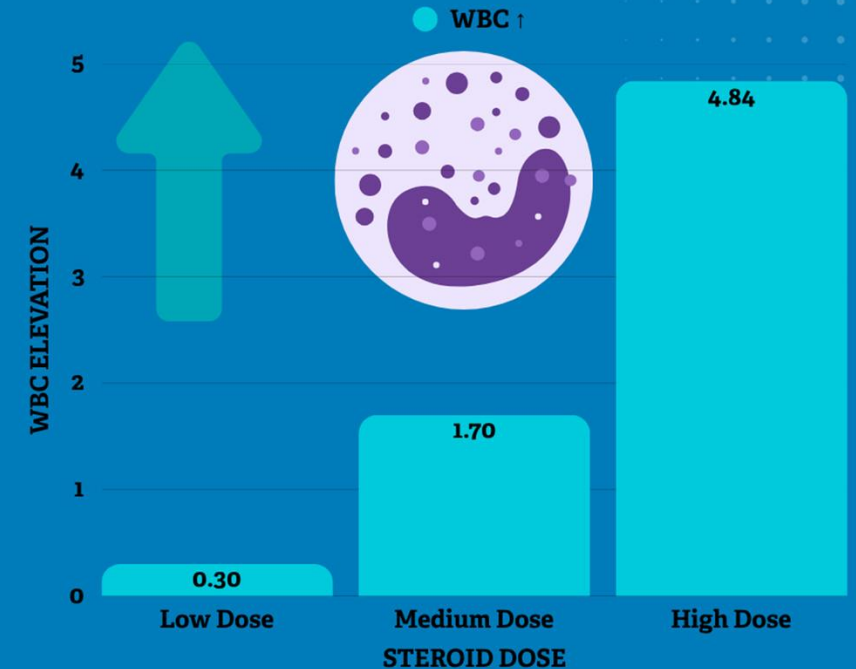
Original Research

Elevation in WBC After Corticosteroid Use in Noninfected Hospitalized Patients



Peak effect seen at
48 hours after
steroid
administration

Journal of
Hospital Medicine



Things We Do For No Reason™

CD4 Testing in Hospitalized Patients with HIV

Why we think testing might be helpful:

Assess immune status

Antibiotic decision-making

Prophylaxis needs



Journal of
Hospital Medicine

Why testing may not be helpful:

Multiple causes for low CD4 count in hospitalized patients
Guidelines spaced out routine testing



When testing might be helpful:

New HIV diagnosis
Unclear immune status
Ask for help!



What you should do instead:

Assess HIV history and medication adherence.

Review most recent outpatient Viral Load and CD4 testing.

From the
Editor-In-Chief

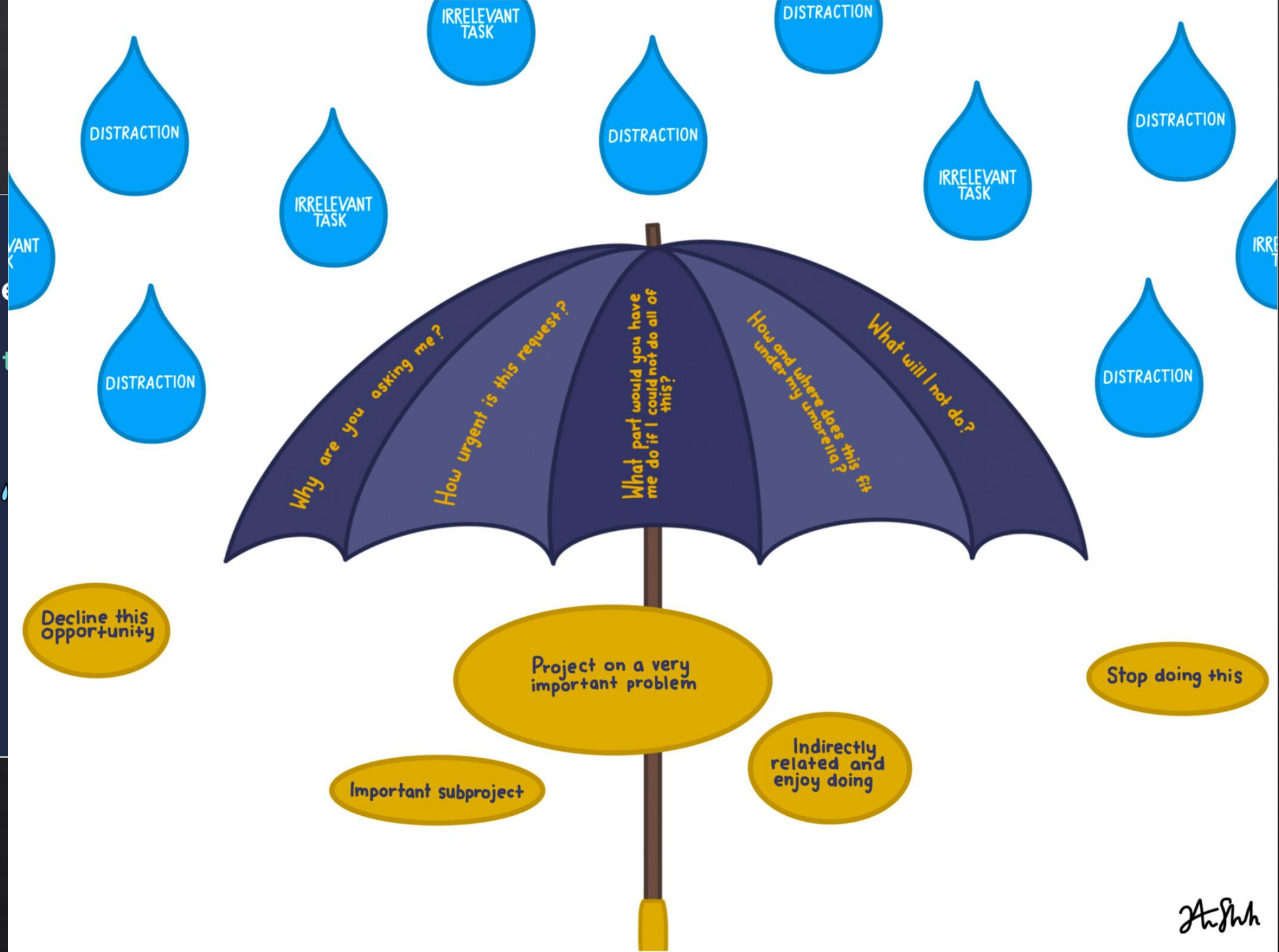
A de

Ask yourself: What is t



Does it fit under
your umbrella or
is it just a raindrop
of **distraction**?

Journal of
Hospital Medicine



Ansah

Review Articles of Note



PROGRESS NOTES |  Full Access

Approach to hyperleukocytosis and leukostasis-inpatient management strategies

Maun R. Baral MD  Sambhawana Bhandari MD

First published: 07 October 2025 | <https://doi.org/10.1002/jhm.70199> |  VIEW METRICS

PROGRESS NOTES |  Open Access |  

Clinical progress note: Hepatitis A virus

James M. McCluskey III MD, MPH  Robyn A. Bockrath MD, MEd, Ravi Jhaveri MD

First published: 11 September 2025 | <https://doi.org/10.1002/jhm.70171> |  VIEW METRICS

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Antiretroviral Therapy

Roy M. Gulick, M.D., M.P.H.¹

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Nutrition Therapy in Critically Ill Adults

Jayshil J. Patel, M.D.,¹ and Stephen A. McClave, M.D.²

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Antidotes for Anticoagulation Reversal

Bianca Rocca, M.D., Ph.D.,¹ and Hugo ten Cate, M.D., Ph.D.^{2,3}

Guideline updates

JOURNAL ARTICLE ACCEPTED MANUSCRIPT

Noninvasive Respiratory Support for Adult Patients with Acute Respiratory Failure. An Official American Thoracic Society Clinical Practice Guideline ^{FREE}

[Neha N Goel](#), [Bruno L Ferreyro](#) ✉, [Tyler Pitre](#), [Kimberley Lewis](#), [Collin Homer-Bouthiette](#), [Federico Angriman](#), [Leticia Kawano Dourado](#), [Matthew Drake](#), [Tammy L Eaton](#), [Cheryl L Esbrook](#) ... [Show more](#)

[Author Notes](#)

American Journal of Respiratory and Critical Care Medicine, aamag302,
<https://doi.org/10.1093/ajrccm/aamag302>

Published: 29 June 2026 **Article history** ▼

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📖 **FREE ACCESS** | ACC Scientific Statement | 30 June 2026



Direct Oral Anticoagulants in Primary and Secondary Prevention of Thrombotic Events: 2026 ACC Scientific Statement: A Report of the American College of Cardiology

Authors: Dharam J. Kumbhani, Anastasia L. Armbruster, Richard K. Cheng, Jonathan Chrispin, Urs Fischer, Anne Marie Holbrook, Jose Joglar, and Marie-Antoinette Sevestre | [AUTHORS INFO & AFFILIATIONS](#)

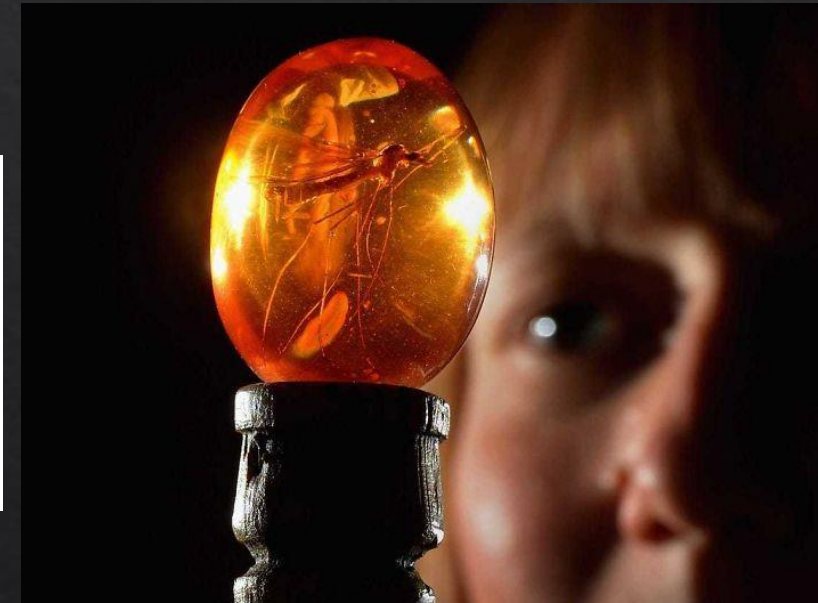
Stroke

Volume 57, Issue 8, August 2026; Pages e316-e436
<https://doi.org/10.1161/STR.00000000000000513>



AHA/ASA GUIDELINES

2026 Guideline for the Early Management of Patients With Acute Ischemic Stroke: A Guideline From the American Heart Association/American Stroke Association



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33.