



An initiative of the ABIM Foundation

Society of Hospital Medicine – **Adult Hospital Medicine**



Five Things Physicians and Patients Should Question

1 Don't place, or leave in place, urinary catheters for incontinence or convenience or monitoring of output for non-critically ill patients (acceptable indications: critical illness, obstruction, hospice, perioperatively for <2 days for urologic procedures; use weights instead to monitor diuresis).

Catheter Associated Urinary Tract Infections (CAUTIs) are the most frequently occurring health care acquired infection (HAI). Use of urinary catheters for incontinence or convenience without proper indication or specified optimal duration of use increases the likelihood of infection and is commonly associated with greater morbidity, mortality and health care costs. Published guidelines suggest that hospitals and long-term care facilities should develop, maintain and promulgate policies and procedures for recommended catheter insertion indications, insertion and maintenance techniques, discontinuation strategies and replacement indications.

2 Don't prescribe medications for stress ulcer prophylaxis to medical inpatients unless at high risk for GI complications.

According to published guidelines, medications for stress ulcer prophylaxis are not recommended for adult patients in non-ICU settings. Histamine-2 receptor antagonists (H2RAs) and proton-pump inhibitors (PPIs), commonly used to treat stress ulcers, are associated with adverse drug events and increased medication costs, and commonly enhance susceptibility to community-acquired nosocomial pneumonia and Clostridium difficile. Adherence to therapeutic guidelines will aid health care providers in reducing treatment of patients without clinically important risk factors for gastrointestinal bleeding.

3 Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds and in the absence of symptoms or active coronary disease, heart failure or stroke.

The AABB recommends adhering to a restrictive transfusion strategy (7 to 8 g/dL) in hospitalized, stable patients. The AABB suggests that transfusion decisions be influenced by symptoms as well as hemoglobin concentration. According to a National Institutes of Health Consensus Conference, no single criterion should be used as an indication for red cell component therapy. Instead, multiple factors related to the patient's clinical status and oxygen delivery should be considered.

4 Don't order continuous telemetry monitoring outside of the ICU without using a protocol that governs continuation.

Telemetric monitoring is of limited utility or measurable benefit in low risk cardiac chest pain patients with normal electrocardiogram. Published guidelines provide clear indications for the use of telemetric monitoring in patients which are contingent upon frequency, severity, duration and conditions under which the symptoms occur. Inappropriate use of telemetric monitoring is likely to increase cost of care and produce false positives potentially resulting in errors in patient management.

5 Don't perform repetitive CBC and chemistry testing in the face of clinical and lab stability.

Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing during short periods of time. Phlebotomy is highly associated with changes in hemoglobin and hematocrit levels for patients and can contribute to anemia. This anemia, in turn, may have significant consequences, especially for patients with cardiorespiratory diseases. Additionally, reducing the frequency of daily unnecessary phlebotomy can result in significant cost savings for hospitals.

How This List Was Created

The Society of Hospital Medicine (SHM) created a *Choosing Wisely*® subcommittee comprised of representatives of the Hospital Quality and Patient Safety committee and included diverse representation of academic, community and adult hospitalists. SHM committee members submitted 150 recommendations for consideration, which were discussed for frequency of occurrence, the uniqueness of the tests and treatments and whether the cost burden for a specific test or treatment proved to be significant, narrowing the list to 65 items. The *Choosing Wisely* subcommittee ranked these items and a survey was sent to all SHM members to arrive at 11 recommendations, of which the final five were determined utilizing the Delphi method. SHM's Board approved the final recommendations.

SHM's disclosure and conflict of interest policy can be found at www.hospitalmedicine.org/industry.

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About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

To learn more about the ABIM Foundation, visit www.abimfoundation.org.



About the Society of Hospital Medicine

Representing the fastest growing specialty in modern healthcare, the Society of Hospital Medicine (SHM) is the leading medical society for more than 34,000 hospitalists and their patients. SHM is dedicated to promoting the highest quality care for all hospitalized patients and overall excellence in the practice of hospital medicine through quality improvement, education, advocacy and research. Over the past decade, studies have shown that hospitalists can contribute to decreased patient lengths of stay, reductions in hospital costs and readmission rates, and increased patient satisfaction.

For more information about SHM and hospital medicine, visit www.hospitalmedicine.org.

