Seizing the Window of Opportunity to Enhance Resident Skills in the Inpatient Setting

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In health care, especially in residency training programs, the term "seize the window of opportunity" has never been more important. With patients experiencing increasingly shorter lengths of stay, residents and faculty have less time to address important issues, such as the goals of care, addiction counseling, and immunizations, and to perform certain portions of the physical examination. We believe these measures should not be time intensive. For many patients who have limited access to outpatient care, an inpatient stay may be the only opportunity to address such issues. We provide our views on some examples of seizing the window of opportunity, which may add "value" to a patient's care during an inpatient admission and enhance a resident's skills. These suggestions are applicable to all residents and faculty who carry the primary responsibility of an adult patient's care in the inpatient setting.

Immunizations

It may be easy to remember to recommend an influenza shot to a patient during flu season, but actually administering the shot before discharge is another issue. The same is true of the pneumococcal vaccine, when indicated.[1] In addition, when caring for a patient with cirrhosis or other types of chronic liver disease, evaluating the immunization status of a patient for hepatitis A and B is appropriate.[2] If a patient is not found to be immune, seizing the opportunity to immunize is evidence-based medicine.[1]

Testing for Hepatitis C and HIV

Testing for HIV infection and previous exposure to hepatitis C are other examples of seizing the opportunity. The HIV testing should be considered part of the routine screening of healthy individuals. It is also recommended that hepatitis C screening be performed on all adults in the United States born between the years 1945 and 1965 as well as on any patient with a risk factor.[3] A resident might not think this testing is a priority, but access to care in the ambulatory setting is problematic for many patients, and this window of opportunity may not open again soon. With the availability of well-tolerated and effective oral antiviral regimens, individuals with hepatitis C can be successfully treated prior to the development of complications.[4] In addition, several state legislative bodies, including New York and Pennsylvania, have mandated the provision of hepatitis C screening in the inpatient setting because it has been found to be cost effective.[5,6]

Goals of Care

Discussions about goals of care take time and skill. In one study, only 37% of patients reported that they had end-of-life discussions with their physicians.[7] An inpatient stay is an opportunity to initiate that discussion. The plan may pertain to the goals of care for the current stay and any care after discharge.[8] Moreover, hospitalized patients with serious illnesses and their family members have identified end-of-life communication as a high-priority target for quality improvement.[8] However, physicians infrequently engage patients and families in such conversations. Hospitalization presents an important opportunity for engaging in discussions about goals of care because it signals a change in the patient's illness, which adds importance to those conversations, and because family members are often present.[8] In this era of hospitalists, more patients are cared for in the hospital by physicians who have not previously been involved in the patient's care and may not be involved after discharge. However, the window of opportunity exists to start the discussion and educate those patients. Residents and hospitalists are in an excellent position to address this critical issue and should not assume that a patient's primary care physician has brought up the topic. Seize the opportunity to start a discussion.

Addiction Counseling

Whether or not a patient is hospitalized with an illness related to smoking, a brief discussion regarding

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smoking cessation should occur.[9] It is an opportunity to be certain that the patient knows the importance of quitting and the potential positive effects on his or her health. Literature and appropriate follow-up should also be provided. The same approach can be used for assistance with alcohol cessation and stopping the use of illicit drugs.[10]

Physical Examination

Our current experience with residents' case presentations reveals that they are less likely to include a fundoscopic, musculoskeletal, complete neurological, or breast examination. These portions of the examination are not mandatory in all patients, but when clinically indicated, a pertinent portion of the physical examination is often omitted. A recent case presented to one of us at morning report highlights this point. A 60-year-old woman with the recent onset of altered mental status was found to have 2 lesions in the brain that were suspicious for metastatic disease. Neurological surgery was consulted to consider a biopsy of 1 of the lesions before a breast examination or mammography had been performed.

Verghese and colleagues[11] discussed how the failure to perform important parts of the physical examination might lead to preventable adverse outcomes. It is our opinion that the fundoscopic, musculoskeletal, neurological, and breast components of the physical examination are very important, but unless performed regularly during training, they are difficult to master. Residents should seize the window of opportunity to perform these portions of the examination and reach out for mentoring or guidance to ensure they are performed correctly.

Potential barriers to the performance of these portions of the examination include the additional time involved and a potential lack of knowledge on the required technique. However, supervising faculty should emphasize the value of a pertinent, thorough examination and become a role model for these portions. Faculty should emphasize that these portions of the physical examination do not have to be performed on every patient but should not be avoided when clinically indicated. We urge a more careful examination on a case-finding, not on a screening, basis. As residents learn these skills and place a priority on them, they are in a better position to then teach them to their students. Lack of knowledge should not prevent the provision of appropriate care, and physicians must have the humility to acknowledge their knowledge gaps and strive to fill them.

In summary, by seizing the window of opportunity, it is our opinion that residents are providing higher quality care, becoming more skilled physicians and, hopefully, better teachers in the process. In addition, spending more time at the bedside engaging in direct patient care and dialogue with patients and families may combat burnout among residents as they find deeper meaning in their work.[12] Faculty should become role models for these behaviors and openly discuss the importance of the detailed and thorough care of a patient (BOX). While planning the discharge of a patient, seize the chance to reflect on whether there is anything else that can be done for your patient. Take advantage of the open window.

BOX Specific Behaviors of Faculty to Seize the Window of Opportunity

1. On initial patient presentation, inquire if trainees discussed specific goals of care with patients and their families.
2. Take the lead on introducing a discussion of goals of care with patients who are stable and those with more acute issues, such as dyspnea and pain.
3. Inquire if trainees have considered addiction counseling, testing for sexually transmitted infections, or immunizations as part of their management plans.
4. Emphasize the importance of all pertinent portions of the physical examination during rounds.
5. Share experiences when failure to perform a portion of the examination affected a patient's outcome.
6. Return to the bedside to perform any omitted portion of the examination and demonstrate the correct technique.
7. Set aside dedicated time to review portions of the physical examination that are often omitted.

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