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Sincerely,

Jeffrey M. Drazen, MD

November 9, 2018

Physician Mentorship: Why It’s Important, and How to Find and Sustain Relationships

Mentorship is a key factor in promoting and maintaining fulfillment in medical practice. Senior colleagues who share your clinical, research, administrative, or community service interests should be approached early in your formal training. An open and honest dialogue can be instrumental in setting your professional goals, defining its trajectory, and learning how to overcome barriers by adopting successful strategies.

—John A. Fromson, MD

By Bonnie Darves

Most physicians who make their way into satisfying practice careers in a specialty they enjoy — and especially those who also end up in leadership roles — are usually quick to point out to their younger colleagues that they received some help, perhaps even a whole lot of assistance, along the way. Almost invariably, these physician success stories usually have a common thread: an important mentor, or possibly more than one key mentor, whose guidance proved invaluable.

In an era when it’s easy to network and seek guidance online in pretty much any area of one’s life, the notion of the traditional physician mentor-mentee relationship carried out over a series of regularly scheduled formal in-person meetings and the occasional phone conversation might seem almost quaint. It isn’t, and such relationships might be more important now than in the past because the in-touch-and-constantly-connected online environment doesn’t necessarily foster or sustain the deep, candid exchanges that characterize good mentor-mentee interactions.

Anne Pereira, MD, MPH, assistant dean for curriculum at the University of Minnesota Medical School, thinks that some physicians in training fail to recognize the value of establishing and cultivating relationships with mentors. “Absolutely, in-person mentorship remains fundamentally important in medicine, because a lot of mentorship is about developing a relationship that’s close enough that your mentor wants to support you,” Dr. Pereira said. “Unfortunately, I think that the value of having mentors is probably underestimated by many trainees.”

One reason, she points out, is that many young people today who end up in residency have never worked because they have been on a fast track. They’re essentially high-achieving, highly driven professional students who
have been “on a fairly regimented pathway,” she explains, “and they haven't reached a point where there are multiple pathways they could take.”

When physicians do get to that juncture, having an established mentor relationship might make the difference between a good, thoughtfully considered decision and a poor one later regretted, longtime physician mentors say. Ideally, that relationship — regardless of the logistics of how the parties meet and how frequently they connect — is a deep one predicated on two-way trust and defined objectives.

“In mentorship, I think anything that leads to a mutually beneficial relationship and the accomplishment of shared goals is fair game, but it’s definitely helpful to meet in person,” said Jennifer Best, MD, associate dean for graduate medical education at the University of Washington in Seattle. “Social media and the online universe can present a false sense of depth, and I think that we sometimes present different ‘selves’ in that environment.”

If there is one absolute prerequisite for a successful mentor-mentee relationship, it is a commitment to candor, according to Nathaniel Scott, MD, director of the combined emergency medicine/internal medicine residency program at Hennepin County Medical Center in Minneapolis. “There has to be some degree of personal connection, even in the most formal mentor-mentee relationship, and that both parties must be invested in it and honest if it is going to provide a benefit,” he said. “I think what the local relationship offers over a remote or online one is that your mentor will be more aware of the circumstances you’re in and the issues you are confronting on a more intimate level.”

To look at how young physicians can identify mentors and ultimately thrive in those relationships, NEJM CareerCenter recently spoke with physicians who have served as mentors or benefitted from the guidance that mentors have given them — or both — to obtain their perspectives on key issues.

When should physicians start looking for a mentor, and what’s the best way to go about that?

“Ideally, people should start looking for a formal mentorship program when they're looking for a residency program. Especially in a large program, having some help finding a mentor is important because it’s difficult to get your feet under you, and get to know the institution and individuals well enough to reach out on your own. I think that mentorship should be an important part of the culture in training programs.”

— Anne Pereira, MD, MPH, University of Minnesota Medical School

“The most important thing is to just start connecting with people in your institution, anyone — you can’t exist in a vacuum. You can do this without necessarily going out and looking for a mentor, by asking someone you admire for advice on a research project, for example, or guidance on how to publish a paper. Start with a specific request, and often, these exchanges will grow organically into a relationship. It’s also helpful to reach out to national physician organizations that provide mentor services on a group or individual level.”

— Chemen M. Neal, MD, assistant professor of clinical obstetrics and gynecology, Indiana University School of Medicine; mentor chair, American Medical Women’s Association

“All physicians should seek mentors as early as possible, and having a mentor when starting training is especially beneficial for international medical graduates [IMGs], because of the cultural challenges they might face. That initial mentor, ideally, should be a successful physician from the IMG physician’s country — whether the mentor is on the program faculty or not. It’s important for hospitals and health systems to help IMGs make those connections, but professional societies can also be helpful.”

— Thomas Norris, MD, board member, Educational Commission for Foreign Medical Graduates and former chair of the American Board of Medical Specialties; former vice dean for academic affairs, University of Washington
“I think the majority of mentor relationships today are informal. By that I mean that you don’t go ask someone, ‘Will you be my mentor?’ I don’t think I’ve ever said that out loud. Instead, look for someone you admire who is ahead of you in the field, or in a position that you might envision for yourself, and establish a relationship by asking a specific question. Then later, ask if that person will grab some coffee with you sometime.”
— Fatima Fahs, MD, dermatology resident, Wayne State University; budding mentor

What qualities or traits should physicians look for in a mentor?

“A good mentor is someone who says, ‘How can I help you succeed?’ and truly wants you to succeed. A lot of people still think that physician mentorship is hierarchical, but it isn’t — and shouldn’t be. When physician mentorship is done well, for the right reasons, the mentor-mentee relationship is a partnership.”
— Susan Reynolds, MD, PhD, president and CEO, The Institute for Medical Leadership

“It’s important to look for mentors who can connect with you on a one-to-one basis and who will inspire you and also give you a pat on the shoulder. It shouldn’t be about idolization; you want someone who will celebrate you as an individual, not intimidate you, and someone who will also help you figure out how to overcome roadblocks. I’ve always found the best mentors to be people who fill up my tank a bit to give me more energy to meet the next milestone.”
— Joseph Vercellone, MD, internal medicine resident in Royal Oak, Michigan, who previously worked in the film and information technology industries

“Look for a person who has the time and desire to truly invest in your future. It matters less what their area of expertise is. You want someone who can act like a sponsor for you and connect you with the right people. And you should ensure that person doesn’t have selfish motives, like recruiting you.”
— Dr. Pereira

How many mentor relationships should young physicians try to establish?

“Most of us benefit from having at least a few mentors — a clinical mentor, a research mentor, and an overall career mentor. They don’t all have to be in your field. I think it’s helpful to have a personal mentor, too, someone you bond with who’ll check in and ask you how you’re doing and whether you’re getting enough sleep.”
— Dominique Cosco, MD, associate internal medicine program director, Emory University, Atlanta

“Physicians absolutely need more than one mentor, maybe not in the beginning but definitely toward the end of residency as they start looking for their first job. There’s no perfect single mentor, so I think it’s helpful to create a quilt of mentors — a mentor who can help you procedurally, once who can help you with career planning, and another mentor for life planning.”
— Dr. Pereira

How should young physicians approach about the issue of expectations in a mentor-mentee relationship, and do they even need to address that formally?

“It’s important to make the expectations somewhat explicit from the start. For example, after a first meeting, you might ask the potential mentor if it’s OK to meet for coffee every few months. And if the person says, ‘sure,’ the mentee should reach out to set up the next meeting. After the relationship is established, there should be expectations set about what the mentor and the mentee will do, and by when, and what both are seeking from the meetings.”
— Nathaniel Scott, MD, director, combined emergency medicine/internal medicine residency, Hennepin County Medical Center, Minneapolis
“The physician who identifies a potential mentor should be direct, and say, ‘I’d like you to be one of my career advisors.’ If that person agrees, the two should set expectations about the kind of communication that will occur and how often, and when the mentor will check in to see how things are going. It’s important to set out the expectations of the exchange, because if one party has higher expectations than the other, that could strain the relationship.”

— Jennifer Best, MD, associate dean for graduate medical education, University of Washington

“Do your homework before you approach your mentor with a question, and don’t use your mid-career mentors or senior faculty member to obtain information that you can get online. Go to your mentor with those more nuanced questions where their expertise and experience will enable you to understand things in a way that you couldn’t by just reading about it.”

— Dr. Pereira

“I think that expectations can be fluid at the start, but as the relationship develops, the parties should set goals and establish what the mentee wants to work on and what he or she will bring to the meeting. It’s important that there be a timeline for goals or projects.”

— Dr. Cosco

What should physicians be sure to do, or avoid doing, when they’re seeking a mentor or working with one?

“Frame your request by telling the person the concrete thing(s) you are interested in, and be specific. One of my pet peeves is when I receive an email that reads ‘Hello, Dr. Fahs. I am interested in dermatology. What advice do you have?’ The right way would be: ‘Hello, Dr. Fahs. I am interested in dermatology. Do you have any advice on how I can obtain a research project in medical school when I don’t have a lot of clinical experience?’”

— Dr. Fahs

“Most of the time when mentor arrangements aren’t working, things tend to fall off naturally. If it’s a mismatch of expectations — one person wants to meet more frequently than the other — that should be addressed in a way that allows the two parties to just move on.”

— Dr. Scott

“It’s very important to be honest with yourself and with your mentor about the kind of help you’re seeking or what you’re struggling with. Be willing, once the relationship is established, to ask for feedback on what you could do better, and then try not to be defensive, because that could damage the relationship. That honesty should be on both sides. Mentors should be open in sharing the things they didn’t do right in their careers.”

— Joshua Corsa, MD, trauma surgeon who trained at Orlando Regional Medical Center and is doing a critical care fellowship at Harborview Medical Center in Seattle

“Prepare well for every meeting with your mentor, and remember that every good mentor is looking for a mentee who is passionate, devoted to the field, and diligent. Because unless the relationship is also gratifying to the mentor, that mentor won’t want to stay in it. Keep in mind that your mentor is very busy, and he or she needs to have a reason to devote that time to you.”

— Nitin Agarwal, MD, neurosurgeon trainee-PGY 4, University of Pittsburgh; American Association of Neurological Surgeons resident advisor

What should physicians do if they’re in a mentor relationship that isn’t working out?

“During training, you only have so much bandwidth. If the relationship isn’t a good fit, let the mentor know that you’re thinking about going in a different direction. Thank the person for the guidance so far, and say, ‘I hope you’re willing to stay in my life in an advisory capacity.’ It’s important to go out on a positive note.”

— Dr. Best

“If the chemistry (doesn’t) feel right when you start talking or meeting, find someone else. Working with a mentor is a little bit like dating; if you don’t connect early on, it’s probably a relationship that’s not going anywhere.”

— Dr. Norris

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Targeting Physician Burnout

With the problem now at epidemic levels, the medicine and graduate medical education communities are undertaking major mitigation initiatives

By Bonnie Darves

Physician researchers and scientists who study physician burnout and the attendant decline in professional satisfaction have pointed to a worsening problem for more than a decade. Until recently, however, efforts to address the issue have been mostly sporadic and largely unorganized. When studies in the past few years started calling a spade a spade — identifying physician burnout as a serious condition that’s reached epidemic levels and now affects more than 40 percent of US physicians — organized medicine and the graduate medical education community began addressing the problem.

The American Medical Association, the Accreditation Council for Graduate Medical Education (ACGME), and the National Academy of Medicine, among other organizations, have launched programs targeting physician burnout. These endeavors initially focused on increasing awareness of what formal research and surveys clearly show: Burnout is increasing among physicians regardless of where they are on their career horizon. The epidemic is affecting residents and fellows; it’s depleting satisfaction among mid-career physicians; and it’s a chief reason cited by physicians who choose to retire early or leave medicine altogether.

The increasing awareness of physician burnout has spawned several recent efforts to mitigate the problem. Many early initiatives set their sights too narrowly, some experts claim, by failing to recognize that the chief causes of physician burnout today are not individual factors and inadequate coping mechanisms, but rather system and organizational issues. Tait Shanafelt, MD, a leading researcher on physician satisfaction and burnout who directs the Mayo Clinic Program on Physician Well-Being, thinks the focus needs to shift.

“Awareness of physician burnout and its potential impact on quality of care has increased dramatically, and most organizations now recognize this problem,” Dr. Shanafelt said. “Unfortunately, to date, most organizational efforts to address the issue have focused on individual-level solutions, such as resilience training, rather than addressing the system issues that are the primary drivers of this problem.” Those issues, while wide ranging, fall into several basic categories, based on Mayo Clinic’s research. Dr. Shanafelt cites the following: work-load, efficiency, flexibility and control, work-life integration, and organizational culture and values. Other key dimensions are finding meaning in work, and social support and community at work.

“System interventions targeting these domains need to be developed and evaluated with robust outcome measures, as well as assessment of cost and return on investment,” Dr. Shanafelt said, “so that effective approaches can be scaled and disseminated.”

Burnout-mitigation initiatives taking hold

The ACGME and the AMA are among the organizations heeding that call, with initiatives that target the burnout factors Dr. Shanafelt cites. The ACGME added a new section on physician well-being to its Common Program Requirements (Section VI) that gives residents more flexibility in their schedules and more control in managing their time. Effective July 1, 2017, residents may choose to stay beyond their shift to remain with a patient whose care is at a critical juncture, in their view; or to continue in an educational opportunity that’s important to the resident — observing or participating in a procedure, for example “One thing we have heard from residents in recent years is that they feel there is a genuine loss of choice,” said Rowen Zetterman, MD, co-chair of the ACGME Common Program Requirements task force. “And we know that one factor that contributes to burnout is being in a situation in which you have no choice.”

Residents have cited circumstances in which they’ve had to leave the bedside of a critically ill or dying patient because they’ve reached the end of a 16-hour shift, Dr. Zetterman noted, or have been forced to leave the hospital before their patient comes out of recovery after surgery. The new requirements attempt to address such dilemmas. Those “overtime” hours still count in the 80-hour work week, but the greater individual flexibility might help alleviate an often-cited stressor: lack of schedule control.

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major piece of this is that there's now a standard for resident well-being in the requirements. That's a huge transformation from when I started my training five years ago.”

In addition, the Section VI requirements include a new policy that permits residents to take time off for personal health care needs, whether that is a dental appointment or a counseling session, or simply because the resident is too sick or fatigued to continue that day. The training program must put in place a policy to accommodate such absences. “I think that residents have sometimes felt that they didn't dare ask for the time off,” Dr. Zetterman said, noting that programs will have a year starting July 1 to operationalize the required changes. The ACGME also recently revised its Clinical Learning Environment Review (CLER) program to strengthen its focus on resident well-being.

**ACGME launches resident-led initiative**

A new ACGME resident-developed initiative called “Back to Bedside” targets another burnout cause: the mounting reporting, electronic health record (EHR) and computer time, and administrative burdens that reduce the time trainees have available to engage with patients. The initiative provides a competitive funding opportunity for residents and fellows to develop innovative ways to enable physicians to spend more time with patients, to improve resident well-being and patient satisfaction. Physicians spend two hours or more on these activities for every hour they spend in direct patient contact, a recent AMA-Dartmouth-Hitchcock study found. “People (physicians-in-training) are quoting up to 3:1 computer versus patient time,” Dr. Kothari said, “and we’re seeing this nationally, regardless of the specialty.”

Through Back to Bedside, the ACGME will fund up to five $10,000 awards annually, for up to a two-year period. “The goal is to generate actionable recommendations for improving the clinical learning environment to combat resident burnout,” said Dink Jardine, MD, an otolaryngologist who chairs of ACGME’s Council of Review Committee Residents. She added that the initiative’s objective is to amass a toolbox of processes, curricula, and projects, and then disseminate those throughout the GME community. (See Resources.)

The Alliance for Academic Internal Medicine (AAIM) is also seeking burnout-reduction remedies. The alliance formed a wellness committee last year, and has expanded its Collaborative on Healing and Renewal in Medicine (CHARM) outside internal medicine. CHARM convenes medical educators and leaders, and burnout experts to investigate the impact of trainee burnout, and develop tools and best practices to foster and support resident well-being. The collaborative encourages residents to join the effort by submitting and presenting papers on wellness issues at national meetings.

“We no longer have to sell people on the idea that burnout is a big deal, but we’re not sure what to do about it – and that’s what we’re working on now,” said Gopal Yadavalli, MD, chair of AAIM’s wellness committee and director of Boston University’s internal medicine residency program. Dr. Yadavalli cites increasing EHR documentation requirements and work compression as key contributors to resident burnout. “Residents are not just working fewer hours because of duty-hour restrictions; they’re also required to do the same amount of work in fewer hours. And that’s a big issue for everyone,” he said.

In tandem with the national efforts occurring, Boston University is pursuing in-house burnout-reduction strategies in its internal medicine residency program, Dr. Yadavalli said. A relatively new resident-led wellness committee has developed several initiatives, and program faculty is working to ensure that mental health counselors can be available to residents after a particularly difficult event, such as a patient death or a bad outcome in the ICU. The BU residents also started a program to support a local family at Thanksgiving, and organized a major holiday party that featured residents in musical performances and an art show.

“Residents respond better to things that their fellow residents come up with. That’s much better than me sitting in my office making up things,” Dr. Yadavalli said. The program also has begun devoting its December academic half-days to wellness activities, which start with a faculty member sharing her or his own struggles with work-life balance and burnout issues. Those presentations have been very well received, Dr. Yadavalli said, and frequently generates thank-you notes from residents. “We need to role model this for trainees, and I think most of us aren’t very good at that,” he said.

**Causes and stressors see shifts**

Some contributors to dissatisfaction or burnout among both trainees and practicing physicians are age-old — work load, exhaustion, and work-life imbalance, to name a few. Others are either new or are new manifestations...
of existing stressors. EHRs, particularly the ever-increasing work required to keep the EHR updated and comply with documentation requirements, is a stressor that keeps showing up on the list. A recent RAND study also pointed to the cumulative burden of externally imposed regulations and rules as a chief cause of professional dissatisfaction.

The AMA, acknowledging that burnout is a major issue throughout the physician-career continuum, launched a multifaceted initiative to seek national-level solutions to both organizational and individual burnout drivers. The AMA’s STEPS Forward program, started in 2015, offers interactive practice transformation strategies intended to reduce the administrative burdens that can lead to physician burnout.

“My observation is that about 80 percent of burnout is driven by systems and organizational practices rather than individual factors. We are targeting most of our efforts at the AMA to those systems issues, but we’re addressing individual burnout factors as well,” said Christine Sinsky, MD, AMA’s vice president of professional satisfaction.

STEPS Forward is organized around online educational modules that feature physician-developed strategies for addressing common practice challenges that reduce physicians’ face time with patients. The modules focus on practice efficiency, technology and innovation, with an emphasis on work flow; and on patient health and physician health. Since the STEPS Forward program began, the dedicated website has tallied more than 250,000 visits, Dr. Sinsky reported, an indication that physician practices are actively seeking burnout remedies. (See Resources.)

“I often tell physicians and others that practices could save three to five hours a day by reengineering the way work is done and redistributing the work according to ability,” Dr. Sinsky said. “Right now, a lot of work landing on the physician’s plate is work that doesn’t require a medical education.”

Two STEPS Forward modules, one on preventing trainee burnout and a second on improving resiliency, provide strategies for individual physicians. Toyin Okanlawon, MD, MPH, a senior health care project leader at Harvard Business School who authored the module on preventing resident and fellow burnout, thinks it’s imperative that physicians learn self-care skills during residency.

“Just as physicians don’t learn about anatomy when they’re done with medical school, physicians need to learn to take care of themselves at the beginning of training,” said Dr. Okanlawon, whose interest in physician wellness evolved from his own experience and the recognition, while he was public health chair of the AMA Resident and Fellow Section, that burnout “was plaguing” the training environment. “Burnout is a huge disease right now [in training programs], and there’s a huge demand for ways to address what has become a very serious problem.”

Call for comprehensive, physician-led response

Dr. Okanlawon said that while it’s gratifying to see physician burnout get the attention it warrants from the medical education community, he thinks that a national-level response has been overdue based on what the data have shown consistently. “I think this [focus] should have started a few years ago, because once something like this pops up, you don’t really need more red flags,” he said, “to tell you it’s time to do something.”

Physicians should “take charge of their own epidemic now,” in Dr. Okanlawon’s view, and not take a haphazard approach to an issue that deserves our full attention. This is not a task force or quality-meeting issue,” he said.

A longtime proponent of proactive approaches to burnout mitigation, Ralph Greco, MD, at Stanford University, echoes Dr. Okanlawon’s view about the delayed collective response; and both agree that residency programs must also work to reduce the stigma associated with residents seeking help for possible burnout. Dr. Greco, who founded Stanford’s Balance in Life program for surgical residents following the suicide of a much-admired resident who had just gone on to fellowship, points to a 2008 American College of Surgeons survey that found a burnout rate of 40 percent. “That was a scathing report, and nine years later, we’re not exactly setting the world on fire,” he said. “Seven or eight academic articles came out of that data, but I think the [burnout] issue was largely ignored until recently.”

The Stanford Balance in Life program — Dr. Greco admits the name is not “universally liked” — seeks to support surgery trainees’ physical, psychological, social, and professional well-being though various activities and resources. Components range from mandatory weekly meetings with a clinical psychologist, to organized physical and social activities, to dedicated professional well-being mentorship. The program, which also features an annual resident retreat, has been well received since it started in 2011. “It is slowly being replicated by other programs,” Dr. Greco said.
Dr. Greco applauds the efforts national organizations and individual programs have undertaken to address burnout. At the same time, he worries that some initiatives might not be robust enough to address the systemic scope of the problem. “My concern is that some of these programs are not well enough resourced to deal with the magnitude of this issue,” said Dr. Greco, who is the Johnson & Johnson Distinguished Professor, Emeritus at the Stanford University School of Medicine. He is also concerned that the great variability among training programs in how they address burnout — if at all — leave many trainees without the support they need.

Timothy Brigham, MDiv, PhD, chief of staff at ACGME and co-chair of its Physician Well-Being Task Force, thinks that the important next step is ensuring that there is a collective, continual effort to combat physician burnout. “The ACGME and the entire house of medicine are working very hard to turn this Titanic around a bit,” Dr. Brigham said. “But it’s clear that we’re not going to ‘resilience’ our way out of this.” He proposes convening all the organizations that are trying to address physician burnout to ensure that successful strategies and best practices are shared as those emerge.

“We need to make sure that we’re all reading from the same page,” Dr. Brigham said, “while recognizing that this is not one disease, one cure. What works for one program or organization might not work for another. We’re trying to identify the constellation of things that work so people can pick and try them — and then as we gather more research from Mayo Clinic and others, find out empirically what works.”

Resources
The following lists several organizations and initiatives targeting physician-burnout reduction; most offer avenues for resident and/or practicing-physician involvement.

ACGME Back to Bedside initiative:
www.acgme.org/backtobedside

Alliance for Academic Internal Medicine CHARM (Collaborative for Healing and Renewal in Medicine):
http://www.im.org/page/charm

American Medical Association STEPS Forward initiative:
https://www.stepsforward.org/

Mayo Clinic Physician Well-Being Program:
http://www.mayo.edu/research/centers-programs/physician-well-being-program/overview

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience:
https://nam.edu/initiatives/clinician-resilience-and-well-being/

Stanford Balance in Life program:
https://med.stanford.edu/gensurg/education/BIL.html
An otherwise healthy 57-year-old man presents with a 48-hour history of pain in the left lower quadrant. He has had three previous episodes of sigmoid diverticulitis that were confirmed by computed tomographic (CT) scan and treated nonsurgically. He has localized tenderness in the left lower quadrant. The body temperature is 101.8°F (38.8°C), the heart rate 110 beats per minute, and the white-cell count 15,600 per cubic millimeter. A CT scan of the abdomen and pelvis with oral and intravenous contrast material shows microperforation of the middle portion of the sigmoid colon, air bubbles in the adjacent colonic mesentery, thickening of the sigmoid wall, and pericolonic fat stranding, without free fluid. How would you manage this patient’s condition?

The Clinical Problem

Colonic diverticulitis is an inflammatory process that most commonly affects the sigmoid colon. A colonic diverticulum is a pouchnlike protrusion in which mucosa and submucosa herniate through the muscle layer at points of weakness where blood vessels traverse the colon wall (Fig. 1). The term diverticulosis describes asymptomatic diverticula, whereas diverticulitis indicates diverticula associated with inflammation and can be either complicated (i.e., associated with abscess, fistula, stricture, or perforation and peritonitis) or uncomplicated. All manifestations are covered by the term diverticular disease.

Diverticular disease is the eighth-most-frequent outpatient gastrointestinal diagnosis in the United States, with 2.7 million associated health care visits annually.¹ The economic burden is high:² in a study of data from the National Inpatient Sample, 216,000 hospital admissions for diverticulitis in 2012 were found to cost $2.2 billion.¹

The prevalence of diverticulosis has seemingly increased over the past century, in contrast to autopsy studies in the early 1900s that suggested prevalences of 2 to 10%, more recent reviews, based largely on administrative data, indicate that the prevalence ranges from 5% among patients younger than 40 years to 50% among patients older than 60 years.³ Rates of diverticulitis have also risen. In a population in the U.S. Midwest, the incidence of diverticulitis rose by more than 60%, from 115 cases per 100,000 person-years in the period from 1980 through 1989 to 188 per 100,000 in the period from 2000 through 2007, and the increase was greater among younger people.⁴

According to an analysis of data from the National Inpatient Sample,⁵ between 1998 and 2005, the rates of hospital admission for acute diverticulitis increased by...
The combination of CT findings (thickening of the colonic wall plus the presence of a complication) and an assessment on an overall scale of the severity of CT findings also predicts the risk of recurrence.17

**Classification**

Diverticulitis is classified as simple (uncomplicated) or complicated. Complicated diverticulitis refers to abscess, fistula, stricture, or free perforation, and simple diverticulitis describes inflammation without these features.

**Diagnosis and Evaluation**

Diverticulitis typically manifests as pain in the left lower quadrant, fever, and leukocytosis. In patients with a redundant sigmoid colon and in Asian patients, pain is more often in the right lower quadrant or suprapubic area. Altered bowel habits (diarrhea or constipation) and pelvic pressure may occur.

Multislice CT imaging with intravenous and luminal contrast material has excellent sensitivity and specificity for the detection of diverticulitis (98% and 99%, respectively)18,19 and is the preferred test for diagnosis. CT should generally be performed for all first episodes and for subsequent episodes that are treated with percutaneous drainage or that contribute to a decision for surgical intervention.

Findings consistent with diverticulitis on CT include thickening of the colonic wall, pericolonic fat stranding (indicating edema or inflammation), abscesses, localized air bubbles, and free air or fluid. A “microperforation” is a radiologic diagnosis reflecting localized perforation and inflammation (Fig. 2A). Free perforation is a surgical diagnosis made on the basis of sepsis and diffuse peritonitis — that is, an acute abdomen. The combination of CT findings (thickening of the colonic wall plus the presence of a complication) and an assessment on an overall scale of the severity of CT findings also predicts the risk of recurrence.17

**Key Clinical Points**

- Rates of diverticulitis are increasing in association with increasing rates of obesity.
- Evidence does not support the idea that seeds, nuts, and popcorn cause diverticulitis.
- Antibiotic agents are routinely used for outpatient management of diverticulitis in the United States, although limited data from randomized trials have called into question their role in this context.
- Patients who have diverticulitis that is successfully managed medically in the outpatient or inpatient setting are at low risk for undergoing an emergency colostomy in the future.
- The severity of recurrent episodes of diverticulitis is generally similar to that of the initial episode.
- When elective surgery is indicated, a laparoscopic approach results in better patient outcomes and lower health care costs than open surgery.
- Sigmoid resection with colostomy creation remains the safest and most widely used surgical procedure for perforated diverticulitis.

**Figure 2. CT Images of the Colon in Patients with Diverticulitis.**

Panel A shows uncomplicated diverticulitis with pericolonic fat stranding. Panel B shows Hinchey stage I diverticulitis, with a small pericolic abscess and a bubble of extraluminal air (arrow). Panel C shows Hinchey stage IV diverticulitis with feculent peritonitis and a defect in the integrity of the colonic wall (arrow).
clinical trials. Stage I disease is characterized by small pericolic or mesenteric abscesses. In stage II disease, the abscess is larger but is confined to the pelvis. Stage III disease indicates purulent peritonitis, and stage IV disease indicates fecal peritonitis (Fig. 2C). Higher stage numbers are associated with higher morbidity and mortality.14 After the specific manifestations of diverticulitis are defined, colonoscopy should be considered if persistent symptoms after one confirmed attack were present, although a prospective cohort study of male health professionals showed no association between intake of corn, seeds, and nuts and the risk of diverticulitis over 18 years of follow-up.16

Localized perforation — uncomplicated diverticulitis
Simple diverticulitis reflects localized inflammation and accounts for approximately 75% of cases of diverticulitis. In the absence of high-risk factors for complications, percutaneous drainage with lavage and resolution of symptoms is as effective as surgery in patients with perforated diverticulitis.27 RCTs comparing these approaches showed similar mortality in the two groups but higher rates of stoma reversal in the primary-anastomosis group.26 Overall, 14 to 20% of patients with acute diverticulitis who undergo emergency and emergency surgical procedures during the same hospitalization.12,13 Slightly more than half of these patients receive a colostomy, and 30% of these will be permanent. Reversal of the stoma depends on coexisting conditions and surgical expertise; not all surgeons who create stomas can reverse them.

ELECTIVE SURGERY FOR RECURRENT UNCOMPlicated DIVERTICULITIS
In most patients who have diverticulitis-associated perforation of the bowel, the perforation occurs during their first attack.28 The decision to pursue elective surgery after an episode of diverticulitis that was treated nonsurgically is challenging. Many patients will not have another attack after an initial episode of uncomplicated diverticulitis.29,30 Only 2% to 3% of patients report another episode within a year.31,32 Despite the lack of data to confirm benefits, oral antibiotics are routinely prescribed in the United States. Common outpatient regimens are oral ciprofloxacin (500 mg twice a day) plus metronidazole (500 mg three times a day), or amoxicillin–clavulanate (875 mg twice a day), for 7 to 10 days. Traditionally, an oral diet of clear liquids is advocated until pain resolves. Inpatient management is indicated for high fever (body temperature >101.5°F [>38.6°C]), leukocytosis, complicated disease on CT, immunosuppression, serious coexisting conditions, a lack of home support, a need for pain control, or an inability to receive oral intake. Standard management includes bowel rest, pain control, and antibiotics, usually administered intravenously because of an inability to receive oral intake. Antibiotic therapy should cover gram-negative and anaerobic bacteria; typical regimens include ceftriaxone plus metronidazole, single-agent therapy with a β-lactam or β-lactamase inhibitor, or meropenem.

Symptoms typically improve within 2 to 3 days after the initiation of treatment, at which time the diet is commonly advanced to clear liquids and then to a low-residue diet, although data from randomized trials to guide dietary management are limited. Deterioration or a lack of improvement should prompt repeat imaging. In the absence of a treatable cause of a poor response (i.e., a drainable abscess), surgical intervention is indicated. Emergency and semiurgent surgical procedures during the same hospitalization.32 Slightly more than half of these patients receive a colostomy, and 30% of these will be permanent. Reversal of the stoma depends on coexisting conditions and surgical expertise; not all surgeons who create stomas can reverse them. Patients with colostomy complications including the need for diversion operation or if medical management fails; failure of medical management alone is more likely in patients with abscesses larger than 5 cm in diameter. Whereas some studies have reported that 70% of patients with abscesses ultimately undergo surgery, others have shown that fewer than half the patients had recurrent diverticulitis and that reoperations were effectively managed nonsurgically.33-35 Before colonoscopy became widely performed (and covered by insurance) for screening purposes, this procedure was routinely recommended to patients with recurrent diverticulitis in the remaining 5% of cases) and leads to repeat surgery only in rare cases (0.4% of cases).36 In the DIRECT trial, patients with three or more proven attacks of diverticulitis or persistent symptoms after one confirmed attack were

emergency intervention
Emergency surgery is indicated for sepsis or peritonitis, and urgent surgery is indicated if the patient’s condition fails to improve despite medical therapy or percutaneous drainage. Free perforation causes sepsis and peritonitis, with severe diffuse abdominal pain, fever, tachycardia, and leukocytosis. A CT scan should be obtained in all patients to localize perforation and rule out other diagnoses. Emergency surgical intervention may be laparoscopic or open. Potential contraindications to a laparoscopic approach include hemodynamic instability, suspected feculent peritonitis, distended abdomen, obesity, and known extensive adhesions, as well as a lack of laparoscopic experience on the part of the surgeon. Commonly, sigmoid resection is performed, removing the perforated segment and leaving a rectal stump and end colostomy (Hartmann procedure). Because more than 30% of these procedures result in a permanent colostomy, two alternative approaches that might reduce this risk have been proposed — laparoscopic lavage and resection with primary anastomosis.

In uncontrolled studies reported good outcomes with laparoscopic lavage,15 the technique was rapidly disseminated, reflecting its ease and simplicity as compared with emergency resection. Subsequent randomized trials comparing lavage with emergency resection, however, yielded inconsistent results. One trial was prematurely halted because of a higher rate of complications with lavage than with resection,16 another showed a shorter hospital stay with lavage but similar morbidity in the two groups,17 and a third reported more unplanned reoperations with lavage but lower stoma rates.18 Laparoscopic lave- age of perforated diverticulitis remains controver- sial and should not be performed outside a randomized trial.

Resection and primary anastomosis with loop ileostomy require two operations (reseption of the perforated sigmoid, anastomosis of the ileostomy first, followed by closure of the ileostomy). However, loop ileostomy is more likely to be reversed than end colostomy, and the resection leaves an end-to-side opening into an abdominal cavity that may have extensive adhesions.20-24 The pro- cedure has not been widely adopted. A review of the National Inpatient Sample from 1998 through 2011 showed that more than 90% of patients had end colostomy and that patients with primary anastomosis and diversion had higher morbidity and mortality.25 A randomized trial comparing these approaches showed similar mortality in the two groups but higher rates of stoma reversal in the primary-anastomosis group.26 Overall, 14 to 20% of patients with acute diverticulitis who undergo emergency and emergency surgical procedures during the same hospitalization.27 Slightly more than half of these patients receive a colostomy, and 30% of these will be permanent. Reversal of the stoma depends on coexisting conditions and surgical expertise; not all surgeons who create stomas can reverse them.

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randomly assigned to undergo surgery or receive conservative management. The trial was stopped early by the data and safety monitoring board owing to slow recruitment (only 109 patients were recruited over a period of 24 months). The Gastrointestinal Quality of Life Index score at 6 months (the primary outcome) was significantly better in the surgery group, and clinical and adverse events appeared to be less common overall with surgery than with conserva- tive management. However, the rate of anasto- motic leak in the surgery group (in the form of abscess or a more serious condition, peritonitis) was high, at 15%.

Whereas older guidelines from the American Society of Colon and Rectal Surgeons (ASCRS) recommended surgery after two attacks of un- complicated diverticulitis, current guidelines rec- ommend that decisions regarding elective surgery should not be driven by the number of episodes but rather should be individualized. A decision- analysis model suggests that elective resection after a fourth episode is not associated with a higher risk of death or colostomy formation than earlier resection. Considerations include the se- verity of attacks, underlying medical conditions, patient preference (or aversion) regarding surgery, and quality of life. It is helpful to com- pare the estimated risk of perforation from an- other attack (which is likely to be similar in sever- ity to previous episodes) with the risk of surgical complications (estimated on the basis of coexist- ing conditions). Patients who have complicated diverticulitis with fistula or stricture may not require emergency surgery but may require elec- tive surgical intervention. Patients with immuno- suppression, collagen vascular disease, glucocor- ticosol treatment, obesity, or an abnormal Crea- tinine may be at risk for recurrence and perforation but have additional coexisting conditions, the patients are less able to undergo resection safely to obviate the source of their symptoms, and al- ternative medications have been suggested. Rafi- xini (a poorly absorbed oral antibiotic) and me- salazine (an anti-inflammatory agent that exerts topical effects) have been proposed as possible agents to reduce the risk of recurrence of diverticulitis, but the available data do not support a substanti- onal benefit. More data on medications that may reduce the need for surgical intervention are needed.

Eelective surgery may be laparoscopic or open. A recent systematic review of 13 randomized trials comparing laparoscopic and open surgery for diverticulitis was inconclusive, the quality of the available data was considered to be low, and a meta-analysis of 25 randomized trials com- paring open and laparoscopic colonic resection for any indication showed superior outcomes with laparoscopy (i.e., less pain, lower rates of hos- pitalization and complications, lower costs, and better quality of life).

Areas of Uncertainty

What we thought we knew is no longer what we know. The mainstay role of oral antibiotics for management of uncomplicated diverticulitis has been challenged. Data from large-scale studies will be required in order to achieve practice change with regard to the prescription of oral antibiotics. The role of antibiotics is compared with percutaneous drainage for medium-size abscesses (3 to 5 cm in diameter) requires further study.

Further investigation is necessary for an under- standing of the pathophysiology of diverticulitis. A major area of uncertainty is when resection is indicated for recurrent disease to prevent future complications.

Conclusions and Recommendations

The patient described in the vignette has signs of localized abdominal tenderness and uncomplic- ated diverticulitis on CT scan; the microperforation that was seen on CT is the localized inflamma- tory process around the causative diverticulum. He should be hospitalized, receive nothing by mouth, and be treated with intravenous fluids and broad-spectrum antibiotics; after the tender- ness resolves, I would switch to oral antibiotics and allow him to eat. If his condition does not improve or deteriorates over the next 24 to 48 hours, repeat CT is warranted and may show an abscess amenable to percutaneous drainage. After resolution of this episode, if he has had a recent colostomy, another is not indicated un- less there are suspicious findings on CT. On the other hand, if a surgical decision is made and severe, I would recommend surgical consulta- tion for consideration of elective surgery after resolution of this acute episode.

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Disclosures provided by the author are available with the full text of this article at NEJM.org.

GUIDELINES

The ASCRS and the American Gastroentero- logical Association have published guidelines for the management of diverticulitis. The level of consistency between the sets of guidelines is high, and the recommendations summarized in this article are generally consistent with those in the guidelines, other than my emphasis on urgent bedside decision making.

REFERENCES

10. Hjern F, W Pakistan, Håkansson N. Obstet- ric, physical activity, and obesity as increas- ing risk for recurrence and perforation but have also increased surgical risks, and tailored deci- sion making is necessary.

Elective surgery can be laparoscopic or open. A recent systematic review of 13 randomized trials comparing laparoscopic and open surgery for diverticulitis was inconclusive, the quality of the available data was considered to be low, and a meta-analysis of 25 randomized trials com- paring open and laparoscopic colonic resection for any indication showed superior outcomes with laparoscopy (i.e., less pain, lower rates of hos- pitalization and complications, lower costs, and better quality of life).

Clinical Practice

Clinical Practice


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<td>Write and finalize cover letters and CV</td>
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<td>Contact Cejka Search and begin preparing for the interview process</td>
<td>Consider offers and options, and begin to negotiate an employment contract</td>
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(see also FM and Primary Care)

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Salary will be commensurate with education and experience. An excellent federal employee benefits package is available. Team lead or supervisory positions may be filled through this advertisement, and candidates may be subject to peer review prior to appointment. Additional selections may be made within the same geographical area FDA-wide.

LOCATION: Silver Spring, MD

HOW TO APPLY: Submit electronic resume or curriculum vitae (CV) and supporting documentation to CBER.Employment@fda.hhs.gov. Supporting documentation may include: educational transcripts, medical license, board certifications. Applications will be accepted through February 28, 2019, although applicants will be considered as resumes are received. Please reference Job Code: OTAT-18-0012-NEJM.

NOTE: This position may be subject to FDA's strict prohibited financial interest regulation and may require the incumbent to divest of certain financial interests. Applicants are strongly advised to seek additional information on this requirement from the FDA hiring official before accepting a position. A probationary period for first-time supervisors/managers may be required for supervisory positions.

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• Family Medicine
• Pediatrics
• Non-invasive Cardiology

• Hospitalist/Neonatologist
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• Electrophysiology
• Orthopedics
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Core Physicians is seeking applicants with board certifications, a desire to provide high-quality care to our underserved patients, and a commitment to lifelong learning. Successful candidates will have an M.D. or M.D.-O.M.D. D. and will have completed a medical residency or fellowship in cardiology.

CVRI research areas and mentors are described on the CVRI website:

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• Electrophysiology
• Orthopedics
• Cardiology
• Radiology
• Emergency Medicine

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dforte@emersonhosp.org
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