

Reflections: The Hospitalist Movement a Decade Later

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August 2006 marks the 10th anniversary of the publication of an article in the *New England Journal of Medicine* in which Lee Goldman and I coined the term *hospitalist*—an event that many people characterize as the start of the hospitalist movement in the United States. The present article describes the history of those early days, highlighting some of the choices the field's initial leaders made to nurture the new specialty. In retrospect, although there were many examples of fortunate serendipity, there were also several key strategic choices, including the focus on gathering research data to demonstrate the value of the field to external stakeholders; the forceful rejection of mandatory hospitalist systems, particularly those promoted by managed care organizations; and the purposeful linking of our new field to the burgeoning movements to improve quality and patient safety in hospitals. Most of all, the field's spectacular growth and successes can be attributed to the daily work of thousands of hospitalists in clinical care, education, research, and systems improvement. These individuals have given life to our theoretical notion a decade ago that a new model for inpatient care would improve the American health care system and the care of inpatients. *Journal of Hospital Medicine* 2006;1:248–252. © 2006 Society of Hospital Medicine.

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Most people believe the term *hospitalist* first appeared in the literature in the August 15, 1996, issue of the *New England Journal of Medicine* (NEJM). That issue carried an article that Lee Goldman and I wrote titled “The Emerging Role of Hospitalists in the American Health Care System.”¹ But the term was actually coined about a year earlier, in an article I wrote for our University of California, San Francisco (UCSF), residents' newsletter, the *Medical Residents' Progress Note* (MRPN), circulation about 180. In that article, I mused about a new model of care in which separate physicians assumed the role of caring for inpatients in place of patients' primary care doctors. Several people—both residents and faculty—approached me soon after the MRPN article was published and said, “I read your article—you should really buff it up and send it to a real journal.” (By the way, when you publish a scholarly article, people generally say, “I *saw*” your article, rather than “I *read* your article...”). This prompting led me to polish up the piece, with Lee Goldman's able assistance, and send it to the NEJM.

Although people often introduce me today as “the guy who invented hospitalists” (to which I typically respond, “yeah, just like Al Gore invented the Internet”), I did no such thing—I merely kept my eyes and ears open, spotted the trend early, and gave it a name that stuck. In the mid-1990s, the California market was being besieged by managed care, which was seeking new ways to cut

I am grateful to Win Whitcomb and John Nelson for their friendship and inspiration, and for reviewing the manuscript, which helped to compensate for my faltering memory.

hospital utilization and costs. In 1994, the huge Kaiser Permanente system decided to reorganize its hospital care around a cadre of “hospital-based specialists” (HBSs), essentially dichotomizing the roles of inpatient and outpatient physicians. (Interestingly, Kaiser’s main motivations were to improve outpatient satisfaction by assuring constant availability of primary care physicians and to create a vehicle to promote inpatient quality improvement activities, not necessarily to improve inpatient efficiency.) Around the same time, I read reports in “throwaway” magazines about Park Nicollet in Minneapolis and the Scripps Clinic in La Jolla, California, doing the same thing. Then one day I heard that a talented young UCSF faculty member was leaving our VA system to take a job as the “inpatient manager” at a local community teaching hospital. A few weeks later, I took him out to lunch—I was intrigued by this new role and wanted to better understand it. As he described it to me over sandwiches, it made all the sense in the world, and the seeds of the *MRPN*—and later *NEJM*—article was planted.

I have always had an abiding interest in the notion of value—a fundamental belief that our system is inexorably becoming one in which health care choices and competition will be based on demonstrable quality, safety, the patient’s experience, and cost rather than on tradition, impression, and proximity. As I began thinking about hospital care, it seemed likely this new model—dichotomizing the roles of inpatient and outpatient doctors such that the former could be constantly available and become an expert in inpatient clinical care and hospital microsystems—would provide more value than the traditional structure, both in community settings (replacing the single primary care doctor managing both inpatients and outpatients) and the academic setting (replacing the traditional one-month-a-year ward attending).

At the time I was thinking all this through, a new chairman of our department of medicine arrived from Harvard. Lee Goldman, who virtually invented the field of clinical epidemiology, came to UCSF with a powerful vision that matched mine—to transform training and clinical care to improve both value and education. Lee had been a resident at UCSF 20 years earlier and returned in 1995 to an inpatient service whose structure and culture had barely changed over a generation. Lee (who, to my great chagrin, recently left UCSF to become Columbia’s medical school dean, and who

does not have the term *good enough* in his vocabulary) sat down with me and articulated his vision for a new type of academic inpatient model, led by faculty who cared for inpatients and taught trainees hospital medicine for a living. This was entirely in sync with my thoughts, and so we set out to build it.

Reaction to both the *New England Journal of Medicine* article and our vision for an academic hospitalist service was swift and negative. One letter to the *NEJM* said it all:

...Patients ill enough to be in the hospital are those who need their regular physicians the most. This is especially true if the patients have incurable diseases, in the context of which the usual buzzwords of “efficiency” and “outcomes” have little meaning. It is sad, but the most important part of medicine, the relationship between the doctor and the patient, is being forgotten. It is especially sad that physicians are beginning to think like MBAs.²

Our response to this and the other letters emphasized the need for evidence:

Our description of the emerging role of hospitalists is based not on an assertion that the hospitalist model is the only way to provide in-hospital care, but rather on irrefutable evidence that both teaching and non-teaching hospitals are adopting the model... We do not believe the debate about hospitalists is served by anecdotal claims about greater satisfaction among patients and providers... We recommend that the shape of our health care system be guided by measuring clinical outcomes, costs, and satisfaction rather than by following passion or tradition.³

My father, a retired businessman living in Florida, brought the controversy to an even finer point a year later. “I met this guy playing tennis today,” he told me on the phone one day. “And he’s heard of you!” I listened for the heartwarming sounds of fatherly pride, but none were forthcoming. “He hates you,” he added.

Our attempts to build an academic hospitalist program generated other concerns. Many faculty enjoyed serving as ward attendings and worried about being “kicked off the wards” (although many privately told me that they knew their “time was up” and were grateful for a way to “exit with dignity.”) One world-famous faculty member bolted out of his seat during the Q&A period after my medical grand rounds at his institution in 1997. “How will the house staff learn anything if we don’t allow them to learn from their mistakes?” he huffed. (I told him that I was flying cross-country the next day, and “I’ll be really pissed off if my pilot is there

to learn from his mistakes.”) Our residents also worried terribly about losing their autonomy, having these bright young attendings “breathing down our backs.” Everyone worried about where the resources to pay for the program would come from.

At UCSF, our strategy was to reassure everyone that we would be measuring the impact of the new model in terms of cost, quality, patient satisfaction, and education. By making clear that the results of this research would guide further change (and that we were willing to end the experiment if it turned out negatively), the faculty and house staff largely suspended their disbelief for the first year. That study⁴ would demonstrate impressive cost savings with no adverse impact on quality and patient satisfaction and a hint of improved resident satisfaction (later proven more conclusively⁵), allowing us to expand the program over time and to make the argument for ongoing medical center support of the new model.

Just as Lee Goldman’s arrival at UCSF in 1995 was a remarkable and crucial bit of serendipity, my partnership with Dr. Win Whitcomb and Dr. John Nelson was every bit as important for the growth of the movement nationally. John, at that time a young internist in Gainesville, Florida, had been practicing as a hospitalist (though it wasn’t called that) since completing his internal medicine residency in the later 1980s. He had hooked up with Win, another young internist who had left a private practice job to begin a hospital-based practice at Mercy Medical Center in Springfield, Massachusetts. Together the two of them had begun to network with the handful of physicians around the country who were practicing in this new model. But they needed a larger megaphone, both to let other hospitalists know about each other, and to make hospitals and systems more aware of this new model of care.

John tells the story of pulling the August 15, 1996, issue of the *NEJM* out of his mailbox, seeing my article, and literally running into to his house to tell his wife that his practice had finally been discovered. John’s thoughtful exuberance is one of the reasons for the growth of our field, and he did something that is uniquely John—calling the author of an article that piqued his interest to discuss its contents, something he’d been doing for years. At that point, Lee Goldman was an internationally known leader in internal medicine; as chair of a major academic department, he had several layers of administrative assistants running interference

when he received cold calls. I, on the other hand, ran a sleepy medical service and had little to do other than to answer calls and to respond to this new thing called e-mail. John didn’t know that; in his experience, first authors of articles in major journals were nearly always too busy to answer calls from “country docs” like him. So he tried Lee Goldman first but failed to get through. Win, on the other hand, decided to call me and had no problem getting through immediately. We hit it off like we’d been buddies for decades, sharing our instinctive recognition that that we were at the cutting edge of a new specialty. In what, in retrospect, seems like an extraordinary amount of hubris, we essentially divided up the world, asking the question: what does an emerging specialty need in order to be successful? I’m reminded of one of my favorite parts of the brilliant dialogue by Mel Brooks and Carl Reiner, “The 2000 Year Old Man.” Brooks, playing the title part, describes his relationship with Joan of Arc (“What a cutie,” he gushes) to Reiner (playing the interviewer), and how Joan’s mission got in the way of their ardor. “She used to say to me, ‘I’ve got to save France,’ ” says the 2000 Year Old Man. “I said, ‘Look, I’ve got to wash up, you save France, I’ll see you later’...” That was us—Win and John agreed to focus on building a new professional society and on networking with community-based hospitalists, while I emphasized the academic side of things: organizing meetings, developing training programs, publishing a textbook, and launching a research agenda.

The first national gathering of hospitalists was astonishing. In the spring of 1997, I hosted what I thought would be a small hospital medicine CME meeting at a Holiday Inn in San Francisco in a seedy part of town. I expected about 50 people to attend and was shocked to see 3 times that (plus several homeless people who wandered into the sessions). Most remarkably, at the end of day 1, following 8 hours of clinical lectures, Win, John, and I asked the attendees if anybody wanted to stay a while and discuss the possibility of forming a new society. To our amazement, virtually everybody stayed—more than 100 people! “Would anybody be willing to contribute some money to get this started?” asked John, expecting nothing. And people began passing \$20 bills up to the front of the room. That was the moment we knew we were onto something very big—the atmosphere was electric, the enthusiasm easily palpable.

We initially called the new society the “National

Association of Inpatient Physicians” (NAIP), as the name *hospitalist* was still very controversial, and many thought it would not have legs—the term *inpatient physician* was believed to be more inclusive. NAIP rapidly reached a crucial turning point. Our few hundred dollars in dues collections and ad revenues lived in Win’s shoebox in Massachusetts (and later in a checking account opened by Ron Angus in Texas), and Win, John, and I were keeping databases of hospitalists on our computers and the backs of napkins. It was clear we needed to either create a full-fledged infrastructure or partner with an organization that could help us. I approached Hal Sox, now the editor of the *Annals of Internal Medicine* but at that time president of the American College of Physicians (and an old fellowship mentor of mine), about the possibility of NAIP establishing a formal relationship with the ACP. Hal was reluctant at first, noting many ACP members were pretty strongly against the idea of hospitalists. In one of many acts of brinkmanship, I told him we would need to look for other partners if ACP did not get over its ambivalence and embrace our new field. To his credit and to the credit particularly of Dr. Walt McDonald, ACP’s executive director at the time, both recognized the potential growth of this new field and worked through the internal politics to offer us an affiliation. However, we found their initial offer—to become the “Section on Hospital Medicine” within the ACP—unattractive. Wanting to be a full-fledged independent organization that enjoyed a relationship with the College, we proposed a relationship that would link us and allow ACP to support our infrastructure, but that allowed us to retain independent decision making, governance, and budget. John, in his charming Southern drawl, described our position to an early gathering of about 100 hospitalists at a NAIP meeting in San Diego. “Their offer would have them up here, and we’d be down there,” he said, his hands depicting an obvious hierarchy, with us on the bottom. “But we insisted on being equal partners,” he said, with his hands on the same plane. I turned to Win, sitting next to me in the audience, and whispered something like, “Yeah, equal...except for the small fact that they have 120,000 members and we have 87.” Nevertheless, they agreed, and our relationship has been incredibly positive for hospitalists, and I believe for the ACP as well.

The rest, as they say, is history. The society, renamed the Society of Hospital Medicine in April 2003, has thrived under the leadership of a strong series of

boards, a wonderful staff, and a charismatic and highly effective CEO, Dr. Larry Wellikson. We successfully navigated the many early challenges and took advantage of key opportunities. In this regard, I consider our 3 most important decisions and actions to be: 1) creating a body of research that demonstrated, in an evidence-based way, that the theoretical promise of the field was real⁶ (it was this research that led hospitals to embrace the field more vigorously and that justified the crucial support that most hospitals provide their hospitalist programs); 2) vigorously pushing back against managed care-based hospitalist models that had begun to force primary care physicians to hand their patients off to hospitalists against their will (NAIP’s first policy pronouncement was to come out strongly against such mandatory models, which seemed counterintuitive to some but which markedly decreased our vulnerability to being tagged as a cost-cutting vehicle of managed care); and 3) linking ourselves as strongly as possible with the growing quality and safety movements. When the IOM reports on medical errors⁷ and later quality⁸ were published, we immediately saw in the new agendas a tremendous opportunity to “brand” hospitalists as indispensable leaders of quality and safety in hospitals—another key rationale for hospitalists’ value proposition and another reason for hospitals and policymakers to support the young field.

Looking back at the 1996 *New England Journal of Medicine* article, I am struck by both the number of things I got right (even a blind squirrel...) and the number that I did not anticipate or got wrong. Lee and I thought that many hospitalists would be subspecialists who would focus on hospital medicine for only part of their work. This was true early on, but the field has evolved to be more of a generalist endeavor (although recently there have emerged “laborists,” “neurology hospitalists,” and even “surgical hospitalists”). I probably could have anticipated the growth of the field in pediatrics, but it certainly was not on my radar screen until years later.⁹ I did not count on the work hours of house staff being regulated; even if I had, I’m not sure I would have fully recognized how the need to create nonteaching services would turbo-charge the growth of the hospitalist field in teaching hospitals. The one mild disappointment: I anticipated stronger evidence by now of the field’s salutary impact on safety and quality. The effort to study and hopefully demonstrate such improvements should be a major focus for the next 5-10 years. Finally, although I thought the field would grow rapidly, I did

not anticipate that a decade later there would be 15,000 hospitalists nationally or 24 in my group at UCSF. I also did not guess that an April 2006 Medline search of “hospitalist” would find 561 articles or that a Google search of “hospitalist” would yield 689,000 entries (hell, there was no Google to search in 1996!).

As I reflect back on the last decade, I am humbled by the remarkable work I have seen from hospitalists around the country and grateful for the wonderful friendships I have enjoyed with my colleagues in our new field. I am even more convinced of the fundamental accuracy of my underlying premise: the U.S. health care system will increasingly embrace models, strategies, and providers who can demonstrably improve the value of care. I have no doubt that—collectively—American hospitalists have saved tens of thousands of lives, prevented tens of thousands of errors, orchestrated tens of thousands of good deaths, comforted tens of thousands of families, and saved billions of dollars. It is an ongoing legacy that gives me considerable pride and joy.

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