EDITORIAL

A New Narrative for Hospitalists

Audrey Young, MD[1]
Anneliese Schleyer, MD, MHA[2]
John Nelson, MD[3]

[1] Evergreen Hospital Medical Center, Kirkland, Washington.
[2] Harborview Medical Center, Seattle, Washington.
[3] Overlake Hospital Medical Center, Bellevue, Washington.

The hospitalist is not typically the hero in contemporary narratives about medical practice. More often, the hospitalist is portrayed as an interloper, a doctor who works for the hospital and not the patient, an employee focused on efficiency and rapid discharge rather than continuous medical care. Elsewhere in this issue, Mai Pham[1] offers an updated story in which a hospitalist organizes the loose ends of a patient's medical history and contributes significantly to healthcare coordination.

Hospitalists acknowledge that an admission to the hospital disrupts established outpatient continuity and that discharge can be a perilous event, with potential for medical errors. The Society of Hospital Medicine has recognized discontinuity as enough of a concern that care transitions are considered a core competency for hospital physicians.[2] This competency requires hospitalists to be able to move a patient safely from the outpatient setting through the hospital wards and back home again.

As our specialty approaches two decades of practice experience, the work that we do in coordinating medical care and ensuring continuity has evolved and deepened. Initial efforts to coordinate care from the inpatient setting focused on how key hospital events could be best communicated to the patient's primary physician.[3,4] Communication at admission and at critical junctures was encouraged, and research demonstrated that a timely discharge summary sent to the primary care office could decrease hospital readmission.[5]

Experienced hospitalists recognize, however, that not every inpatient can identify a primary care doctor; sometimes, it is this very lack of established outpatient care that triggers a patient's admission. Reasons for discontinuous prehospital care include disrupted outpatient relationships, particularly as provider networks and insurance status are re-evaluated, as well as cultural and social barriers. Complex, overcrowded outpatient health systems can be challenging to navigate even for the savviest of patients.

These concerns have helped us to focus on the hospital as a critical setting for delivering continuity of care. The mechanisms for ensuring continuity include, harnessing the inpatient capability for real-time diagnosis and treatment synthesis, which, in Mai Pham's case,[1] enabled decision-making and timely care coordination for her dying grandmother. Hospitals typically offer an array of tools needed to assist physicians in coordinating a patient's care, including rapid diagnostic testing and simultaneous multidisciplinary evaluation with consulting physicians; nurses; case managers; physical, occupational, and speech therapists; pharmacists; nutritionists; social workers; and palliative care teams. The patient's family members and friends are frequently present in the inpatient setting and can provide additional data points that are not always available in a timely manner in the ambulatory setting. Each of these inpatient interactions can help patients to develop routes of access to healthcare after they are discharged from the hospital.

Despite the advantages of the hospital setting, however, the knock on hospitalists is that we are just on the clock. Frequent handoffs, both when physician shifts change and when a fresh hospitalist rotates on service, present a significant concern to seamless care.[6] Increasing fragmentation in hospital staffing may correlate with lengthened hospital stay and increased difficulty in receiving follow-up outpatient care.[7] A new narrative for hospitalists, one focused on enhancing continuity, requires mindfulness toward schedule fragmentation and balances personal desires with the need to maintain a continued presence and availability for patients.

Enhancing continuity and care coordination in the hospital also means continually working to improve provider-to-provider communications. Solutions may include well-executed chart documentation, with active concerns flagged for the oncoming physician, and an electronic medical record that is easy to access from various locations. Computerized templates may enable more thorough handoffs in certain settings.[8] As the use of systems and checklists gains traction for their ability to reduce iatrogenic complications and save money,[9] hospitalists may come to rely more widely on systems that improve continuity, especially for aspects of inpatient care such as medication reconciliation.[10]

We believe that the most critical way in which hospitalists can ensure continuous care involves increasing physician efforts to engage with patients during their hospitalization. Hospitalists meet patients at particularly intense and vulnerable times of life, and we have all observed how patients can lose autonomy simply by being hospitalized. In the hospital, things happen to patients, sometimes because of the sheer size and force of the inpatient team and the momentum of a hospital stay.

Yet hospitalists can quickly develop a rapport with their patients through the number and intensity of their patient interactions. The free-form structure of the inpatient schedule means a flexibility to be present with patients on short notice, to respond to acute events in real time, and to be available to talk with family members and other caregivers at

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their convenience. Hospitalists can take part in multiple bedside interactions in a single day and on consecutive days. Because of this flexibility, hospitalists can bond with their patients in a short time frame[11] as they access critical social and clinical contexts, often more efficiently than possible elsewhere. As one primary care physician wrote when she gave up caring for her hospitalized patients, "I know what happened to my patient, but I didn't really experience it with my patient."[12] Hospitalists do get to share in this drama.

The medical community has been slow to recognize that hospitalists, as much as any generalist physician, can and do engage patients actively in their medical care. The hospital can be an ideal setting to ensure continuity through real-time diagnostics and therapeutics and even more so through the intense bonding that can happen between physicians and patients on the wards. The old story of an outpatient provider single-handedly managing a patient's care is rapidly disappearing in many locales. However, the story of the hospitalist is more than that of the "hero" in waiting. The story is a cautionary tale, one in which the relationship between the hospitalist and his or her patients is still under development, a tale for which much work remains. As hospitalists, we must continue to refine our skills and systems to deliver continuous care for patients in transition. We must also continue to focus on experiences with our patients and their families and, when called upon, to engage in those challenging conversations that Mai Pham[1] says "force us to align our expectations of one another." Forging this human connection will always be part of seamless healthcare for every physician, not least for the hospitalist.

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Address for correspondence and reprint requests:
Audrey Young, MD, Evergreen Hospital Medical Center, 12040 NE 128th Street, Kirkland, WA 98034; Telephone: 425-899-2560; Fax: 206-731-6063; E-mail: audreycrissman@gmail.com Received 12 June 2008; revision received 29 August 2008; accepted 6 September 2008.

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