EDITORIAL

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Hospital Medicine: An Important Player in Comprehensive Care

Congratulations to the Society of Hospital Medicine (SHM) for launching this important new journal. Congratulations as well to the SHM members, who have identified an important patient care need and moved to meet that need by defining the special competencies of the "hospitalist." *The Core Competencies in Hospital Medicine: A Framework for Curriculum Development* (the Core Competencies), by the Society of Hospital Medicine, accompanies this inaugural issue of the *Journal of Hospital Medicine*.

As a geriatrician, I can personally attest to the need to have skilled physicians on-site in the hospital to care for elderly patients. Older people with complex illnesses are susceptible to multiple hospital complications, which often present subtly but can quickly turn into life-threatening—but potentially reversible—illnesses. Given the demography of hospitalized patients in the 21st century in the United States, every good hospitalist also has to be a good geriatrician.

As evidenced in the Core Competencies, the hospitalist community recognizes as well the importance of developing expertise in caring for both the medical and surgical conditions of patients. Providing attentive diagnostic and management skills to pre- and postoperative patients, especially those with preexisting chronic conditions, will surely improve outcomes.

Continuity and coordination within a single hospital episode and across multiple hospitalizations are major challenges for our fragmented and often chaotic health care system. The Core Competencies recognizes the centrality of systems-based practice to the foundation of hospitalist skills. We at the American Board of Internal Medicine (ABIM) share the belief that every physician must understand the principles of quality improvement; accordingly, this competency is now demanded of every resident and is assessed in the maintenance of certification (MOC) of every internal medicine specialist. That hospitalists have grabbed the quality-improvement mantle is a welcome development and shows that hospitalists are likely to become key teachers of systems-based care and quality-improvement competencies in teaching hospitals.

The growth of hospital medicine in the United States has raised many important issues concerning quality of care that cannot be totally solved by the creation of a hospital-based practice discipline. The vexing issues of continuity of care, continuing relationships, and efficient management of resources over the entire trajectory of a patient's illness (not just during a hospitalization) are not fundamentally addressed by the existence of hospital medicine as a discipline. However, hospitalists can partner with others in the health care system to create a clinically mean-

DOI 10.1002/jhm.5
Published online in Wiley InterScience (www.interscience.wiley.com).

ingful continuum that truly would serve patients, especially those with the greatest need such as the elderly and the chronically ill. The ABIM has been in discussions with the Society of Hospital Medicine, the Society of General Internal Medicine, the American College of Physicians, and the Alliance of Academic Internal Medicine to develop a response to the important and evolving arenas of specific expertise in hospital and outpatient medicine. The *Core Competencies in Hospital Medicine* will significantly help to further these discussions.

Let me raise two concerns whose resolution will need the input of hospitalists as the discipline of hospital medicine becomes more mature. First, hospitalist models are quite variable. Many academic physicians who call themselves hospitalists attend on an inpatient service 2, 3, or 5 months a year and still see outpatients. Many physicians who consider themselves general internists (and not hospitalists) have a weekly half-day clinic and attend on the wards 3 months a year. Which is a hospitalist? Does it matter? Will the definition of a hospitalist be based on achievement of the competencies described here, or will it be based primarily on the amount of time in hospital-based practice? This will be an important question to resolve, especially as we embark on a path toward offering a "hospitalist credential."

Second, general internal medicine is becoming an increasingly vital part of the continuum of care for patients with multiple complex chronic illnesses, at the same time that poor reimbursement has undermined its vitality and threatens its existence. (Family medicine is also suffering from reduced interest among medical students.) Because most institutions function on an "each tub on its own bottom" model, it is unrealistic to expect the practice of ambulatory general internal medicine to support itself. Generalist practices thrive in integrated group models. These practices recognize the importance of the physician who provides a coordinating function for all the specialists who care for a "complex" patient. Such an outpatient generalist thus reduces excess and unnecessary care while identifying gaps where relevant specialties could improve function or quality of life. Ambulatory practice also requires skill in systems and improvement, but few of the 80% of generalists who practice in small groups have sufficient infrastructure and resources to support practice redesign. Indeed, a new report from Mercer consultants coined the phrase "ambulatory intensivists" to identify practices with Medicare patients and recognizes that these practices are every bit as intense and complex and in need of systems management as an inpatient practice. What the complex patient needs is a seamless interface between the two.

The authors of the *Core Competencies in Hospital Medicine* hope that this document will stand the test of time as it evolves. I would urge that the document remain flexible—a living document—because the one thing about which we can be sure is that hospital practice will change. More and more critical care will be delivered throughout the hospital, more and more of all kinds of care will be performed outside the hospital, and the nature of hospitals will surely change with shifts in reimbursement that we cannot yet imagine but that might be right around the corner. If able to provide hands-on care less expensively, physician assistants and nurse-practitioners functioning according to protocols developed by systems thinkers, only some of whom will be physicians, may replace the physician in some settings. What will become of hospitalists as these systems change? I hope that hospitalists, together with other general internists, will be at the forefront of ensuring that the changes in practice that result from the combination of new technologies and financing structures will ultimately also serve the needs of patients. The patient is at the center of our discipline and, as articulated so clearly in the Core Competencies, should always be the focus of our future thinking.

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Received 5 October 2005; accepted 9 November 2005.

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