

EDITORIALS

Hospital Medicine in 2015: Remarkable Successes and a Crucial Crossroads

Robert M. Wachter, MD*

Department of Medicine, University of California, San Francisco, San Francisco, California.

This year, we celebrate the 10th anniversary of this esteemed publication, and it is indeed an occasion for celebration. For those of us who were there at the creation of the hospitalist field, the establishment of a vibrant academic journal was a dream, one whose fulfillment was central to the legitimization of our field as a full-fledged specialty. After a decade and 83 issues, the *Journal of Hospital Medicine* is a formidable source of information, cohesion, and pride.

The anniversary comes at a particularly interesting time for hospitals and hospitalists. Our field's lifeblood has been in trailblazing and continuous reinvention. We were the first physician specialty that embraced the mantra of systems thinking, as captured in our famous metaphor that we care for "two sick patients: the person and the system." We were the first field that proudly, and without a hint of shame, allied ourselves with hospital leaders, believing that we were mutually dependent on one another, and that our ability to make change happen and stick was better if we were working with our institutions' leaders. In creating our professional society (and this journal), we took unusual pains to be inclusive—of academic and community-based hospitalists, or hospitalists entering the field from a variety of backgrounds, of hospitalists caring for adults and kids, and of nonphysician providers.

Our efforts have paid off. Leaders as prominent as Don Berwick have observed that hospitalists have become the essential army of improvers in hospitals and healthcare systems. Hospitalists have made immense contributions at their own institutions, and are increasingly assuming leadership roles both locally and nationally. It is not a coincidence that Medicare's top physician (Patrick Conway) and the Surgeon General (Vivek Murthy) are both hospitalists. Although there have been a few bumps along the way, hospitalists are generally satisfied with their careers, respected by their colleagues, accepted by their patients, and

pleased to be members of the fastest growing specialty in the history of modern medicine.

All of this should leave us all feeling warm, proud . . . and more than a little nervous. We are now a mature medical specialty, no longer upstarts, and the natural inclination, in a changing world, will be to hunker down and protect what we have. Of course, some of that is reasonable and appropriate (for example, to fight for our fair share of a bundled payment pie),¹ but some of it will be wrong, even self-defeating. The world of healthcare is changing fast, and our ability to stay relevant and indispensable will depend on our ability to evolve to meet new conditions and needs.

Let us consider some of the major trends playing out in healthcare. The biggest is the brisk and unmistakable shift from volume to value.² This is a trend we have been on top of, because this really has been our field's *raison d'être*: improving value in the hospital by cutting costs and length of stay while improving (or at least keeping neutral) quality and safety.³ However, a world under intense value pressure will work hard to move patients from hospital to less expensive postacute settings, and will insist on seamless handoffs between the hospital and such settings. Thoughtful hospital medicine groups are thinking hard about this trend, and many are placing colleagues in skilled nursing facilities, or at the very least tightening their connections to the postacute facilities in their healthcare ecosystem. We no longer have the luxury of confining our talents and energies to those things that take place within the 4 walls of the hospital.

Another trend is the digitization of healthcare, a trend turbocharged by \$30 billion in federal incentive payments distributed between 2009 and 2014.⁴ Here too, hospitalists have emerged as leaders in information technology (IT) implementations, and a disproportionate number of chief medical information officers and other IT leaders seem to be hospitalists. Splendid. But it is also up to us to help figure out how to use IT tools effectively. The notes have morphed into bloated, copy-and-paste-ridden monstrosities: let us figure out what a good note should look like in the digital era, and then implement educational and system changes to create a new standard. We no longer go to radiology because we do not need to see our films; let us think about what the loss of the collegial exchange with our radiology colleagues has cost, and then set out to develop new systems to reimagine it. Right now, big data are mostly hype and unrequited

*Address for correspondence and reprint requests: Robert M. Wachter, MD, Department of Medicine, University of California, San Francisco, Room M994, 505 Parnassus Avenue, San Francisco, CA 94143-0120; Telephone: 415-476-5632; Fax: 415-502-5869; E-mail: bobw@medicine.ucsf.edu

Received: May 4, 2015; Accepted: May 6, 2015
2015 Society of Hospital Medicine DOI 10.1002/jhm.2398
Published online in Wiley Online Library (Wileyonlinelibrary.com).

promise. Who better than hospitalists to dive in and start making sense of the data to predict risks or help point to better treatments?

Another trend is population health. Although I do not foresee a return to the Marcus Welby model of a kindly physician following the patient everywhere, I can imagine certain patients (mostly those with several social and clinical comorbidities and at least 3 admissions per year) who might be well served by a back-to-the-future system in which a primary care provider follows them into the hospital, perhaps comanaging the patients with the on-service hospitalist. David Meltzer, at the University of Chicago, is currently studying such a model, and I look forward to seeing his results.⁵ Rather than rejecting such experiments as violating the usual hospitalist structure, we must embrace them, at least until the evidence is in.

In the end, the field of hospital medicine emerged and thrived because of the promise, and later the evidence, that our presence led to better quality, safety, patient experience, education, and efficiency. This

mandate must remain our mantra, even if it means that we have to evolve our model in keeping with a changing healthcare landscape. The minute we stop evolving is the minute our field starts planting the seeds of its own destruction.

Disclosure: Dr. Wachter reports that he is a member of the board of directors of IPC Healthcare.

References

1. Burns J. Bundled payment. Hospitals see the advantages but face big challenges, too. *Hospitals & Health Networks*. Available at: http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2013/Apr/0413HHN_coverstory. Published April 1, 2013. Last accessed May 29, 2015.
2. VanLare JM, Conway PH. Value-based purchasing—national programs to move from volume to value. *N Engl J Med*. 2012;367:292–295.
3. Wachter RM, Goldman L. The emerging role of “hospitalists” in the American health care system. *N Engl J Med*. 1995;335:514–517.
4. Wachter RM. *The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine’s Computer Age*. New York, NY: McGraw-Hill; 2015.
5. Simmons J. Comprehensive care physicians: an emerging specialty for chronic care. Fierce Healthcare website. Available at: <http://www.fiercehealthcare.com/story/comprehensivists-close-chronic-care-communication-gaps/2011-05-02>. Published May 2, 2011. Last accessed May 29, 2015.