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Hospital Medicine Viewed Through Practice Management Dictums

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In the spring of 1998 at the Society of Hospital Medicine's (SHM) (then known as the National Association of Inpatient Physicians) first annual meeting, Dr. John Eisenberg asked, "If the hospitalist model of practice were a drug, do we have enough evidence about its risks and benefits to support its use?" His question is only one of many often-repeated dictums and phrases regarding how the hospitalist model of practice is organized and performs. These can serve as useful lenses to assess the past and future of the field.

Data and opinions used to answer Dr. Eisenberg's question continue to evolve. Many studies and opinions of its effects on costs and quality have appeared in the peer-reviewed literature, including the *Journal of Hospital Medicine*, which has become a principal home for studies of the hospitalist model of care. In 1998, hospital medicine's impact on outcomes and costs was only beginning, and descriptions of the hospitalist's role in implementation of new programs, such as team-based rounding models, geographic assignment of hospitalists, or the costs of interruptions, were not even on our radar. Effective management of these and other operational concerns will help ensure we are able to answer Dr. Eisenberg's question with an increasingly confident yes.

Early in the history of hospital medicine, it became common to speak of the *voltage drop* of information loss as a patient's care transitions to and from hospitalists and other caregivers. This term remains in common use today and encourages a focus on handoff communication. As of April 2015, the *Journal of Hospital Medicine* has published 15 articles that mention handoffs in the title, and many more that address the topic more peripherally.[1] Collectively, these provide thoughtful strategies to mitigate a voltage drop and its risks,[2] even though it persists and more work is needed to overcome it.

Referring to work as a hospitalist, many have said that this is a young doctor's game; one cannot do it for a whole career. The field is young enough that one cannot convincingly prove or disprove this idea, and evidence can be found on either side. Hospitalist burnout is distressingly common, though potentially similar to many other physician specialties.[3–5] Through both peer-reviewed literature and more informal channels, primarily SHM activities, there is a substantial and growing set of data and opinions regarding factors related to burnout and potential mitigation strategies.

Donald Redelmeier observed that a hospitalist's time is to a large degree governed by a pager, in contrast to an office-based physician whose time is governed by a clock.[6] Frequent interruptions delivered by a pager, many of which are of low importance and not urgent, are a significant issue for hospitalists, and to some extent all healthcare providers, and one begging for solutions.[7] Technology that replaces pagers will be helpful and will need to be paired with new methods around what is communicated, how urgently, and by what method.

Perhaps the most common dictum used by those who think about sharing best practices across our field is: If you have seen one hospitalist practice, you have seen one hospitalist practice. This has been invoked countless times as shorthand for the myriad ways hospitalist practices are organized, differing significantly in scheduling, workloads, compensation, leadership, cost structure, and other operational details. Here, the SHM serves as a valuable forum for exchange of ideas and information about the relative merits of different operational structures, and in 2014 published expert opinion regarding valuable characteristics of hospital medicine groups associated with success.[8]

In the 1990s, the principal mission of a hospitalist group was to replace primary care physicians who were leaving hospital practice and to increase efficiency of care. Many activities have since been added to this still-important original mission, including improving performance on patient safety, quality, and satisfaction, and ensuring good hospital performance during the transition to dramatically different forms of reimbursement for services. Moreover, hospitals are increasingly organized into networks, most of which are now seeking to reduce variation in hospitalist organizational models and performance across all of their hospitals.[9]

This final dictum is a foundational one for our field, and will help us solve the challenges posed by the others: A hospitalist's job is to provide care for the sick person occupying a room in the hospital, and to care for and improve the performance of the hospital itself. Laurence Wellikson, Chief Executive Officer of

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the SHM, may have said this first. By embracing both of these goals, hospitalists have the opportunity to achieve much on behalf of individual patients and the healthcare system as a whole.

New dictums and sayings are sure to arise, and there is ample room for optimism that they will increasingly highlight the successes and vital role of hospital medicine.

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