

CLINICAL VIGNETTE

A Decade of Academic Hospital Medicine at UCLA

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In 1996 Lee Goldman and Robert Wachter¹ coined the term “hospitalist”. As a junior resident (ML) my attending physician, an Infectious Disease specialist and community internist, was skeptical it had a future. He expressed this pessimism between stories of his weekend exploits spent flying from St. Louis to New York City piloting his own private plane. Little did we know at that time how dramatically the field of Hospital Medicine would change over the ensuing 17 years. It is remarkable to reflect on how the hospitalist movement has shaped not only the way health care is delivered in academic medical centers but across all health care models throughout the nation.

After completing a year as (ML) chief resident, and never quite finding a sub-specialty that appealed to me, I joined three of my chief resident colleagues and a fourth graduating senior resident as part of an academic hospitalist program of our own. The Vice Chair of our Department of Medicine told us that we were on probation for the year and that the onus was on us to prove our worth to the institution. The hospital newsletter got wind of our plans and featured us on the cover of their July publication under the dramatic headline: HOSPITALISTS: A NEW BREED OF SPECIALIST. A half page photograph of the five of us accompanied the piece. There was mixed opinion in the hospital, those who wondered why we would voluntarily prolong residency training beyond 3 years and those who feared we would “steal” their patients to start our own private practices.

Once the euphoria of being “A New Breed” died down the reality of every 4th night call in an urban teaching hospital on a non-house staff service began to set in. The shifts were very long, the patient volumes high and the threat of burnout very real. At that point there was no guidance from a Society of Hospital Medicine to suggest a “safe” average daily census and the seven on/seven off model had not come into being. For us the only relief was the 1-month of ward attending time that we were reluctantly allotted on the teaching service each year. Even then, given our astute and accomplished residents, we all needed to remain relevant and had to keep up with the latest literature to be credible

teachers. After our first year we were all well above the 90th percentile for work units (RVU’s) based on Medical Group Management Association criteria but the toll was high. We did not spend much time out of the hospital and inevitably lost some of our colleagues to sub-specialties and fatigue. Fortunately however, we learned valuable lessons on career sustainability in this field.

As our second year began, we developed our skills in medicine consultation and perioperative care. We were enthusiastically received by the orthopedists, the first of the surgical specialists to embrace co-management. Their need was great, the patients far less complex than on internal medicine services and the esteem that came with a consultative role was empowering. We were developing an appetite for attending on the wards with residents, we did not mind working extra weekends, we were always available and our evaluations were among the best in the department. The hospital administration was impressed as we tended to ask for fewer sub-specialist consults and our average length of stay was shorter than our non-hospitalist peers.

In 2002, corresponding with the five year anniversary of the movement², I (ML) attended my first National Association of Inpatient Physicians Conference in Philadelphia. Being among a group of like-minded hospitalists was an eye-opener. Robert Wachter was (and remains) a prominent, charismatic and inspiring leader. When he said that our cohort was here to stay and becoming “indispensable” to the practice of medicine in the United States we believed him. He told us of his battles with the hospital administration in San Francisco and how each year at budget time, he would reveal the worth of his team based on their quality, cost effectiveness and patient satisfaction data. It was a compelling narrative that we were determined to repeat when we returned to our own institutions.

In July of 2003, I moved west to UCLA. I was enticed by the prospect of helping build their young hospitalist program and after three years in the trenches in St. Louis, the offer of six months of ward attending on the teaching service was an offer too good to decline. I was tasked with attending and teaching on the inpatient medicine service for half the

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year, alternating with general medicine consults, in addition to growing the co-management service. In hindsight, it was the ideal time and place for this concept to take root. That year, 2003, was the beginning of mandated residency work hour restrictions³. The Institute of Medicine report on patient safety⁴ was casting new light on the need for more consistent supervision of trainees to reduce medical errors and managed care was demanding shorter lengths of stay and new responsibilities for cost containment. The Quality Improvement era was growing and hospitalists were in a wonderful position to be the catalyst for this new wind of change. Nationally, hospitalist numbers began to climb exponentially. Wachter's pronouncement about indispensability had come to pass and the challenge was to live up to the great promise of a safer, more evidence-based, more cost effective and equitable healthcare system.

By 2006, at UCLA, we had expanded to a 15-physician hospitalist group covering two facilities. UCLA Santa Monica Medical Center and Orthopedic Hospital had grown to become an active teaching site. We found it to be a fertile training ground for residents on the inpatient medicine rotation and a perfect setting to hone our blossoming co-management skills with our busy orthopedic colleagues. Cross-departmental teaching activities were planned and a true division of labor and a focus on teamwork allowed for safer, higher quality and more efficient inpatient care⁵.

That same year the national hospitalist movement turned 10. As a group we were doing a disproportionate amount of ward attending and teaching medical students both in the clinical setting and in the school of medicine. In the name of patient safety, we decided to take residency training "beyond the bedside" and began running courses at the simulation center where residents could practice managing patients who were experiencing acute life-threatening complications in a safe environment where they could get concrete feedback. Eventually, the skill and enthusiasm for teaching displayed by many members in our group began to be recognized⁶. Several hospitalists were recipients of the residency program-teaching award, outstanding tutor awards and by 2011 three hospitalists had been honored with the David Geffen School of Medicine's Award for Excellence in Education in recognition of "outstanding dedication, innovation and sustained excellence in education." Hospitalist faculty were being promoted to leadership roles in the medical center as unit directors and in the school of medicine we were given roles as site directors and block chairs.

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We had established our place in the hospital and the David Geffen School of Medicine and were now recognized as some of the most dedicated and outstanding teachers for medical students.

In 2008 the quality movement was expanding and the electronic medical record was becoming a huge part of improved efficiency and quality in our increasingly data driven healthcare culture. Hospitalists created this new niche both at UCLA and nationally. This trend accelerated the career development of some of our most promising young faculty. One of our faculty hospitalists was appointed Associate Medical Director of Quality and Safety at the Medical Center as well as for the Department of Neurosurgery. She implemented quality and safety programs for all 70 of the ACGME-accredited residency and fellowship programs at UCLA. Likewise, as our institution sought a new integrated medical record system another hospitalist faculty evolved into the institutions catalyst for new EMR implementation. His information technology knowledge, communication and leadership skills were just that much more credible given his understanding of our clinical service and his intimate knowledge of our residents' skill sets, work flows and training program requirements.

Last year, as the national hospitalist movement turned 15, our group took on a service at a third hospital and plans were initiated to expand our reach beyond West Los Angeles. Substantial recruitment was needed for the consolidation of our co-management service in two training sites, providing night coverage in all three hospitals, expanded opportunities on teaching services, preoperative evaluation clinics and an initiative in skilled nursing facilities. As the new academic year began we now numbered 58 hospitalists. We had expanded our administrative team to 8 full time employees; we were caring for a sizable percentage of all inpatients either as the attending of record or co-managing. Under normal circumstances such growth would be considered rare and unprecedented, but a quick look around the country at comparable academic programs in New York, Boston and San Francisco revealed a very similar picture.

As we look forward to the next 15 years we see a pivotal role for hospitalists as teachers, supervisors and role models on inpatient services. The new ward attending is comfortable taking over the team on resident days off and expects to be more 'hands on' when needed. This has the potential to erode housestaff autonomy if not recognized and managed carefully⁷. This issue taken in conjunction with the

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reduced time in the hospital setting spent managing patients that has inevitably accompanied work hour restrictions for residents will erode the competence of graduating senior residents further. This will continue to be a challenge and adequate solutions for these situations will be a great challenge for our specialty in the years ahead.

Hospitalists now make up a majority of the core faculty of our residency-training program. They have displaced general internal medicine faculty who are increasingly ambulatory based. Thus, having the ability and commitment to objectively evaluate residents' clinical skills and providing timely, honest and constructive feedback to trainees while working with them "on the front lines" has become even more critical. The effective ward attending starts a rotation on the wards with much more than just a repository of clinical facts. It has become increasingly important to display expertise in the leadership of a large team of healthcare providers that often includes residents, interns, several medical students, a dedicated care coordinator and a social worker. Beyond this "inner circle" the ward attending must skillfully interact with representatives of patient placement, nurse managers and other members of the hospital administration to make sure that patients move safely and efficiently through the ever more complicated healthcare system.

Other recent programs have hospitalists increasingly focused on transitions of care and readmission reduction. We have a cohort of hospitalist faculty who now attend in skilled nursing facilities thus enabling us to continue to provide for our patients across the continuum of care.

In closing, we believe that the growth of hospital medicine will continue. We foresee expansion of our management to cover all hospitalized patients regardless of specialty. Like many of the new areas of expertise acquired by hospitalists over the last 15 years co-management skills, perioperative medical care, quality improvement, medical school and residency curricular development will require an enhanced skill set and further training. We believe hospitalist faculty have embraced systems-thinking, patient safety, resident and medical student mentorship and quality improvement as a routine and are now more than ever truly an indispensable part of health care in America.

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