

## A Reflection of the Hospitalist Movement from 1996 to Present: An Interview with Bob Wachter, MD

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### How would you define the hospitalist movement?

On one level, the hospitalist movement has simply been about the emergence of a new specialty: physicians taking care of hospitalized patients. But on another level, it is the emergence of a new field of medicine that positioned itself as being about two distinct types of improvement: the care of individual hospitalized patients and making systems of care work better. In terms of the latter area, now it is common for other fields to work in systems improvement, but in many ways we led the way, and that’s really quite gratifying.

My main contribution was giving the field a name and a focal point with my *New England Journal of Medicine* article in 1996. And I was one of the people who, early on, pushed the field toward this idea of systems thinking.

When I coined the term, there were only a few hundred hospitalists in the United States. Recent data show that there are now roughly 40,000 to 50,000. That makes it the fastest growing specialty in the history of American medicine, which is pretty remarkable.

### Even in 1996, you described the concept of value, which you had defined as the quality of care divided by its cost. Do you think this concept of value has changed at all?

Yes, it has. Throughout my career, my touchstone has been that, ultimately, the health care system will be driven to providing high-value care. And value is generally defined as the thing that people want divided by the resources that it takes to deliver that thing. Calculating the resources is relatively straightforward. That is generally articulated in cost, though in medicine it gets complicated because the question is whose cost or money is it—the patient’s or the insurance company’s.

The numerator is even more complicated. Different patients will have different ideas of what they care about, and so to me the value equation includes evidence-based practice (what we think of as quality), access to the right kind of providers and systems, IT [information technology] safety, and the patient’s experience. And, at an academic institution, it includes the trainee’s experience as well. Things get pretty complicated, in that different people will assign different values for each of those parts of the numerator. The question becomes, “Who wins?” The right answer, of course, should be the patient, but two different patients might have two different views of this.

### How do you think that hospitalists can help with high-value care?

We founded the field on the premise that we would all be driven to provide the highest value care. But when I first made that argument in 1996, the pressure to provide high-value care was pretty wimpy. The best hospital and the worst hospital got paid the same. Nobody knew who was providing safe care or whose patients were having a good experience—so it was all quite theoretical. And when you can’t measure the numerator, then you pay a lot of attention to the denominator. And so in the early days, the focus of hospitalists was, to a large extent, on cutting costs. There was a lot of pressure on efficiency, and one of the reasons that hospitalists grew so rapidly was the demonstration that having hospitalists in the building, as compared to either primary care doctors or traditional academic ward attendings, decreased hospital costs and lengths of stay.

That is all changed now, and today the way hospitalists think about value is really the way most people think about value. The numerator is quality, which is being measured in terms of evidence-based practice. Patient experience is being measured through HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems] and other surveys. And all those measurements are being translated into public reporting and differential payments.

Where I think things get a little bit dicey is when there are really important variables that are not being measured. And then you have to decide whether to simply play to the test and just do well on the things that are being measured or try to do the

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right thing regardless of what is being measured. And that's a test of one's ethical compass.

For example, in terms of patient safety, we know how to measure central line infections and falls, but we have no idea how to measure diagnostic errors. So the dominant incentives would have us think a lot about hand hygiene, which is fine, and preventing central line infections, which is fine too, but no time focusing on getting the diagnosis right. That's not fine, particularly when diagnostic errors are as important a safety hazard as these other measures.

### **Now that the field is established, hospitalists are getting older too, and some are showing signs of burnout and changing careers. Do you have any feelings on the seven days on and seven days off schedule?**

I personally don't love seven days on and seven days off as the dominant schedule for hospitalists. I think it evolved because, in the beginning, the field mostly involved young people. It became very popular and, for many hospitalists, it was seen as a nice schedule—particularly if you're coming right out of residency. The problem, of course, is that the field has matured and that we've all gotten older. The average age of hospitalists is no longer 36; it's now in the early 40s. There are now even some 50-, even 60-, year-old hospitalists. For them,

a seven-on-seven-off schedule really doesn't work very well.

Also, in order to make things work out economically with a seven-on-seven-off schedule, you have to work your tail off—you really have to be running around all day long on the days you're in the hospital. Again, that's no big deal if you are two years out from residency. But it's a very big deal if you are 20 years out from residency. So personally I think that embracing this as the core schedule was a tactical error, but it certainly helped the field grow, and it's very popular. If you say, "We're not doing seven on, seven off," it can be hard to staff your program.

I think people will realize that it is not a sustainable model, and we'll move toward something that might be five days in a row on then two to three days off, or something like that—the advantage being if you don't have to stuff all the work into seven days, you can actually have a lower patient load, slightly lower intensity, and still have enough time to catch your breath between your shifts. Overall, I think that will turn out to be a more sustainable schedule.

### **Any tips for young hospitalists who are interested in academics or moving up in the field?**

Sure. At UCSF, we have felt very strongly that if you are in an academic setting you need to find a special niche—an area of specialization. That's a little tricky to talk about with

a generalist physician—as most hospitalists are—in that generalists become generalists partly because they like doing a lot of different things.

But as I look at my own group, I think the people who are the most satisfied are the ones who balance their work as clinician-educators with some other kind of work that gives them a creative outlet and a source of pleasure and diversity. There are all kinds of ways to do this: I have faculty who do this with information technology, with global health, with quality improvement, with patient safety. Others do deeper dives into medical education with medical students or residents. The area doesn't seem to matter as much as simply having a special focus that is a source of pride and variety.

In a community setting, creating this diversity is not as easy to do, but I do find versions of this model where people take on an administrative role or run a committee. These folks seem to have less burnout than people who do pure practice all the time. I think clinical practice is a terrific and important job, and for some people it will be more than enough for them. But as we look to creating sustainable careers over long careers, my recommendation—particularly for those in academics—is to find a niche. To do this, the environment is important, too—it helps to be in a program in which you have a little bit of time in the schedule to do that work and the support of the leadership. *SGIM*