

## Welcome to the Hospitalist Theme Issue

In 1996, the hospitalist movement was born, introducing us to what would soon become the fastest growing specialty in American medicine. Appreciated for their commitment to care transitions, patient safety, and bridging care in the era of duty hour reform, hospitalists are our honored colleagues and friends. This month, we pay tribute to hospitalists with two terrific interviews from leaders in the field and thought pieces on the specialty's impact on graduate medical education, quality improvement, and academic linkages to community hospitals. We hope you enjoy the issue and look forward to your feedback!

—Karen R. Horowitz, Forum Editor

## IN CONVERSATION: PART I

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

Michele Fang, 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.

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**Educational Value and Design of Hospitalist-directed Nonteaching Services**

Daniel I. Steinberg, MD, FHM, FACP

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For decades, nonteaching services have cared for patients without residents. In a recent national survey, 90% of hospital medicine groups at teaching hospitals report staffing nonteaching services.<sup>1</sup> A properly designed nonteaching service is both an institutional asset and an important partner to a residency program.

Hospitalist-run nonteaching services have been integral to achieving compliance with Accreditation Council for Graduate Medical Education (ACGME) resident admission and ongoing care patient cap rules and duty hour regulations by offloading volume on the teaching service and by increasing discharges from the emergency department.<sup>2</sup> Of note, 87% of adult hospital medicine groups staff surgical co-management services, 51.7% staff observation units, and 69.7% provide ICU coverage that would have otherwise required effort from subspecialty faculty or residents.<sup>1</sup>

A recent meta-analysis of 108,570 patients admitted to US hospitals between 1987 and 2011 found no difference in mortality, 30-day readmissions, or length of stay be-

tween teaching and nonteaching general medical services.<sup>3</sup> Similarly, a study of 2,189 patients admitted to a university-affiliated community hospital in 2002 found no difference in overall patient care costs between patients admitted to teaching versus nonteaching services.<sup>4</sup> In contrast, a hospitalist and nurse practitioner-directed nonteaching service that admitted patients with low-risk chest pain demonstrated statistically significant reductions in length of stay and total hospital charges as compared to the teaching service.<sup>2</sup>

A 2005 retrospective study found that patient acuity was higher on a teaching service as compared to a nonteaching service. Residents saw more acute renal failure, respiratory failure, septicemia, and HIV and saw less chest pain, cellulitis, alcohol withdrawal, and sickle cell crisis.<sup>5</sup> Underexposure of residents to common, less complex inpatient cases could negatively affect their clinical competence in the inpatient and ambulatory settings. Overexposure of residents to complex inpatient cases may drive career interest toward medical subspecialties and alter resident perspectives on inpatient resource utilization. If residents only care for complex cases while admission and ongoing care caps and ward team composition remain constant, residents may be overloaded with work. This would upset the balance between service and education, cause duty hour violations, and threaten patient safety.

In contrast, an equal service model in which a nonteaching service delivers the same level of care as a teaching service has multiple benefits. This model can reduce transfers from nonteaching service to a teaching service for the provision of a higher level of care. Furthermore, an

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# The Evolution of Academic Hospital Medicine Within SGIM: Generalist *Déjà Vu*

William P. Moran, MD, MS

The techniques of measuring and improving quality of care and patient safety, so long a major focus for hospitalists, are now increasingly needed by outpatient generalists.



As I have watched the evolution of hospital medicine as an academic discipline, I have been struck by a sense of *déjà vu*. I am gray enough to remember the early years of SGIM and the barriers general internists—clinicians, educators, and researchers—faced in achieving academic recognition and promotion at their institutions in the early years. Between 1970 and 1980, there was explosive growth in formation of academic general internal medicine (GIM) divisions, yet the initial expectations of GIM division faculty were viewed through a traditional lens, and many chairs of medicine felt that “research” should be the focus of GIM.<sup>1</sup> By the late 1980s, SGIM was well established, and over time divisions were viewed as providing outstanding clinical care and education, and the expectations for “research” as the dominant mission of GIM were moderating. Finally, at the turn of the century, the diverse role of GIM faculty as educators, clinicians, and researchers was being recognized,<sup>2</sup> and academic medical centers’ promotion and tenure committees were beginning to broaden criteria beyond grants and publications to excellence in education and scholarly work. Along the way, national foundations (most notably the Robert Wood Johnson Foundation Clinical and Faculty Scholars Program), the Health Resources and Services Administration, and the Veteran’s Administration were staunch supporters of the mission of GIM in all domains: research, clinical

care, education, and leadership development.

The explosive growth in the number of hospital medicine faculty over the past 15 years has led to similar challenges for the development of academic hospital medicine. Unfortunately there has been less external support for developing hospitalist faculty skills to help meet academic medical centers’ missions as there was for GIM several decades ago. Thus the role of faculty development fell to the societies, and SGIM has made significant strides in meeting hospitalist faculty needs. In 2006, the SGIM Academic Hospitalist Task Force (AHTF) was formed as a joint SGIM/Association of Chiefs of General Internal Medicine (ACGIM) effort to assure that academic hospitalists had a “home” within SGIM.<sup>3</sup> The goal was to extend the resources and expertise of SGIM to support the new challenges faced by academic hospital medicine faculty. In 2009, the AHTF produced the Quality Portfolio as a tool to formally organize and document scholarly activities in quality improvement to support career development and promotion and led the first Update in Hospital Medicine at the SGIM annual meeting. A meeting in Michigan among SGIM, Association of Chiefs and Leaders in General Internal Medicine (ACLGIM), and Society of Hospital Medicine (SHM) leaders developed into a major collaborative effort between the organizations and led to the first Academic Hospi-

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talists Academy (AHA) in 2010. In conjunction with the Academy, the AHTF created the Mentorship to Product program. In that program, AHTF matches interested AHA alumnae with a mentor. One focus of the mentorship program is work on a specific project resulting in a presentation at an SGIM meeting and subsequent publication. The AHTF also conducted a survey of hospitalists to identify barriers to academic promotions and initiated SCHOLAR Project—SuCcessful HOspitaLists in Academics & Research—in collaboration with the academic and research task forces of SHM. The goal of the effort was to understand the elements required

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## Academic Hospitalists in the Community

Michael E. Lazarus, MD, and Magdalena E. Ptaszny, MD

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**W**hen the hospitalist movement began in the United States, programs differentiated themselves as either academic or community hospital based, but medicine's evolution into an era of high-value care has prompted a convergence of these two groups. In order to remain financially viable, cost effective, and patient centered, some academic medical centers have begun to diversify by developing innovative programs designed around managing population health in an integrated health system model.<sup>1</sup>

Historically, academic medical centers attracted a young cadre of energetic teachers who were comfortable in the resident and medical student milieu, having been recently trained in an environment where their role models were inpatient providers. These new faculty began to replace traditional generalist outpatient attendings who would devote a month or two of their time to the wards or sub-specialists who would keep up with their general medicine skills by periodically supervising house staff. In the community, the hospitalist model thrived based on the doctors' accessibility to nursing staff, patients, and their families. Furthermore, administrators promoted the community model, as hospitalists were able to improve throughput and champion newly required quality measures.

The University of California, Los Angeles, has been expanding its primary and secondary care networks within the Southern Californian communities it serves; this expansion, although challenging, has laid the foundation for a successful model of academic and community integration. Over the last several years, the department of internal medicine has grown its community outreach to in-

clude medical and sub-specialty offices and services to the north, south, and west of Los Angeles. In parallel to this health system expansion, our hospitalist section, in the division of general internal medicine, has increased its staff to 85 faculty members working in nine hospitals: three academic and six community based. We currently utilize the integrated group model as defined by the SGIM Academic Hospitalist Task Force.<sup>2</sup> This system requires that every faculty member be involved with house staff or medical student teaching activities as well as varied clinical responsibilities at a minimum of two facilities encompassing teaching and nonteaching activities. The staffing models within this system have become increasingly complex, and we rely on resilient and diverse faculty to help staff our distant sites.

With UCLA's rapid expansion and growth in regional presence, there was a definite advantage to acquiring existing community groups and appointing them within our hospitalist faculty model; however, this posed a challenge for both sides. Some new hires were not familiar with the academic way and felt less comfortable around residents and students. Similarly, in circumstances where we integrated graduating residents from our urban training program into a community setting, our younger faculty required stronger incentives to relocate and struggled with the mundane, less academic environment of the community.

As our hospitalists integrated into community settings, we discovered solutions to challenges and benefits to this integrative model. One solution was to combine more senior faculty who are settled and invested in the community with younger early-career hospitalists who are incen-

tivized financially and have a continued interest in academic medicine. The junior faculty members divide their time between the urban academic setting and the community model. A second successful initiative was to recruit a cadre of hospitalist-nephrologists. These highly trained individuals graduated from our fellowship programs and had a strong desire to stay in the region and continue as faculty when they completed training. Fortunately, there is a paucity of urban academic nephrology positions in our market, and we have been successful in creating a niche where these young faculty members are appointed in the department of medicine. They function primarily as hospitalists, develop a relationship in a given community hospital, remain involved in teaching and mentoring nephrology fellows, and slowly grow a referral base in the community setting. Some of these doctors successfully transition to their own outpatient-based hemodialysis practices within a few years or are laterally recruited back into nephrology, whereas others have developed this hybrid model as a career path. We have had similar success with infectious disease-trained physicians, palliative care, and even rheumatology hospitalists. These "double threats" have enabled us to broaden our clinical and teaching scope, provide a more comprehensive level of care, and share salary costs with different divisions.

Another byproduct of our integration is reduction of inpatient costs. At Ronald Reagan Medical Center, our flagship academic hospital and quaternary medical center, it is far more expensive to provide post-surgical care for a patient after a resource-intensive procedure, such

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## Perioperative Beta-blockade: Where do we stand?

Paul B. Cornia, MD, and Clifford D. Packer, MD

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The postoperative period is a hyperadrenergic state with associated increases in heart rate and blood pressure. Beta-blockers attenuate the effects of increased catecholamine levels. Early studies of perioperative beta-blockade using surrogate cardiovascular end points, such as ECG evidence of myocardial ischemia, yielded promising results. In the late 1990s, two influential trials studying perioperative beta-blockade were published. In the first, 200 patients with preexisting coronary artery disease (CAD) or multiple risk factors for it who were scheduled for noncardiac surgery were randomized to receive atenolol or placebo initiated immediately before surgery and continued in the postoperative period.<sup>1</sup> No difference in outcomes was demonstrated in the immediate postoperative period, but the atenolol group had reduced overall mortality and cardiac outcomes over the ensuing two years.<sup>1</sup> This study was criticized for concerns regarding inclusion of patients previously treated with beta-blockers and lack of intention-to-treat analysis. The second trial, the Dutch Echocardiographic Cardiac Risk Evaluation Applying Stress EKG (DECREASE) study, was a small unblinded study comparing perioperative treatment with bisoprolol to usual care in patients with a positive dobutamine stress echocardiogram undergoing major vascular surgery.<sup>2</sup> DECREASE reported a 90% relative risk reduction in the combined endpoint of postoperative cardiac death and nonfatal myocardial infarction (MI). The DECREASE study group published several additional influential perioperative beta-blocker trials; however, the DECREASE trials have been discredited due to major flaws, including the fabrication of data.<sup>3,5</sup> (In 2011, Don Poldermans, the lead au-

thor of the DECREASE trials, was relieved from his post at Erasmus University in the Netherlands for academic misconduct.)

A number of subsequent studies of perioperative beta-blockade in a variety of patient populations predominantly showed no benefit. The PeriOperative ISchemic Evaluation (POISE) trial, involving 8,000 patients from 190 hospitals in 23 countries, was published in 2008. Patients with CAD or with multiple risk factors for it and undergoing major noncardiac surgery were randomly assigned to receive placebo or high-dose oral and/or intravenous metoprolol succinate immediately before and continued after surgery.<sup>6</sup> The primary composite outcome of cardiovascular death, nonfatal MI, or nonfatal cardiac arrest was decreased by metoprolol succinate. However, this benefit was offset by an increased risk of stroke and all-cause mortality. Subsequent meta-analyses,<sup>7</sup> excluding the DECREASE trials and dominated by the POISE trial, have reported similar findings.

Most recently, a propensity-matched retrospective cohort study using the Veterans Health Administration databases was conducted.<sup>8</sup> Patients “exposed” to beta-blockers (i.e. received beta-blockers on postoperative day 0 or 1) after noncardiac nonvascular surgery were found to have reduced overall mortality and cardiac morbidity without an increased risk of stroke; for uncertain reasons, no difference was observed in vascular surgery patients. Most patients with beta-blocker “exposure” were receiving long-term beta-blocker therapy; however, similar outcomes were observed when the beta-blocker was initiated within 30 days of surgery. There were insufficient data to assess outcomes when

a beta-blocker was started within seven days of surgery.

### “Con” Opinion (Paul B. Cornia)

When I began practicing perioperative medicine 12 years ago, the use of perioperative beta-blockers for prophylactic purposes (i.e., started prior to surgery to reduce the risk of postoperative cardiac events, including death) was fairly common. Beta-blockers are well known to be beneficial in a variety of settings such as acute myocardial infarction and for the first few years after, heart failure with reduced left ventricular ejection fraction, and the treatment of angina. Additionally, beta-blockers have been in clinical use for several decades and are generally well tolerated by patients. The long positive track record of beta-blockers almost certainly aided in the rapid uptake of use in the perioperative setting. In retrospect, however, it remains surprising to me how quickly and widespread this practice became based on the two small studies in the late 1990s.

The recently released American College of Cardiology/American Heart Association Perioperative Guideline<sup>9</sup> contains several class IIb recommendations (i.e. benefit greater than or equal to risk) for prophylactic perioperative beta-blockade, including for patients with intermediate- or high-risk preoperative tests (e.g. cardiac stress tests) or those with at least three points using the Revised Cardiac Risk Index. However, others have argued strongly that prophylactic beta-blockade should not be recommended, and I agree with this.<sup>10</sup> Based on the results of the POISE trial, the practice guideline further stipulates that if a beta-blocker is started prior to surgery, it should be done more than one day before

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## Celebrating the Successes We Share

Karen R. Horowitz, MD

In 1996, the general internal medicine (GIM) family welcomed a new member: the hospitalist. Like many older siblings, GIM physicians in academic medicine were excited and scared. Who was this new creature in our midst? Would he/she be our friend? Would we share best practices, increase efficiencies, build collaborations, and improve patient care, thus strengthening the position of GIM in the academic medical center? Or would our new family member create competitions among us, rob us of our authority, and diminish our leadership in academic departments? How would this new model affect the physician-patient relationship? What about research dollars and reimbursements? Would our increased efficiencies be profitable for the whole enterprise, or would we witness the development of a two-class system within GIM?

In retrospect, these concerns seem far away. Our sibling has grown into a strong, independent, competent, respected member of the family. We are proud of the success of the hospitalists among us and grateful for the collaboration, leadership, and service they provide to our divisions. The hospitalist is a partner to those whose career focus is ambulatory care and an ally for the teaching and service functions of GIM divisions everywhere.

Academic medical centers and community hospitals have each adapted the hospitalist service

model to suit the needs of their individual institutions. The reach of the hospitalist has been broad, impacting initiatives that include quality improvement, patient safety, and health care system redesign as well as development of best practice models. The rapid adoption of this model of care has led in some instances to strong collaborations and in others to parallel systems of care with limited interactions.

Looking back to 1996, as clinician-educators in the faculty practice at University Hospitals of Cleveland, we all knew the first hospitalists in our program. Rick and Jeff were graduates of our residency program, and Teji was one of us (an experienced clinician-educator). In an era of handwritten medical records and dictated discharge summaries that took more than a week to be processed, we spoke almost daily. Handoffs were in person or over the telephone. Follow-up appointments were scheduled by the appointment clerk in our office and relayed to the patient on a handwritten slip of paper. With no electronic health record (EHR), text paging, or text messaging, we nonetheless stayed in touch with our patients and managed our referrals. We developed strong collaborations, mutual respect, and a sense of shared purpose with excellence in patient care at its core.

We now have 22 hospitalists at University Hospitals and another 16

at our VA. The EHR has allowed physicians in ambulatory practice unlimited access to the daily progress of our inpatients. We can view discharge notes and orders in real time and receive discharge summaries as soon as they are completed. Despite all this, personal communication between hospitalists and ambulatory clinicians is much less frequent than before. The rapid expansion of the hospitalist service at our institutions has been strained further by time constraints and administrative pressures. Perhaps it is a sign of the times, as we also tend to text more and talk less with our friends and family in this sped up world of the Internet.

Working on this issue of *Forum* has allowed me to reflect on how far we have come and how appreciative I am of the hospitalist partners who contribute much to the tripartite mission of research, education, and clinical excellence in our GIM divisions.

It is fitting that the 2015 SGIM Annual Meeting, titled "Generalists in Teams: Adding Value to Patient Care, Research, and Education," will focus on teamwork and collaborations. This is an ideal time to revisit our roles in GIM and dedicate our energy to maintaining the bonds that have made GIM strong.

This issue is in celebration of the success of the hospitalist movement and the multifaceted world of GIM. We appreciate the partnerships we share, our mutual dedication to excellence, and our innovative spirit. Together, our GIM family will continue to grow from strength to strength.

I would like to thank Associate Editor Michele Fang for leading this issue of *Forum*. Her insight and experience were invaluable assets, enabling us to represent the broad scope of issues faced by hospitalists today.

The hospitalist is a partner to those whose career focus is ambulatory care and an ally for the teaching and service functions of GIM divisions everywhere.

## Hospitalists and Quality Improvement: A Natural Pairing

Emily Fondahn, MD, and Rachel H. Bardowell, MD

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Physicians strive to improve the health of their patients every day; however, some of the changes needed for patients to achieve better health, as opposed to the traditional focus on the physician-patient dyad, involve changes in the physician-health care system relationship. Physicians must know how to navigate the system and have the ability to change the system to ultimately improve the care of their patients. Hospitalists naturally have a vested interest in changing the health care system to improve patient care, decrease medical errors, and improve working conditions. Clinicians interested in making the health care system more efficient and effective face many challenges including the severity and complexity of a patient's illness, the rapid pace of clinical care, and the multiple competing and interdependent systems of health care delivery in which they work.

Hospitalists provide a unique insight into hospital operations. They fulfill many roles within the system—from frontline worker to physician leader. In their day-to-day practice, they implement safety and quality processes such as handoffs, medication reconciliations, and infection control procedures. Part of the unique perspective hospitalists may provide comes from their ability to build collaborations that integrate the needs of frontline workers and senior administrators. Furthermore, when new quality improvement (QI) initiatives are proposed, hospitalists can provide immediate feedback on how such initiatives will affect the daily workflow of those directly delivering patient care. As a consequence of their unique perspective, hospitalists are enlisted to serve in leadership roles at many institutions. These leadership positions include oversight of QI or patient safety pro-

grams and service as physician champions for QI projects.

Hospitalists undoubtedly bring value through clinical work but can also add value through non-clinical activities like QI, patient safety, health information technology, committee service, and utilization review.<sup>1</sup> As health care systems focus on accountability for clinical outcomes, the hospitalist group will be expected to develop, implement, and sustain quality initiatives.<sup>2</sup> The Society of Hospital Medicine (SHM) lists “quality improvement” as a core hospitalist competency.<sup>3</sup> Basic QI skills include defining structure, process, and outcome measures; selecting stakeholders; describing the institution's organizational structure; and defining the QI methods and infrastructure used at the institution.<sup>4</sup> Examples of hospitalist-led initiatives that have been successful include improvements in transitions of care, glycemic control, and venous thromboembolism prevention.<sup>5</sup>

Physicians often face many barriers when initiating QI projects. Some practicing physicians may lack knowledge about quality improvement methodologies. Even if they see a system in need of change, they may not have the skills to execute a QI project effectively.<sup>6</sup> Conversely, other hospitalists may be suffering from “QI fatigue” since the same handful of physicians are constantly being asked to help on projects. Often, hospitalists receive no compensation or support for these projects. Moreover, if a hospitalist's primary compensation is based on clinical productivity, little incentive exists to participate in or lead a project especially if it takes time away from clinical responsibilities. These professional barriers can be compounded by systemic barriers such as a lack of efficient sys-

tems for data collection, absence of a cohesive supportive team, and poor alignment with institutional and departmental goals.

Many solutions are available to overcome these barriers. First, multiple training opportunities exist for QI. These include online courses (Institute for Healthcare Improvement (IHI) Open School, SHM Hospital Quality and Patient Safety), national conferences (SGIM Academic Hospitalist Academy), local training (Association of American Medical Colleges Teaching for Quality), longer training programs (Association of Clinical Leaders in General Internal Medicine LEAD, IHI Improvement Advisor Professional Development Program), patient safety and quality fellowships, and practice-improvement opportunities (American College of Physicians Quality Connect, American Board of Internal Medicine Performance Improvement Modules). Residency programs that offer hospitalist tracks strongly incorporate quality and safety into the curriculum as well. As QI is increasingly being taught in medical school and residency, an increasing number of physicians will be equipped with this knowledge from the start of their careers.

Just as having a strong inpatient team is critical to care for patients, having a strong knowledgeable team is critical for QI projects. A multidisciplinary team is better equipped to handle complex problems because team members understand the various stakeholders and workflow processes that contribute to a problem. Hospitalists can align with preformed teams to serve as subject matter or process experts. Before joining a project, the physician should know what the project requires from him/her, including the time commitment for meetings, data collection, continued on page 10

## An Interview with Jeffrey Wiese, MD

Amanda Clark, MD

*Dr. Clark is a member of the Forum editorial board and is an academic hospitalist at the Louis Stokes Cleveland VA Medical Center. She can be reached at amandavclark@gmail.com.*

**J**effrey Wiese, MD, MHM, FACP, is currently professor of medicine at Tulane University School of Medicine where he serves as director of the Internal Medicine Residency Program, senior associate dean for Graduate Medical Education, and chief of the Charity Hospital Medical Service. He is past president of the Society of Hospital Medicine (SHM) and currently serves as faculty for the Academic Hospitalist Academy (AHA).

### Where are you from? What was life like growing up?

Oklahoma. I love Oklahoma, and I love the work ethic of Oklahomans. I grew up on a farm squarely in the middle of nowhere. Life on a farm was tough. I suppose the biggest lesson I learned on a farm was to never ask the question, “Do I want to do this?” before doing a job. If the fence had to be fixed, you just did it because if you didn’t, you knew there was going to be even more work waiting for you on the other side. I see lots of parallels in clinical medicine.

### What brought you to New Orleans?

The somatic reason was to build a hospitalist program at Charity Hospital. At that time, there were very few organized hospitalist programs and even fewer at urban safety net hospitals, so it was a great opportunity. The visceral reason, though, was simply because I wanted to make a difference. And that’s what we did, and I think that’s what we still do here. It’s why I’m still here.

### Why did you choose medical education as a focus of your career?

Well, like so many of us, I went into medicine because I thought it was the best way for me to change the world for the better. But given the skills that I did have, medical educa-

tion seemed like a way I could make an exponential difference in the world. If I am coaching [residents] in the right way, then the lives of all successive patients for whom my students provide care are improved. That’s meaningful to me.

### Tell us about a career accomplishment that is important to you.

It’s funny, isn’t it? Every career accomplishment seems like the biggest thing ever until you accomplish it; then it starts to fade. Carse’s *Finite and Infinite Games* was a very meaningful, indeed, life-changing book for me. Most “career accomplishments” are the end product of the finite game—the “honors” grades, publications, grants, awards, RVU benchmarks, etc. There is certainly nothing wrong with winning finite games because in academic medicine, if you don’t, then you don’t get to keep playing. And I’ve won my share. But I think the important thing is to never let the finite games compromise the infinite game—the latter being the investments you make in people along the way since even after all of the finite games are done, it is the people who persist.

So what am I most proud of? It’s that so many people that I have coached have gone on to do such great things... doing not only well, but doing good, in this world. I think I am up to at least 15 past residents who are now clerkship directors or program directors, and I’m pretty excited about that. Hopefully I’ve inspired that same “measure of success” in them.

### What do you love about hospital medicine? What do you see as an academic hospitalist’s biggest challenges?

My favorite part is that it is about teams. The patient, the primary care

physician, the hospitalist, the nurse, the resident, the clerk, the janitor, and on and on. One big team, and I love that.

Hospital medicine has the potential to be exceptional for patient care. Hospitalists are not dual-tasked with trying to be in clinic and in the hospital at the same time, and that allows them to be more accessible to their patients. But for the model to work, the hospitalists do have to be there both physically and mentally. I worry that improperly designed hospitalist models, especially without good leadership, run the risk of devolving into ER shifts up on the wards. There has to be continuity of care both within the hospital stay and at the time of discharge, and neither is as easy as it seems. This is the reason why the work SGIM and SHM [Society of Hospital Medicine] are doing together—at the academic hospitalist academy and at the annual meetings—is so important.

### You said in your book *Teaching in the Hospital* that since hospital medicine has a demanding fast pace, to be an effective teacher requires planning. What tips can you offer for being successful as an inpatient teaching attending physician?

Too much to say with the time we have here. It’s all in the book, but here are a few tips. The biggest mistake I see new attendings make is not investing enough time up front in setting expectations for the team. If you do not have enough time to devote to expectations, you definitely do not have time to fix the mistakes that are about to happen on that team. Second, while you do have to see every patient every day, you do not have to see every patient *with the team* every day. I see a few patients in greater depth with

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## A Quick Overview of the SGIM Academic Hospitalists Task Force (AHTF)

Maria G Frank, MD, and William Southern, MD

*Drs. Frank and Southern are co-chairs of the SGIM Academic Hospitalists Task Force.*

**T**he SGIM Academic Hospitalist Task Force (AHTF) was created in 2006 as a joint effort between SGIM and the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) to establish a professional home for academic hospitalists within SGIM. The AHTF is dedicated to promoting scholarly activity and career development opportunities in education, research, patient care, and leadership in hospital medicine by providing the necessary tools for hospitalists to succeed in academia.

The AHTF is currently composed of 17 members. New members are always welcome. We are a group of academic hospitalists with varied interests and backgrounds—representing all SGIM regions—who share a passion for medical education, research, and leadership within the niche of hospital medicine. We conduct monthly conference calls during which we discuss ongoing projects and areas to be developed or improved in hospital medicine.

The task force has participated in many initiatives—some in coordination with other societies such as the Society of Hospital Medicine (SHM). Since 2009, the SGIM AHTF has proudly collaborated with SHM and ACLGIM in presenting the Annual Academic Hospitalist Academy (AHA). The goal of the AHA is to support the career development of junior academic hospitalists as educational leaders in their institutions; assist with the design, progress, and output

of scholarly work; enhance awareness of quality improvement (QI) and patient safety initiatives; and support academic promotion of attendees.

The SuCcesful Hospitalist in Academics and Research (SCHOLAR) project was initiated by the AHTF and was completed in collaboration with the Academic and Research Task Force of SHM. The goal of this project was to understand the elements required for successful academic hospital medicine programs. Successful programs were identified based on grant funding, research presentations at SHM or SGIM national meetings, and the proportion of faculty who had been promoted. Leaders of these programs were surveyed, and results were presented at the SGIM 37th Annual Meeting.

Other projects in different stages of development relevant to academic hospital medicine include the Housstaff Oversight Project, which seeks to examine ways in which hospital medicine programs are responding to new ACGME requirements for resident supervision, and the Jobs of Academic Hospitalists, Clinicians, and Teachers in University Programs (JACT-UP) project, which aims to clarify the roles of clinical and academic hospitalists and to understand similarities or differences between them.

We strive to provide academic hospitalists with resources relevant to their practice and professional growth. These resources are available on the AHTF website and in-

clude the Hospitalist Quality Portfolio (created by a group led by Benjamin Taylor, MD), which addresses a way to better document the work and accomplishments of hospitalists involved in QI; the Academic Hospitalists Promotion Survey, which reflects promotion data on academic hospitalists collected by a subgroup of the AHTF; Updates in Hospital Medicine slides since 2010; a guide to journal venues for clinician-educators and for safety and QI work; and a description of hospital medicine sessions at annual meetings.

Our future projects include subjects that are both familiar and challenging involving patient flow, patient satisfaction, hospital management, health care finance, defining core competencies for academic hospitalists, and work-life balance. We encourage passionate hospitalists to get involved and participate in the evolution and progress of our young specialty.

The future opportunities for academic hospitalists are numerous. Please join us at the 38th SGIM Annual Meeting in Toronto on April 23 at 8 am for the Academic Hospitalist Interest Group meeting, or participate in the American Board of Internal Medicine Medical Knowledge Module in Hospital Medicine on April 25 at 11 am. The annual meeting schedule is available at <http://connect.sgim.org/annualmeeting/programming/schedule>. You can follow the AHTF in GIM connect (Academic Hospitalists) where we will be posting a summary of hospital medicine sessions at the annual meeting. If you are a junior academician, consider joining the 2015 AHA. Furthermore, if you are interested in joining the AHTF, please visit the SGIM volunteer center for available task force volunteer opportunities or contact any of us through the SGIM website. We would love to hear from you!

The goal of the AHA is to support the career development of junior academic hospitalists as educational leaders in their institutions; assist with the design, progress, and output of scholarly work; enhance awareness of quality improvement (QI) and patient safety initiatives; and support academic promotion of attendees.

## NEW PERSPECTIVES

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and presentations. If a project does not align with personal and professional goals or if the time commitment is excessive, declining to participate is perfectly acceptable.

QI can be amazingly rewarding or intensely frustrating. If a change in the system leads to an improvement, thousands of patients can have better, safer care. But creating the institutional motivation and cultural change needed is difficult and time-consuming. At times a QI team may need a boost. Finding a patient story related to the QI project can remind the team members about the importance of their project. A brainstorming session for change ideas or a field trip to the inpatient ward can break up the typical meeting and create some excitement. Emphasizing improvement in a process measure or a successful plan-do-study-act cycle enables the team to focus on small wins and maintain motivation. Creating a timeline with

specific action items is useful to keep everyone on track.

Over the last decade, the hospitalist movement and the patient safety and quality movements have each grown tremendously. Hospitalists have demonstrated that they can effectively lead QI initiatives. Hospitals need to evaluate how they can incorporate hospitalists into safety and quality initiatives and ease barriers such as time and compensation for these activities. Hospitalists are natural partners for QI projects, and their involvement can result in greater professional satisfaction and safer, more effective care for patients.

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## IN CONVERSATION: PART II

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the team each day, reserving the remainder to be seen alone. I find great "intel" when I go around in the afternoon/evening and see patients on my own. I can talk to the nurses and patients about how the residency team is providing care, and that's pretty insightful. Third, I lab-spy. Spying on the EMR [electronic medical record] allows me to learn about them ahead of time, which in turn allows me to time-manage my rounds, spend more time on rounds coaching the residents, and assess where they are on their milestones. And it allows me to quickly read up on something in the morning and then drop the line on rounds, "Well, I don't know much about sarcoid, but here's what I remember" followed, of course, by a full discourse on sarcoid. And when the team says, "Wow, how did you know that?" I can say, "Well, because I'm a doctor."

### What piece of advice regarding leadership do you wish you had known 15 years ago?

Well, probably all of it. It's been a school of hard knocks in learning those lessons. I've made a ton of mistakes along the way. But if I had to choose a few:

1. Leadership is the art of persuasion, not debate. The only person to change a person's mind is that person. But because the same minds that created the problem cannot be the ones to change it—if you want to lead change—leadership becomes the art of getting people to change their minds, and that takes patience.
2. The art of leadership is not just knowing how but the knack for knowing when. There is a right time for everything. The best idea at the wrong time is destined to fail.
3. You have to find your sincerity, whatever that might be. Caryle spoke to it in *Of Heroes and Great Men (sic)* ... great leadership begins by cultivating sincerity in everything you do. People will follow the sincere leader because they know where to find her. The lack of sincerity is the reason, if you ask me, that you see so many leaders fail these days.
4. Great institutions are comprised of people, not name brands or bricks and mortar. I love Covey's "emotional bank account" metaphor. The more you genuinely invest in the people on your team, the more loyal they will be to the team. Once you've build that, then bring us what you got—Katrina or otherwise. The team will overcome it.

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## EDUCATORS' CORNER

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equal service model facilitates throughput from the emergency department (ED), which can improve patient satisfaction, and reduces disagreements about patient service assignment from the ED. In this model, patients and faculty are less likely to perceive two care standards, and admitting faculty are less likely to adopt service preferences that could further complicate patient flow.

Nonteaching services that care for specific patient populations (e.g. low-risk chest pain or observation units) are important to hospitals and are also valuable partners to a residency program. Nonteaching services in this model facilitate patient flow from the ED to the wards; promote efficient management of routine clinical conditions; and have the potential to increase patient satisfaction, improve clinical outcomes, and decrease costs. Cases of particular educational value can still be admitted to the teaching service so that trainees have opportunities to see rare diseases and interesting presentations of common diseases.

Hospitalists commonly serve as teachers for residents<sup>6</sup> and are highly rated for teaching by residents.<sup>7</sup> Hospitalists are also ideal faculty to staff nonteaching services in teaching hospitals. Common staffing models include hospitalists delivering care directly or doing so in conjunction with mid-level providers such as physician assistants or nurse practitioners. Training of mid-levels must keep pace with any expansion of a nonteaching service. No matter what the model, clearly defined expectations and support from department of medicine leaders are key to the success of hospitalist services.

Many hospital medicine groups require a faculty member to spend time working on both the teaching and nonteaching services. Some hospitalists prefer to work exclusively on either a nonteaching or teaching service, although many hospital medicine group directors find it difficult or impractical to maintain separate faculty cohorts. Hospitalists who were hired before

the start of a nonteaching service may be dissatisfied with working on that service, feeling that it "isn't what they signed up for." The first-hand knowledge of hospital care delivery systems gained from working on a nonteaching service can improve hospitalists' ability to supervise and evaluate residents on the teaching service. Having recent graduates work first on a nonteaching service can give them time to adjust to the clinical and administrative responsibilities of being an attending physician before they take on teaching duties. The continued participation of faculty on the teaching service must be approved by the residency program director and based on evaluation data.<sup>8</sup>

If the admitting capacity or the coverage footprint of a nonteaching service is decreased, patient volume on the teaching service may rise, upset the balance between service and education, and jeopardize patient safety. Interruptions in the functioning of a nonteaching service during busy admitting hours is a source of resident dissatisfaction—an unfortunately ironic situation as nonteaching services are often in place to protect residents. If hospitalists working on the teaching service are required to simultaneously cover nonteaching duties, this will impair their ability to teach and supervise residents and medical students. The negative impact of staffing shortages will be more pronounced on off hours when coverage is often thinner to start with.

Hospitalists who are trained to perform—and bill for—procedures are an increasingly common solution, with 33% of adult hospital medicine groups reporting that they routinely provide procedural service.<sup>1</sup>

In conclusion, with thoughtful design and appropriate support, nonteaching services staffed by hospitalists can help achieve institutional and residency program goals. The value nonteaching services can add to education and patient care will be best realized through an on-

going partnership between hospital leadership, hospital medicine division chiefs, and residency program directors.

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## IN CONVERSATION: PART I

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**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 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 domi-

nant 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 hos-

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## PRESIDENT'S COLUMN

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for successful academic hospitalist programs. Over the past several years, the SGIM annual meeting committees created submission tracks on hospital medicine as a specific venue to present scholarly work.

The original SGIM founders realized generalist leadership was critical to establishing academic GIM, and the long-term success of hospitalists at academic institutions has required that they have leadership roles both locally and nationally. Early on, SGIM assured that hospitalist leaders were represented on SGIM Council and the ACLGIM executive committee. At academic medical centers, hospitalist leadership career paths have become more diverse. The role of chief medical officer and hospital CEO are potential career goals in addition to the traditional leadership roles in departments of medicine and the dean's office. The ACLGIM LEAD program supports the development of general internal medicine leaders and is another opportunity for academic hospitalists to develop leadership skills critical to their career success.

So what should SGIM do next in supporting academic hospitalist careers? Clearly supporting scholarly work and career advancement of hospitalist and outpatient clinician-educators is a fundamental goal of SGIM. To take advantage of the broad SGIM membership, where can hospitalists and outpatient generalists intersect and synergize academically? The techniques of measuring and improving quality of care and patient safety, so long a major focus for hospitalists, are now increasingly needed by outpatient generalists. Safe care transition is another developing partnership, as is the physician role within inter-professional teams managing complex populations. As more challenges evolve, SGIM will continue to develop mechanisms to support faculty

hospitalist career advancement because, as Yogi Berra was purported to say, "It's like *déjà vu* all over again."

*Acknowledgement:* Thank you to Kay Ovington for the SGIM timeline.

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## University of Cincinnati College of Medicine General Internal Medicine Opportunities as Academic Hospitalist

The Section of Hospital Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking Board Eligible Internists to join our faculty as academic hospitalists. Hospitalist faculty are members of the Division of General Internal Medicine, **which performs the bulk of resident and student teaching for the Department of Medicine.**

### Responsibilities include:

- Providing patient care in several settings, including attending on traditional resident-led ward teams, attending on the resident-led medical consultation service, and leading a hospitalist team including an intern;
- Teaching in our Internal Medicine Residency program which has been granted status as an ACGME Educational Innovations Program; and
- Teaching medical students on clinical rotations.

### Academic opportunities include:

- Direct teaching of medical students in all four years of our new clinical curriculum;
- Collaboration with researchers in our Center for Clinical Effectiveness and Center for Health Informatics; and
- Participation in Hospital quality improvement activities.

Opportunities also exist for training in Improvement Sciences and traineeships with mentored research experiences in Outcomes and Clinical Effectiveness leading to a Master's degree in Clinical and Translational Research.

Our hospitalists **are leaders in improving both patient care and clinical processes** at the University of Cincinnati Medical Center and have a **passion for teaching and improving patient care.**

Salaries are competitive, with opportunities for increases based on productivity.

If you are interested in joining the University of Cincinnati in Hospital Medicine, applicants should contact either: Mark Eckman, Director, Division of General Internal Medicine, via email at Mark.Eckman@uc.edu or Kevin Dell, Director, Hospital Medicine, via email at Kevin.Dell@uc.edu. We are recruiting for immediate availability.

*The University of Cincinnati is an affirmative action/equal opportunity employer.*

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## POINT/COUNTERPOINT

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surgery (class IIb recommendation) and not on the day of surgery (class III recommendations [harm]).

Given the problems with the DECREASE trials, these results should be excluded from clinical decision making. Presently, the best available randomized controlled trial (RCT) data (i.e. POISE) show increased mortality and stroke with prophylactic perioperative beta-blockade. As part of the recently released ACC/AHA clinical practice guidelines, an independent scientific review of perioperative beta-blocker RCT data was conducted. Among the RCTs included, non-fatal MI was reduced; however, stroke and overall mortality were increased. Importantly, the results were qualitatively unchanged even when the POISE trial was excluded. All trials (excluding DECREASE) initiated beta-blockade at least one day prior to surgery.

So where do we stand? It is critical to bear in mind the context of this

discussion—that is, perioperative therapy (beta-blockade) purely for *prophylactic* purposes. It is essential that the benefit of a prophylactic treatment clearly outweighs the risk. The available evidence shows real harm (i.e. increased overall mortality and stroke) when beta-blockers are started at least one day prior to surgery. Concerns about the dosing regimen used in the POISE trial (i.e. high dose and started immediately prior to surgery) have led many to question the results. I agree with the conclusion of the ACC scientific review that “multicenter RCTs are needed to address this knowledge gap.” Until we have data that confirm that an alternative regimen of prophylactic perioperative beta-blockade started prior to surgery (e.g. started days to weeks prior to surgery, possibly with dose titration) is both safe and effective, I do not believe that it should be recommended.

### “Pro Opinion” (Clifford D. Packer)

There is ample evidence that perioperative beta-blockers reduce rates of MI and cardiac mortality in high-risk patients. The physiologic plausibility of the benefit is clear—beta-blockers reduce catecholamine levels, heart rate, and myocardial oxygen demand and have been shown to reduce rates of troponin leak and ECG evidence of ischemia in the perioperative period.<sup>11</sup> Most of the perioperative beta-blocker trials, including POISE, have shown substantial reductions in both fatal MI and non-fatal cardiac complications. There are two major quandaries, however, that have led to uncertainty about the utility of perioperative beta-blockers: the Poldermans scandal and the findings of increased stroke risk and increased overall mortality in the POISE trial.

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## SIGN OF THE TIMES

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as a liver transplant, than it is at a community hospital. Many of these patients require prolonged inpatient care for hemodialysis, aggressive rehabilitation, and postoperative recovery monitoring. In an integrated model, care can easily be transitioned from faculty at the quaternary center to those in the community setting closer to the patient's home. Furthermore, it allows for the integration of technology, like telemedicine and team-developed care protocols, to improve the quality of care in the community. UCLA is actively exploring such cost-saving initiatives in which our community faculty partner with their colleagues in the academic medical center to keep post-transplant patients in a more sustainable setting while monitoring anti-rejection status, progress of recovery, and resolution of deconditioning. These initiatives lead to lower-price and higher-value care than can be

achieved in the academic medical center and improve the overall care delivered to our patients.

Integrated health systems and population-based health management are crucial for the future success of academic medical centers. Institutions accustomed to conducting research, identifying new treatment strategies, providing tertiary and quaternary care, serving as referral centers for community hospitals, and training future physicians must now begin to evolve. Academia is facing a future concerned with reducing costs and finding ways to be more productive while still remaining true to the academic mission. Traditional revenue streams from grant funding are becoming scarce, and while philanthropy is now playing an ever-increasing role in filling this void, clinical revenue is by far the most reliable source of income for academic centers, especially when favorable contracts can be negotiated with third-party payers. Integrating

academic centers with community hospitals allows academia to benefit from the throughput, infrastructure, and quality measures championed in the community. Community hospitals benefit from the ease of tertiary referral services as well as the higher-caliber staffing provided by the academic health care system. Increased experience in this model of care is an investment that is worth making.

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## POINT/COUNTERPOINT

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POISE is by far the largest prospective beta-blocker trial, and therefore it profoundly affects the meta-analysis results described above. Unfortunately, POISE is a seriously flawed study. In an elderly cohort of patients (average age 69), 100 mg extended-release metoprolol was given two to four hours before surgery, with no titration period. Subjects were then given an additional 100 mg in the first six hours after surgery if their heart rate was greater than 80 and systolic blood pressure greater than 100; then an additional 200 mg was given 12 hours after the first postoperative dose, followed by 200 mg daily. Many patients, therefore, received 200 to 400 mg of extended-release metoprolol in the first 24 hours. Not surprisingly, substantially more patients in the treatment group had hypotension, bradycardia, and ischemic stroke than in the placebo group. "Our post-hoc analysis," the authors concluded, "suggests that clinically significant hypotension, bradycardia, and stroke explain how B-blockers increased the risk of death in this trial." This is true as far as it goes; what the POISE trial proved is that excessive doses of perioperative beta-blockers given without a titration period can lead to bad outcomes. This is a classic overtreatment effect. We know that bradycardia and hypotension are bad in the perioperative period. The question is, "Would a prospective trial with low initial dosing and careful dose titration over more than one week (so that bradycardia and hypotension were avoided or minimized) reduce both cardiac and overall mortality?"

Based on all available evidence, I think the answer is likely to be yes, at least for high-risk patients with revised cardiac risk index (RCRI) scores of two or more. Two large well-constructed retrospective studies by Lindenauer et al.<sup>12</sup> and London et al.<sup>8</sup> show remarkably similar overall mortality benefits for patients with risk scores of two or more, with the benefit increasing as the RCRI score rises, which supports the concept of a strong protective

physiologic effect. London et al. also showed that long-term beta-blocker use was associated with lower rates of adverse outcomes than with initiation of treatment within a week or less, supporting the importance of a titration effect.

Beware of pendulum swings in medicine. Sometimes we abandon useful treatments too quickly on the basis of flawed or limited evidence. I conclude, POISE and Poldermans notwithstanding, that the preponderance of the evidence still supports the careful use of perioperative beta-blockers for high-risk patients. A well-designed prospective trial, with low starting doses and a sufficient titration period, would hopefully settle the question.

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## IN CONVERSATION: PART I

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pitalists 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

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