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From the editor

Hospitalists – too much baggage to travel?

Leaders historically are clearly recognisable from afar – dominating and towering above their fellows, even if of diminutive (Bonopartean) dimensions. In medicine, leaders of that stature are rare and those examples that one is tempted to cite are more likely to be memorable for pioneering achievements and innovating in the face or apathy or disbelief – vaccination, chloroform and antisepsis, for example – rather than for leadership in the sense of bringing teams together around them and providing direction, motivation and vision. On the other hand, in the context of everyday medicine – whether it be hospital, a multipartnership general practice or a postgraduate deanery – the latter type of leadership is both widely in evidence in some cases and in other instances sadly lacking.

Can that sort of leadership be taught or is it innate? Or do leaders arise when surrounding circumstances demand it? At least two contemporary issues in British medicine pose this question. The first is the call for clinical leadership in the commissioning process – and on that the jury is still out, particularly if the blue skies first perceived by enthusiasts for GP commissioning seem to be becoming somewhat clouded. The second is the debate on the relative role of the generalist and the specialist in hospitals – who leads in the management of inpatient care? The latter is the subject of Kirthi *et al*'s article in the current issue of *Clinical Medicine* and it draws out a number of themes.[1]

They highlight the important issue of ensuring optimum care for the acutely ill, frail and elderly patient (constituting the majority of emergency patients in UK hospitals) and emphasise the need for a cadre of trained and focused physicians to take a clear overview, provide leadership and carry responsibility for the inpatient care of this group. While they pose the question in the context of the frail, elderly patient with comorbidities, the question is similarly relevant to all emergency patients.

Kirthi *et al* champion the potential candidature of both geriatricians and general physicians (the vast majority of the latter also having a subspecialty interest) for this role. They also point to the practice of the US hospitalist – the fastest growing specialist role in the USA – as an exemplar that could possibly be developed. The term hospitalist was coined in 1996 by Wachter and Goldman.[2] Perhaps it is worth briefly reviewing the genesis and role of this specialty – even today the US internet is densely populated by questions from patients and others saying 'what is a hospitalist?'.

Historically, the rise of the hospitalist mirrored the decline of the involvement of US private practitioners in personally looking after patients when they were admitted to hospital. It became an economic necessity for many hospitals to employ a generalist to ensure the flow of patients from private doctors into their wards. Some of the advantages for institutions and patients of having a physician based full-time in hospital (pursuing the specialty of 'hospital medicine') appear to be have been recognised surprisingly recently, and some of the arguments that hospitalists can drive up standards of care seem to refer to improvement from a rather low base. 'A primary care doctor might be annoyed if she finds during her rounds that two patients…hadn't gotten out of bed...a hospitalist who finds the same conditions with seven patients will do something about it.'[3] It is important to remember that the specialty developed in a healthcare system very different from the NHS, and even now its roots protrude in a dictionary definition formulated in 2002 and repeated in 2012: 'hospitalist – a physician specialised in inpatient medicine, who acts as a patient's primary doctor while the patient is hospitalised, ensuring that tests are evaluated in a more timely manner than possible for private physicians. Pros, increased efficiency in patient management, decreased hospital stay; cons, decreased personalised physician-patient contact.'[4]

Reviews of the opinions of US hospitalists themselves on their posts also make interesting reading and suggest that despite the apparent autonomy and centrality to patient care, and presumably therefore satisfaction that the role implies, there remain areas of dissatisfaction. Perhaps unsurprisingly, career dissatisfaction professionally was highest amongst hospitalists in the north-east of the USA – eg Boston, New York, Philadelphia – and was thought to reflect the number of academic centres in the region. As one hospital medical director surmised: 'through teaching and fellowship programs, physicians [hospitalists] in this region are exposed to other specialties; they see the opportunities in those specialties, whether those are reimbursement, lifestyle or prestige. That might make physicians consider whether hospital medicine is the best career for them.'[5] Thus it seems that in at least some institutions the hospitalists, who have made pure generalism their creed, make unfavourable self-comparisons with more specialised physicians.

It is surprising to appreciate the rapid growth of this specialty in the USA – more so to note the very recent date of the definition by hospitalists themselves of what they are about –'hospital

medicine – a medical specialty dedicated to the delivery of comprehensive medical care to hospitalised patients.'[6] If in the USA, to paraphrase Larkin, 'hospital medicine began, in nineteen ninety six', how much does the NHS really have to gain from adoption of nomenclature and a system introduced to deal with such different problems in such a different health care system?

References

1 Kirthi V, Temple RM, Patterson LJ. Inpatient care: should the general physician now take charge? *Clin Med* 2012;12:316–19.
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5 Doyle E. How does your region stack up? 2012. http://todayshospitalist.com/index.php?b=articles_read&cnt=1471 [Accessed 25 May 2012].
6 Definition of a hospitalist and hospital medicine, 2009. www.hospitalmedicine.org/AM/Template.cfm?Section=Hospitalist_Definition&Template=/CM/HTMLDisplay.cfm&ContentID=24835 [Accessed 25 May 2012].

In the next issue of *Clinical Medicine* and thereafter, we plan to publish a noteworthy clinical image as a free-standing contribution. Readers are encouraged to submit images for this regular feature – as a high-res, 8-bit, RGB/CMYK or grayscale tif, jpg or pdf – together with 60 words or less of explanatory text.

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