

# INTRODUCTION TO CLINICAL CARE CONUNDRUMS IN HOSPITAL MEDICINE

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One of the challenges of a generalist field—one that cannot define itself by its expertise in managing the derangements of an organ (as with cardiology) or by its skills in performing a procedure (as with surgery)—is to develop a core curriculum and a *raison d'être*. From the time that Lee Goldman and I coined the term *hospitalist* in 1996,<sup>1</sup> hospitalists began to struggle with this existential question. What was their field about, and what justified its existence?

This struggle abated in 1999–2001, with the publication of two seminal reports on patient safety and healthcare quality by the Institute of Medicine.<sup>2,3</sup> Soon, the hospitalist field had put its collective nickel down: while hospitalists would be excellent doctors in the traditional, Marcus Welbian sense of the word, our unique niche would be as system leaders, helping to build systems to ensure the highest quality, safest care for hospitalized patients.

This focus—which was codified in the publication of the Society of Hospital Medicine's Core Curriculum in 2006<sup>4</sup>—has unquestionably helped the field establish credibility within the House of Medicine and with a variety of important stakeholders, such as legislators, the media, regulators, accreditors, and, most importantly, patients and their advocates. Also, as the overall pressure to improve quality, safety, and value has increased, many hospitals, training programs, and national and international organizations have turned to hospitalists to “see how it is done.” This is all for the good—for both patients and for our rapidly growing field.

But, just as we now understand that certain safety fixes can have unanticipated consequences, so too can a narrow focus on systems improvement. I think we have begun to see these consequences play out over the past few years, both as they pertain to our entire system of care and more specifically to the core work of hospitalists.

In 2010, I wrote an article entitled *Why Diagnostic Errors Don't Get Any Respect ... and What can be Done About Them*,<sup>5</sup> in which I argued that the focus on systems thinking to address safety targets such as medication errors and falls was terrific, but the crucial matter of diagnostic errors had been strangely omitted from the safety agenda. This “diagnostic errors exceptionalism” began at the beginning, with the IOM report, *To Err is Human*.<sup>2</sup> In that report, the term *medication error* is mentioned 70 times, while the term *diagnostic error* is mentioned fewer than 5 times.

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However, diagnostic errors make up nearly one in five preventable adverse events in the famous Harvard Medical Practice Study<sup>6</sup> and they are far more common than medication errors in studies of closed malpractice claims.<sup>7</sup>

It is easy to see why diagnostic errors have been overlooked in the safety field: they are hard to measure and fix. But by ignoring them, we risk a self-fulfilling prophecy, one in which we get better in developing process changes, information technology, and checklists that address system errors, while neglecting interventions and research that could ultimately improve diagnostic accuracy.

Luckily, diagnostic errors have recently started to receive the attention they deserve, from academic experts, accrediting boards, and researchers.<sup>8–10</sup> Also, some promising solutions are beginning to emerge, both in the form of new ways of thinking (such as metacognition and cognitive de-biasing)<sup>11</sup> and in new models of computerized decision support.<sup>12</sup> But even with these methods, I believe that the time-honored tradition of having clinicians learn from tough cases remains central to our efforts to improve diagnostic reasoning.

This brings me to the more specific issue for hospitalists. While the American hospitalist model has taken on unique aspects, the US hospitalist in some regards resembles the Canadian or British internist—a hospital-based highly trained physician who specializes in managing the really knotty cases that have stumped everyone else. In America, we know what such a doctor looks like: Dr. Gregory House (hopefully without the arrogance, inappropriateness, and substance abuse). Andrew Holtz, in his 2006 book, “The Medical Science of House,” recognized this.<sup>13</sup> “Although Dr. House is called a ‘diagnostician,’ he is really a hospitalist,” wrote Holtz. While we have focused on the hospitalist as systems improver, the need for a “go-to” diagnostician remains, and hospitalists have assumed this role in many of their institutions, not just on television.

Perhaps in the distant future, a computer—maybe a version of IBM’s Jeopardy-beating computer Watson—will obviate the need for a really smart physician, willing and able to gather all the relevant facts and armed with the experience and training required to convert these facts into a differential diagnosis, a diagnostic plan, and ultimately the right diagnosis. But today, we depend on physicians to serve in this role. To excel as a diagnostician, we know that clinicians need to constantly mine both their own cases as well as the cases of others for lessons. It would be best if these learning cases were carefully selected for their lessons, and if one could follow the thinking of a master clinician as he or she worked through their cognitive twists and turns.

All of which is to say that the lessons contained in this book are crucial for hospitalists if we are going to fulfill our dual missions of being system improvers and superb diagnosticians. I suspect you will read it, then return to it over and over through the years for wisdom and inspiration.

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