Most primary care physicians will tell you it’s getting harder to maintain a traditional medical practice with a foot in both the outpatient and inpatient realms. Caseload demands, inadequate reimbursement, and other professional and medical pressures are forcing primary care physicians to choose one setting or the other.

For those interested in exploring the field of hospital medicine, a unique, three-day, hands-on training course at the University of California San Francisco (UCSF) Medical Center offered an opportunity to address some of the gaps in their inpatient clinical knowledge and skills, which either were not sufficiently covered in residency training or have atrophied from lack of practice.

The hospitalist “mini-college” allowed working hospitalists and prospective hospitalists to practice short neurological exams on real patients, use ultrasound to guide needle placements, interpret radiologic evidence, engage in diagnostic...
reasoning exercises, and even conduct online medical information searches, all under the watchful eyes of UCSF faculty. The course was limited to 27 participants to maximize small group interactions. It emphasized clinical practice needs identified in surveys of hospitalists and assessments by the faculty, led by Robert M. Wachter, MD, professor and chief of the division of hospital medicine at UCSF, a former SHM president, and author of the blog “Wachter’s World” (www.wachtersworld.com).

Participants in this intensive course were a mix of working hospitalists in stable positions seeking to enhance their clinical practice, and physicians in various stages of transition—in or out of hospitalist positions. More than half of the participants are in their first hospitalist job and have worked in the field for less than two years, according to attendee surveys. Two-thirds say they are pretty satisfied and 24% say they are very satisfied with their work, according to the survey. Most say they love the clinical aspects best, but others express frustrations with caseload pressures and ownership changes at their practices.

“For me, being a doctor always meant being a primary care doctor, and I find great joy working in both the inpatient and outpatient settings. But primary care is becoming a losing proposition,” says Ronald Distajo, MD, who has maintained a primary clinic practice for Cambridge Health Alliance in Cambridge, Mass., for the past three years—all the while moonlighting as a hospitalist for the health system.

With student loans, long hours, and relatively low pay in the outpatient setting, Dr. Distajo plans to find full-time work as a hospitalist. At the mini-college, he received a phone call informing him the outpatient clinic he practices in will close by the end of the year. The UCSF course seemed like a timely opportunity to bolster his inpatient management skills in areas he believes he could benefit from a refresher. “They’ve done a good job of picking all of them,” Dr. Distajo says.

Another mini-college participant in transition, Madeleine Martindale, MD, was looking to hear what “hospitalists in other places are doing, to confirm and validate my own experience.” Dr. Martindale recently left a hospitalist position in Anchorage, Alaska, in part because of high caseloads. “A lot of the topics presented here will help me. I also wanted to learn more about the range of responsibilities expected in hospital medicine.”

With few work settings for hospitalists in Alaska, Dr. Martindale is planning to become a traveling hospitalist in the lower 48 states next year. She is hoping to devote part of the year to practicing medicine in a high-altitude clinic, as she prepares to staff a clinic in Nepal operated by the Himalayan Rescue Association. She also plans to serve as the support physician—stationed mainly at base camp—for a two-month Mount Everest climb.

“There are a lot of hospitalist services and places to practice, if I’m willing to leave Alaska,” she says. “I feel inspired to hear hospitalists who love their jobs and are interested in quality of care and safety.”

Student and Staff Member

Mini-college participants were issued temporary visitor privileges at UCSF, name badges and lab coats. “So much of our planning for this experience was about getting [participants] into the hospital, and to offer [them] a set of knowledge and skills that may be new or taught in a new way; which [they] can apply in [their own] hospitals,” says Arpana R. Vidyarthi, MD, a hospitalist at UCSF and mini-college co-chair.

The first session, hosted by Gurpreet Dhaliwal, MD, assistant professor of medicine, nocturnist, and recipient of a distinguished teaching award at UCSF, led participants through an exercise in clinical reasoning, using a challenging case to exercise diagnostic skills. “When you leave medical training, the assumption is that you’re done, and you will get better and better on the job somehow through experience,” Dr. Dhaliwal explained. However, there is little in the literature addressing how doctors actually get better and what...
separates those who continue to improve from those who plateau in their careers.

“Have you ever thought about what you do to put yourself in the upper 10% of diagnosticians? We know from other fields that innate smartness rarely counts the most, and that expertise is not something that necessarily comes with experience.”

Dr. Dhaliwal recommends a program of “progressive reinvestment” in diagnostics—a deliberate practice of challenging mental processes and learning something new from every case. He also suggests regularly seeking feedback from peers, tracking down what happened to patients treated and comparing treatment plans with the discharge diagnosis matched the hospitalist’s initial assessment, and even practicing diagnostic skills with sample cases like the New England Journal of Medicine’s “Case Records of the Massachusetts General Hospital.”

Participants broke into small groups to visit hospital wards with UCSF neurologists and intensivists, discuss actual cases and practice their examination skills at the bedside. H. Quinny Cheng, MD, a hospitalist and director of the UCSF’s medical consultation and neurosurgery co-management services, walked them through current research and controversies in the pre-operative evaluation and management of surgical patients, including recent data on the use of anti-coagulants, beta blockers, deep vein thrombosis prophylaxis, and drug-eluting coronary artery stents. UCSF respiratory therapist Brian Daniel, RRT, reviewed recent advances in ventilator equipment, including the high-flow nasal cannula.

S. Andrew Josephson, MD, a neurologist and director of the neuro-hospitalist program at UCSF, says hospitalists gener-
SAN FRANCISCO SOUVENIRS

Participants in the UCSF mini-college received hands-on training and nuggets of new information. Here are some snippets of what they took home from the three-day course:

The clinical reasoning session with Dr. Dhalwal was exceptional and very unique. To spend time with someone like that makes for a special experience. The preoperative evaluation review of where the evidence hands with practice and decision moments we often see in the hospital was also helpful. From a career standpoint, the knowledge covered here is very applicable and very high yield. —Kevin Leary, MD, internal medicine faculty, Walter Reed Army Medical Center, Washington, D.C.

The hands-on experience. Best was the neurology—how you do a quick neurologic exam on a hospitalized patient? The procedures workshop was also invaluable. Vascular access is the procedure I do most often, and if my hospital provides the ultrasound monitor, I’ll start using it. I thought this course would be a great refresher for me, four years out of residency. It was not only a refresher, it’s an inspiration. We all want to be the best at what we do. —Leslie Copeland, MD, hospitalist, St. Tammany Parish Hospital, Covington, La.

I thought the ultrasound laboratory was a lot of fun, which I’ll bring back to my institution. I’m sort of old school in how I place my lines, but we do have two ultrasound machines in the hospital, one on the units and one in the emergency department where they’re most likely to be used. It takes a little more preparation and time to use ultrasound, but it clearly benefits the patient. —Marcus Zachary, MD, group leader, Cogent Healthcare of California, St. Francis Memorial Hospital, San Francisco

I liked best were the small sessions. They were really informative. Also, the pearls, such as neurological physical exams that don’t take 30 minutes, and the signs of upper motor neuron disease. We often get calls from the emergency department for patients who are reporting weakness, asking if they should be admitted. You are trained to deal with that, but this was about how to do it in the real world. —Reina Rodriguez, MD, hospitalist, Summit Medical Center, Oakland, Calif.

At my hospital, we don’t have intensivists. So there’s not a lot of structure for critical care. I was interested in seeing the studies about sepsis and the emphasis on washing teeth twice a day in the ICU. I was also interested in the discussion about how not to just plateau in your career. I’ve never been average my whole life. I don’t want to be an average physician, and that’s why I came to this course. —Moira Ogden, MD, hospitalist, Terrebonne General Medical Center, Houma, La.

I think the course was fantastic. The ultrasound labs were phenomenal. I learned a lot of new things. I thought the course covered a whole lot of material. —Leslie Copeland, MD, hospitalist, St. Tammany Parish Hospital, Covington, La.

What it’s all about, you can learn to do it with a bit of practice.” Attendee Moira Ogden, MD, hospitalist at Terrebonne General Medical Center in Houma, La., is interested in bringing ultrasound-guided procedures into her practice, although she fears access to the equipment may not be easy to obtain. “I want to start using them; I just need to know the cost,” she says.

Mini-college Motives

“We’ve been at it for a year with our new hospitalist program,” Dr. Ogden said. “There’s such a difference between academic medicine and practice in the hospital. It’s very busy, although we’ve really just scratched the surface. It’s hard to keep up with the literature, and when I saw the flyer for this course, it looked so in-depth—almost like a re-introduction to hospital medicine.”

“Part of it was just plain curiosity—what is this going to be about? What do they see as blind spots for hospitalists in their day-to-day jobs?” asks Dr. Zachary, a six-year hospitalist, discussing his interest in attending the UCSF mini-college. “For the most part, my sense of the gaps has been dead-on.”

Kevin Leary, MD, internal medicine faculty at Walter Reed Army Medical Center in Washington, D.C., is not a hospitalist, although his position with the teaching service is similar in many ways. “My goal in coming here is to learn more about the field of hospital medicine and to meet physicians who are hospitalists,” Dr. Leary explains. “When I leave my role in the military service, I would get a lot of job satisfaction out of becoming a hospitalist.”

Charles Oppong, MD, a native of Ghana who now lives in Los Angeles with his wife and infant daughter, is waiting for his application for a California medical license to be processed and currently works part-time as a hospitalist in Circleville, Ohio, and in LaCrosse, Wis. “Personally, I enjoy caring for patients in the inpatient setting. I like the challenges of keeping my medical skills current,” he says. “I

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heard about UCSF and its famous hospitalist program, and when they sent me a flyer, I saw all of these topics to improve my inpatient management skills.”

Organizers of the mini-college are attempting to give participants an opportunity to re-experience “what it was like in residency to participate in rounds with a truly spectacular teacher. With the teaching resources we have here at UCSF, we have the capacity to offer that kind of experience,” Dr. Wachter says.

“Those of us who stay in academic settings are constantly jazzed by our interactions with young people, who tend to ask a lot of questions,” he adds. “For many other hospitalists, they don’t have much opportunity to step back and recapture what brought them to the field in the first place. That’s what I hoped to capture with the mini-college. If we can do that, then we’ve succeeded.”

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