In the mid 1990s, a new model for hospital care began to take hold in the United States, in which a separate physician, who I dubbed a “hospitalist,” assumed the responsibility for managing the inpatient stay in place of the primary care physician. A 2006 American Hospital Association survey indicated that there are more than 20,000 hospitalists in the United States, making this the fastest growing medical specialty in American medical history. In this article, I briefly trace the reasons for the field’s remarkable growth, describe some of hospital medicine’s key issues and concerns, and speculate about the future shape of the field.
evaluating patient safety interventions and discuss specific interventions hospitalists should consider.

Prevention and Treatment of Health Care–Acquired Infections 295
Leanne B. Gasink and Ebbing Lautenbach

Health care–acquired infections present a tremendous challenge to the care of hospitalized patients. Unfortunately, the risk of acquiring a health care–associated infection (HAI) is rising. The vast majority of HAIs are of four types: urinary tract infections, surgical site infections, bloodstream infections, and pneumonia. This chapter aims to provide current data and strategies relating to the prevention of HAIs among hospitalized patients.

Care Transitions for Hospitalized Patients 315
Vineet M. Arora and Jeanne M. Farnan

Ensuring safe care transitions is a core part of hospital medicine. These transitions include inpatient-outpatient transitions and in-hospital transitions. To ensure safe care during these transitions, clinicians should be aware of the types of transitions and the way in which these transitions can impede safe patient care. With this knowledge, strategies to ensure patient safety during care transitions can be adopted and training directed at teaching physicians safe hands-off practices could be developed and supported.

Perioperative Medicine for the Hospitalized Patient 325
Paul J. Grant and David H. Wesorick

Given the increasing complexity of hospitalized patients and the increasing specialization among surgeons, there is greater reliance on hospitalists for preoperative assessment. Several institutions have developed surgery/medicine comanagement teams that jointly care for patients in the perioperative setting. Despite a growing body of evidence, it is important to recognize there are many gaps in the perioperative literature. This has led to considerable dependence on consensus statements and expert opinion when evaluating patients perioperatively. This review focuses on the preoperative cardiovascular and pulmonary evaluation of the hospitalized patient: the two systems responsible for the greatest morbidity and mortality. Prevention of postoperative venous thromboembolism and management of perioperative hyperglycemia are also discussed.

End-of-Life Care for the Hospitalized Patient 349
Steven Z. Pantilat and Margaret Isaac

The majority of Americans die in hospitals where shortcomings in end-of-life care are endemic. Patients often die alone, in pain, their
wishes unheeded by physicians. Hospitalists can improve end-of-life care in hospitals dramatically. Hospitalists must relieve symptoms, such as pain, dyspnea, nausea, vomiting, delirium, and depression; communicate clearly; and provide support to patients and families. Hospitalists can increase the number and the timeliness of hospice referrals, allowing more patients to die at home. Finally, physicians must attend to their own sense of grief and loss to avoid burnout and to continue to reap the rewards end-of-life care provides.

Pain Management in the Hospitalized Patient 371
Joseph Ming Wah Li

Effective management of acute pain should be a primary goal of each health care provider. Acute pain is a complex medical problem with multiple possible etiologies. This article describes the pathophysiology of pain, discusses the ways to assess pain, and reviews the principles of acute pain management, including the use of both pharmacologic and nonpharmacologic measures to treat pain.

Acute Hospital Care for the Elderly Patient: Its Impact on Clinical and Hospital Systems of Care 387
Paula M. Podrazik and Chad T. Whelan

A significant portion of hospital care involves elderly patients who have frequent and severe disease presentations, higher risk of iatrogenic injury during hospitalization, and greater baseline vulnerability. These risks frequently result in longer and more frequent hospitalizations. The frailty and complication rates of the elderly population underscore the importance of hospital-based programs of education and screening for cognitive and functional impairments to determine risk and needed additional care and services during hospitalization and at discharge. In addition, physicians are needed to take the lead in instituting programs of prevention and improving the systems of care. It is such a multi-tiered approach, with interventions in the areas of education, screening, prevention, and systems of care improvements, that is needed to improve the clinical care and outcomes of the hospitalized elderly patient.

Diabetes Management in the Hospital 407
Thomas W. Donner and Kristin M. Flammer

Hyperglycemia is an increasingly common and often complex condition to manage in the inpatient setting. Numerous clinical trials have demonstrated associations between uncontrolled diabetes and poor clinical outcomes in a number of inpatient settings. Insulin remains the treatment of choice for the majority of hyperglycemic hospitalized patients and should be prescribed in a physiologic manner, employing basal and bolus insulin.
Intravenous insulin should be used liberally in the ICU setting where randomized studies have demonstrated improved outcomes. Recommendations for insulin use in the inpatient setting are provided.

**Infectious Disease Emergencies**

Nelson Nicolasaora and Daniel R. Kaul

This article reviews principles of recognition and management of a selection of commonly encountered infectious disease emergencies, including sepsis, necrotizing soft tissue infections, acute meningitis, and the emerging issue of severe Clostridium difficile colitis. Less common but potentially deadly environmentally acquired or zoonotic pathogens are discussed, as are special patient populations, including the febrile returning traveler and the asplenic patient.

**Diagnosis and Management of Venous Thromboembolism**

Tracy Minichiello and Patrick F. Fogarty

Venous thromboembolic disease is a common disease associated with significant morbidity and mortality. Accurate and timely diagnosis should be guided by the use of validated clinical prediction rules. The mainstay of therapy is anticoagulation, although alternative approaches, such as use of concurrent thrombolysis or placement of vena caval filters, may be appropriate in selected patients. Determination of duration of anticoagulation requires a detailed assessment of the risk factors associated with the event allowing estimation of recurrence risk, and careful assessment of bleeding risk. Although extremely effective, anticoagulants have a narrow therapeutic window; systems should be in place to reduce risk of adverse events associated with these agents.

**Critical Care Medicine for the Hospitalist**

Derek J. Linderman and William J. Janssen

The aim of this article is to review some of the important topics in critical care medicine, including the latest management recommendations for sepsis, the use of noninvasive ventilation in respiratory failure, and practice guidelines for transfusion in critically ill patients.