Hospitalist:
A clinical specialty, an administrative or management specialty, a venue to practice a specialty, or a new hospital employee?

Over the past decade there has been a lot of discussion about "Hospitalists" and the specialty of "Hospital Medicine." The Society of Hospital Medicine defines a "Hospitalist" as "a physician who specializes in the practice of hospital medicine. Following medical school, hospitalists typically undergo residency training in general internal medicine, general pediatrics, or family practice, but may also receive training in other medical disciplines." They further define "Hospital Medicine" as "a medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients." For more information go to http://www.hospitalmedicine.org.

Ever since Dr. Lee Goldman and Dr. Robert Wachter coined the term "Hospitalist" in an article in the New England Journal of Medicine in 1996, there has been a flurry of activity surrounding what has now become a "movement" within the medical community.1 Soon after this article, non-ACGME approved fellowships in "Hospital Medicine" began popping up throughout the country. The focus of training in each of these programs ranged from procedural training to medical staff leadership to case management to a combination of all three. This new brand of practitioners began organizing themselves into a formal society first known as the National Association of Inpatient Physicians (NAIP) which ultimately morphed into the Society of Hospital Medicine. The specialties of Internal Medicine and Family Medicine were quick to point out that the qualifications for becoming a "hospitalist" were well within the scope of the residency training for both specialties. Recently, the American Board of Internal Medicine approved a new Focus Practice in Hospital Practice Maintenance of Certification (MOC) program. The first MOC exam will be offered on October 25, 2010. There has been some speculation that Family Medicine will soon follow suit so as to not run the risk of being excluded.

So what is the future of Hospitalist Medicine? Has it truly shown value to the quality and cost in the continuum of patient care? Some would argue "yes" and some would argue "no." This author would argue that "it depends." In reviewing the curriculum published by the Society of Hospital Medicine, which outlines the core competencies for a hospitalist, one can easily argue that the clinical competencies and procedures are well within the scope of a good Internal Medicine or Family Medicine Residency Program.2 So, if the specialty does not require a new fund of clinical knowledge or a new scope of procedural skills, what added value does it truly provide to a hospital? Indeed, a 2007 study published in the New England Journal of Medicine concluded, "For common inpatient diagnoses, the hospitalist model is associated with a small reduction in the length of stay without an adverse effect on rates of death or readmission. Hospitalist care appears

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2 Pistoria, MJ; Amin, AN; Dressler, DO; McKean, SCW; Budnitz, TL. The core competencies in hospital medicine — a framework for curriculum development. Society for Hospital Medicine. 2006.
to be modestly less expensive than that provided by general internists, but it offers no significant savings as compared with the care provided by family physicians."

The original thought process was that if a physician was providing dedicated, on-site hospital care for the entire day, addressing the ongoing studies and changes in the patient’s condition throughout the day, the care could be accomplished in a more efficient, cost-effective manner with higher quality. Intuitively, this does seem to be more efficient than the old model in which a physician stopped in prior to his or her office hours to see the hospitalized patients and then may or may not stop back at the end of office hours to tie up any loose ends before the process recycled itself the next day. The element that was lost, however, was the continuity of care that could be provided by the physician who knew the patient. He or she knew the patient’s history, knew the studies that had already been performed, knew the consultants already familiar with the case and possibly most importantly, he or she enjoyed the trust of the patient and the family. The number of dollars that are potentially lost due to the duplication of tests or evaluations has never accurately been captured.

So is there a potential benefit to Hospitalists? Putting an Internist or a Family Physician in the hospital for an entire day to care for patients with whom he or she has no history potentially has some benefits and some detractors to care. In order for a Hospitalist Program to be effective a number of areas must be addressed: (1) Effective mechanisms for patient hand-off must be established; (2) Hospitalists must act in direct collaboration with the hospital to meet quality goals, address patient safety issues, and promote patient satisfaction; (3) The hospitalists must be confident in their role as “captain of the ship” and be willing to actively coordinate consultant care, communicate with patients and family members, and collaborate with utilization management; (4) Hospitalists must be dedicated to the “business” of inpatient care to assure that their documentation and coding accurately reflect the severity level of the patients to whom they are delivering care.

The role of effective hand-offs cannot be stressed enough. This is true both within the hospital and in the transfer of a patient to another level of care — whether that be to another institution or back to the primary care physician. A colleague of mine compared the current hand-offs to a relay race. The current system has “runners” who throw the baton at the next runner and hope that the next “runner” is skilled enough to catch it and keep running the race. Other “runners” lay the baton down, wander away, and hope that somebody will find it and pick it up to continue the race. It is a rarity that the exchange of the baton is done smoothly, efficiently, and with the grace that wins a race. This is probably one of the greatest patient safety issues and quality of care issues that face the hospitalist movement. Interestingly, this was probably the greatest strength of the previous model in which primary care physicians cared for their own patients in the hospital. Working a time-efficient effective communication strategy is potentially the singularly greatest opportunity for the current hospitalist movement.

The hospitalists’ role in promoting quality goals, patient safety goals and patient satisfaction scores cannot be minimized. This generally requires either an employment model or a very directive contractual model to align the hospital’s and the hospitalists’ values and incentives. As patient satisfaction scores and quality outcomes become more available in the public arena and become tied to compensation, it will be important for hospitals and physicians to find ways to work creatively as a team. The Hospitalist Movement provides a framework to facilitate that relationship. In that role, however, the hospitalist becomes a quasi-clinical administrator as well as a clinical and marketing liaison between the hospital, the consultants, and the patients. The hospitalists can no longer be satisfied with only providing

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sound medical care, they now need to partner with the hospital to create a safe environment, a friendly environment, and a customer-centric environment for the patient. In the past, that role was left primarily to administrators and nurses. History has taught us, however, that without direct physician involvement, safe, evidence-based care becomes compromised.

Having hospitalists assume the role of “captain of the ship” can be a difficult challenge. In the past, when the primary care physician was the attending physician, they felt direct ownership of the patient’s care. This was their patient and all other providers generally served at their invitation. That “ownership” was innately understood and was reinforced by the close relationship that most primary care physicians shared with their patients. The Hospitalists currently have no more of a relationship (and sometimes less of a relationship) than the various consultants on a case. This is compounded by the fact that some graduates use a hospitalist position as a “placeholder” until they are accepted into their sub-speciality fellowship program. This frequently causes a rotating door of inexperienced hospitalists who have yet to build up the confidence necessary to make them effective “captains of the ship.” The importance of aggressive coordination of medical care is frequently underestimated by the physicians, the hospital and the hospital staff. When multiple consultants are involved, it is important for families to have a single individual who can interpret and coordinate the multitude of medical information with which the family and the patient is being barraged. It is also important to have a person who can sometimes be the objective voice of reason when multiple specialties offer differing points of view. This role requires experienced, confident, diplomatic physicians, which is sometimes lacking in a “specialty” that is less than a decade old and frequently populated with new graduates who plan to be transients to the specialty.

Finally, effective hospitalists need to have an appropriate business sense. Sister Irene Krause, a Daughter of Charity, who was the first woman to serve as the Chairman of the American Hospital Association is credited with bringing the concept of “no margin no mission” to the healthcare arena. The current billing system for hospitals and for physicians is frequently not medically intuitive and requires the active engagement of physicians in understanding its intricacies. The Hospitalists are positioned to be the experts in this field and could then serve an integral role to the success of hospitals, their consultant colleagues, and their own new burgeoning specialty. This is frequently not a popular role for physicians who often see themselves in a caring profession that they feel should not be tainted by common lucre. It would seem, however, that taking the “high-road” above a nun is at best presumptuous, particularly when most physicians live with the expectation of a six-figure income. Physicians need to be intimately connected not only to their own financial success, but to the financial success of their hospital. Particularly as hospitalists, the resources that can be saved without compromising patient care can be utilized to promote quality and safety in patient care. If money is lost by poor documentation, unnecessary inpatient days, and medical errors this is money that cannot be used to improve staffing, buy new technology, and construct up-to-date healing environments.

Hence, this author believes that the hospitalist movement is here to stay. It has the potential for providing high-quality, cost-effective, coordinated care in a very complex system. To date, however, it appears that only a few programs have implemented an effective model that addresses the vast array of needs. It would seem that part of the reason for this failure is the lack of acknowledgement that a true hospitalist is a physician that possesses skills and a role that goes beyond clinical expertise and flirts with administrative, marketing, and utilization expertise. These skills are usually not a focal part of residency training and can therefore either be learned on-the-job or through formalized training programs. Unfortunately, the former requires good mentors and an environment that can afford a lengthy and frequently repetitive learning curve. The role of fellowship training in hospital medicine needs to be explored further. While there is probably a role for

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A common Sharp Healthcare adage is, "It's a marathon, not a sprint." Now in our sixth year of our team training journey we look back on the great progress that has been made, but we also look forward to the work still to be done. This critical initiative is about continual learning and steady progress toward our goal to be a safer organization to care for our patients.

SOURCES:

Internet Citation for Kotter's Change steps:

AHRQ TEAMSTEPPS home page
http://teamstepps.ahrq.gov/

Professional Conduct Toolkit, 2010
http://health.mil/dodpatientsafety/ProductsandServices/Toolkits/ProfessionalConduct.aspx

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advanced training in hospital procedures and clinical management of complicated cases, there must be a recognition that the business and administrative aspect of being a hospitalist must be incorporated into educational programs for hospitalists. Furthermore, it must be accepted that this knowledge and skill can generally not be effectively learned without some formal education and mentoring. Residencies generally do not enjoy the expertise or the inclination to provide this type of education. Hopefully Sister Irene has opened the door to the possibility that being a care-giver and an effective administrator and businessman are not mutually exclusive career goals in today's healthcare market.

THE DISTANCE

We will again administer the AHRQ Survey of Patient Safety Culture following error prevention training to determine if employees perceive the safety culture is improving in our region. Our Steering Committee will be especially interested in the areas of (1) increased reporting, i.e., a non-punitive environment; (2) the perception of overall hospital safety; and (3) the support of leaders in promoting safety in the organization.

The ultimate question remains — are our patients safer? The objective is to develop a culture of safety that results in our health system being among the safest places in the nation to receive care. Our goal is to reduce serious safety event rates by 80 percent in pursuit of no patient harmed by 2018.

SUMMARY

Over the past decade the hospitalist movement has taken on a new force within the structure of healthcare. It is seen by many to have an integral role in the future of hospital medicine. Nevertheless, its role and its definition within medical education and the healthcare community are still debated. What are the missing links necessary to formalize the hospitalist movement in the future of healthcare reform? This article explores some of the topics that need further discussion in this new "specialty."