Hospitalists in Teaching Hospitals: Opportunities but Not Without Danger

One thing seems clear: hospitalists do not appear to be going away. After Wachter and Goldman first used the term hospitalist to describe a new type of U.S. physician 8 years ago,[1] the concept of hospital medicine was not warmly embraced by all.[2–4] Even at the 1999 Society of General Internal Medicine's 22nd annual meeting in San Francisco, more than a few boos were heard when the topic of hospitalists came up. Hospital medicine is now one of the fastest growing medical "specialties" in the United States. The Society of Hospital Medicine, the national organization that represents hospitalists, boasts upward of 3,500 members. The number of want ads in the *New England Journal of Medicine* and *Annals of Internal Medicine* for hospitalists rivals those for primary care-based internists. Medical residents seem genuinely excited to enter the field of hospital medicine because they often consider being a hospitalist almost like being a subspecialist but without the required several years of subspecialty fellowship (subspecialist-lite). Even some graduates of *primary care* residencies are choosing to become hospitalists rather than office-based internists.[5]

Teaching hospitals have adopted the hospital medicine model to suit their needs. Among the most famous academic medical centers, most actually had a form of hospitalist care even before the recent advent of hospitalists. Many of us can remember the 1 month-per-year attendings who would emerge from their basic science laboratories to attend on the wards for a few weeks. Often these distinguished scientists provided limited clinical input or teaching related to the patient care issues that arose on a daily basis. A handful, perhaps, should even have been offered continuing medical education credit for the month. Interestingly, most residents did not mind this model because it allowed them great autonomy in patient care. During the 1990s, however, teaching hospitals were under increasing pressure from payers and government agencies to modify the way they cared for inpatients. These changes, along with the practice-makes-perfect argument, provided much of the catalyst for the rising number of hospitalists within the walls of teaching hospitals.

A major paradigm shift has recently occurred, one that has the opportunity of solidifying the role of hospitalists in teaching hospitals. As of July 1, 2003, the Accreditation Council for Graduate Medical Education (ACGME) has imposed new requirements restricting resident duty hours.[6] As teaching hospitals have learned that not all members of their medical staffs are either interested in or capable of caring for patients without a resident buffer, they are turning toward hospitalists as the solution to the residency work duty problem. One approach is to "uncover" patients so that the hospitalist cares for the patient without resident involvement. In fact, the majority of hospitals listed as *U.S. News and World Report*'s Best Hospitals either have developed or are developing such a "hospitalist-only" service.

What about the hospitalist educator's role within teaching hospitals? The study by Kulaga et al.[7] in this issue of the *Journal of General Internal Medicine* sheds light on this issue. The authors found that hiring two hospitalist educators at their community-based teaching hospital led to decreased resource utilization and improved resident education when compared to having private physicians manage hospitalized patients.[7] Enhanced efficiency due to hospitalists has been demonstrated in several previous studies, in both community and academic settings.[8] The finding of an educational benefit for hospitalists in a community teaching hospital, however, is relatively new. Others have found that hospitalists improve resident learning and satisfaction in academic medical centers,[9,10] and that hospitalists provide positive, and perhaps improved, experiences for medical students at academic medical centers.[11] The limited number of studies evaluating this phenomenon notwithstanding, the reason underlying the educational benefit of hospitalists should surprise few. Most hospitalists hired at teaching hospitals are chosen because they are known to possess superior clinical and educational skills. While the prehospitalist's clinical efficiency (in terms of resource utilization) is rarely known during residency, residency program directors are acutely aware of the resident's inpatient abilities with regard to teaching, medical decision making, leadership, and navigating a patient through the increasingly complex inpatient environment. We would even venture that if the person hiring hospitalists at a teaching hospital finds that these individuals are not among their institution's top clinician educators, they need look no farther than the mirror to assign blame.

What does the rise of hospital medicine within teaching hospitals portend for the future? We'll put our collective nickel down. We believe that because of the ACGME duty hour restrictions more teaching hospitals will move toward developing "resident-free" inpatient services. We believe that hospitalists will be the providers who are primarily hired by these teaching hospitals to provide direct patient care (let's call them "capital H" Hospitalists). Furthermore, Hospitalist Educators (capital H and capital E)—who will attend anywhere between 3 and 6 months a year—will continue to have a major role in patient care as well as house officer and medical student education. Similar studies to the one appearing in this month's *Journal*[7] will likely continue to reveal the educational advantages of hospitalists, thereby spurring more teaching hospitals to hire their former star residents to attend on the wards.

These new opportunities for hospitalists are considerable but do not come without danger. As hospitalists are increasingly utilized to provide care for nonresident services

in academic medical centers, the potential exists for these faculty members to be seen primarily as "super-residents." In many academic centers, they will be the *only* faculty members who manage hospitalized patients without the assistance of either residents or fellows. If clinical care is the only tangible responsibility of hospitalists in the teaching hospital, we fear they will be perceived as second-class members of the academic community. Therefore, staffing a non-house staff service should not come at the expense of visible teaching roles. Hospitalist involvement in several educational activities—such as didactic medical student education, hospitalist electives for fourth-year medical students, hospitalist residency tracks for internal medicine house officers, and training of allied health professionals—are compatible with also staffing a non-house staff service. Because hospitalists will ultimately be evaluated primarily by their contributions to medical education and inpatient-oriented research, emphasizing only efficient, non-house staff clinical care will likely result in an unfavorable judgment by the academic community. Indeed, the experience of other new specialties—such as emergency medicine and critical care—has revealed that in addition to filling a clinical niche, successful specialties also must develop robust training programs and research agendas.[12]

Thus, like others, we believe that much of hospital medicine's future in teaching hospitals—especially within large academic medical centers—will depend on developing a vigorous hospitalist-led clinical research agenda.[13,14] The current small cadre of hospitalist investigators (who spend the bulk of their time pursuing scholarly endeavors) will undoubtedly grow and focus on all aspects of inpatient care. The lasting impact of hospital medicine at academic medical centers depends heavily upon this group. Finally, as the hospital medicine model matures, hospitalist administrators will be chosen not only to run hospitalist programs but also to perform vital duties within the hospital such as chairing important committees (e.g., patient safety, pharmaceutical, and therapeutics). Eventually, hospitalists will likely rise to the ranks of chief operating officer, chief of staff, or chief medical officer in their respective organizations. The reason is simple—these are likely to be individuals who are well regarded clinically and viewed as first-rate educators, and, importantly, know how the hospital works.

The table is set. All the ingredients are at hand. The external forces—the marketplace, regulatory bodies, and cost pressures—seem to be aligned. The early data appear promising. Only one thing remains: a tincture of time.—**Sanjay Saint, MD, MPH**, *Ann Arbor VA Medical Center, University of Michigan Health System, VA/UM Patient Safety Enhancement Program, Ann Arbor, Mich.* **Scott A. Flanders, MD**, *Hospitalist Program and Department of Internal Medicine, University of Michigan Health System, Ann Arbor, Mich.*

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