

## Hospitalists: The New Wave of Hospital Medicine

By Pamela W. Montgomery, R.N., M.S.N., J.D., LL.M. candidate (Health Law)  
pmontgomery@robertsmarkel.com

### Introduction

Historically, primary care physicians admitted patients to a hospital and were responsible for the day-to-day management of the patient while hospitalized, all the way through discharge. Times have changed and continue to evolve in the area of hospital medicine and more particularly with patients' management of care. An emerging trend in recent years has been the development of a medical specialty in which the physicians practice medicine only in hospitals. These physicians have been termed "hospitalists."

### Historical Perspective

To understand the development of the hospitalist specialty, one should understand the background of the establishment of hospitals and their traditional functions. Hospitals initially began as charitable institutions or "almshouses" in the 19<sup>th</sup> century.<sup>1</sup> However, by the time the 20<sup>th</sup> century rolled around it was clear that the cost of maintaining such institutions was far reaching. Employing the necessary staff to maintain a facility and providing the most up-to-date technology and operating facilities became increasingly important to hospitals. Staffing itself included hiring nurses, pharmacists, respiratory therapists and administrators.<sup>2</sup> Rather than hiring physicians, physicians remained solo practitioners or practiced within a small group and "brought the business" into the hospital.<sup>3</sup> Consequently, it became vital for hospitals to seek out and "lure" physicians who could then admit their patients to the hospitals. As the hospital system developed, those outpatient physicians were the admitting and primary caretakers of their individual patients. If patients were admitted for any condition that required specialized care, be it childbirth or surgery, the outpatient physician was listed as the admitting physician and coordinated all the day-to-day care through consultation with other specialty physicians.<sup>4</sup> Other developed countries did not adhere to the same philosophy. In most other developed countries a hospital-based physician assumed the responsibility for a patient's hospital care during the entire hospitalization according to the nature of the illness and would then turn then patient back over to the outpatient physician upon discharge.<sup>5</sup>

The U.S. plan worked very well for decades. Patients were able to have their regular physician care for them from a time prior to hospitalization all the way through discharge. Physicians generally cared for several patients in the hospital at one time. Additionally, insurance companies paid both hospitals and physicians a daily fee.<sup>6</sup>

---

<sup>1</sup> CHARLES E. ROSENBERG, THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM, (The Johns Hopkins Univ. Press, 1995).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

Everyone seemed to win, at least until the 1980s. In 1983, Medicare changed the reimbursement system to a diagnosis-related group (DRG) system that paid hospitals according to the patient's diagnosis rather than per day.<sup>7</sup> Because the issue of reimbursement became fixed, hospitals became intensely aware of the need to shorten hospital stays and lower hospital costs in order to operate and still exceed expenses. While the hospitals came under the DRG system of payment, physicians did not, but rather, were still paid for each day of service.<sup>8</sup> Financial interests and incentives between hospitals and physicians no longer coincided. In general, the length of stay for hospitalization decreased, thereby decreasing the number of patients a physician was treating in the hospital setting on a given day, with only the most critical remaining for a protracted length of time. This meant that the coordination of patient care by outpatient physicians necessitated these physicians do so on a much more limited amount of time in the hospital. Those non-critical patients who would have been hospitalized in years gone by were now being seen in the physician's office and consuming more of the physician's time in the physician's office. It was not until the 1990s when physicians began spending day and night in the hospital, caring for and managing, overall patient care.

### The Hospitalist Is Born

The term "hospitalist" was first used by Drs. Robert Wachter and Lee Goldman in 1996.<sup>9</sup> The term denotes a physician who specializes in the care of hospitalized patients.<sup>10</sup> The hospitalist is the admitting physician for patients upon presentation to the hospital and "handed off" by the outpatient physician. They direct and coordinate all care for the patient during the hospitalization and upon discharge, hand off the patient back to the outpatient physician for follow-up and continued care. Essentially, the hospitalist is the case manager or full-time attending physician.

The majority of hospitalists are physicians with either a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) degree.<sup>11</sup> Most hospitalists are trained through residency programs in internal medicine (80%), family medicine (5%), or pediatrics (10%).<sup>12</sup> A small percentage of reported hospitalists have training in infectious disease or pulmonary disease.<sup>13</sup> Internal medicine appears to be the most rounded of the traditional residencies in dealing with the various issues hospitalists face in the providing comprehensive hospital care, including diagnosing patients, treating with medications, performing basic procedures, and coordinating with medical specialists.<sup>14</sup> However, while some believe that any residency program with a concentration on inpatient training has historically provided adequate hospital training to assume the role of a hospitalist,

---

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> Wachter R, Goldman L, The emerging role of hospitalists in the American health care system, 335:7 NEW ENG. J. MED 514 (1996).

<sup>10</sup> *Id.*

<sup>11</sup> *New Kinds of Primary Care*, O, The Oprah Magazine, (March 2010).

<sup>12</sup> W.H. Plauth, S.Z. Pantilat, *et al.*, *Hospitalists' perceptions of their residency training needs: results of a national survey*, 111 AM. J. MED. 247 (2001).

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

there are those who contend that general residency training is inadequate to handle some specialized area. New training programs are emerging to improve quality and safety, to facilitate working effectively with other providers of care (nurses, pharmacists, respiratory therapists) and non-providers of care (administrators), co-managing the care of specialized care (neurology, orthopedics), and communication skills on all levels to ensure optimum facilitation of care.<sup>15</sup> It is believed that future hospitalists will obtain the advanced training sought in hospital medicine through a Hospital Medicine fellowship.<sup>16</sup>

The Society of Hospital Medicine reported data from the 2007 American Hospital Association survey, indicating that there are currently approximately 28,000 practicing hospitalists in the United States.<sup>17</sup> These physicians practice in approximately half of the community hospitals in the United States.<sup>18</sup> In order to further improve the care provided to hospitalized patients, recent certification programs have been developed. The American Board of Hospital Medicine, made up of members of the American Board of Physician Specialties, developed the first board certification devoted exclusively to hospital medicine in North America.<sup>19</sup> In similar fashion, the American Board of Internal Medicine devised a program that is aimed at allowing general internists practicing in the hospital setting the opportunity to maintain an Internal Medicine Certification with a focus on hospital medicine.<sup>20</sup> The American Board of Internal Medicine is currently working to develop an option for those physicians who have already attained a certification in Internal Medicine, whereby such physicians who demonstrate the care of a high volume of hospital patients and quality improvement activities in a hospital can take a test aimed at hospital care rather than ambulatory care to maintain their certification.<sup>21</sup>

### Effects of Use of Hospitalists

The typical and historical hospitalization for patients was one in which the patient's own physician admitted them to the hospital and followed them throughout the hospitalization as the attending physician. With the emerging use of hospitalists nationwide, patients and physicians may have concerns about the quality and advantages to patient care in handing patients over to hospital physicians.

Virtually all of the various studies on the results of the use of hospitalists have revealed decreased lengths of stay for those patients being treated by hospitalists.<sup>22</sup> Additionally,

---

<sup>15</sup> *Id.*

<sup>16</sup> S.R. Ranji, D.J. Rosenman, *et al.*, *Hospital medicine fellowships: works in progress*, 119 AM. J. MED. 72 (2006).

<sup>17</sup> *New Study Finds Over Half of US Hospitals Utilize Hospitalists*, MEDICAL NEWS TODAY, Jan. 9, 2009, <http://www.medicalnewstoday.com/articles/134949.php>.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> R.M. Wachter, *What will board certification be—and mean—for hospitalists?*, 2 J. HOSP. MED. 102 (2007).

<sup>22</sup> R.M. Wachter, L. Goldman, *The hospitalist movement 5 years later*, 287 JAMA 487 (2002).

hospital costs are cut, saving hospitals billions of dollars each year.<sup>23</sup> Additional studies have indicated decreased mortality rates<sup>24</sup> and hospital readmissions.<sup>25</sup> Hospitalists are generally more familiar with the hospital system and functions than the outpatient physician and are more familiar with the hospital staff, resulting in better working relationships that can only serve to benefit the care of the patient. Hospitalists are always available on-site to handle situations as they arise without a delay in attention to the patient.<sup>26</sup> These physicians are repeatedly exposed to diseases and complex illnesses that improve their level of skill in the management of the illnesses with each presentation.<sup>27</sup> Medication mistakes have shown to decrease.<sup>28</sup> Still others have shown decreases in length of stay, use of resources, costs per case, and complication rates and increases in patient satisfaction and comfort levels.<sup>29</sup>

The use of the hospitalist can be seen as a threat to some physicians. However, they actually serve to allow the outpatient physician more time to spend with his/her office patients, rather than rushing back and forth to the hospital for patient coverage. It is a matter of convenience. Physicians are guaranteed that expert medical care is always available for their hospitalized patients, even when they can not be present. Once patients are discharged, they are once again treated by their outpatient physicians. Thus, there is no concern about the hospitalist “stealing” their patients.

Hospitalists typically work in a block schedule of five to seven consecutive days, for 10-12 hours each day, and then are off five to seven consecutive days. This type of block scheduling allows the hospitalist quite a bit of time off. Additionally, during their time off, hospitalists do not have to take calls and do not have to worry about patients, as those patients are covered by the hospitalist on duty. Unlike their outpatient physician counterparts, they do not have to worry about managing their own practice and the issues that go with a practice, such as staffing, billing, marketing and advertising. They work as part of a team rather than autonomously. The average salary for a hospitalist is from about \$175,000 per year to upwards of \$250,000, with the median salary at \$179,352.

## Conclusion

Although the future of the hospitalist movement is uncertain, it seems to have been successful so far. If the trend continues, it can be expected to expand from the general internal medicine arenas to more specialized areas such as pediatrics, surgical specialties, neurology, and obstetrics. Much of the success of expansion depends on the acceptance and promotion of the hospitalist in those areas by the outpatient physician. Studies will

---

<sup>23</sup> *Id.*

<sup>24</sup> A.D. Auerbach, R.M. Wachter, *et al.*, *Implementation of a voluntary hospitalists service at a community teaching hospital: Improved clinical efficiency and patient outcomes*, 137 ANN. INTERN. MED. 859 (2002).

<sup>25</sup> D. Meltzer, W.G. Manning, *et al.*, *Effects of physician experience on costs and outcomes on an academic general medicine service; results of a trial of hospitalists*, 137 ANN. INTERN. MED. 866 (2002).

<sup>26</sup> Soc’y of Hosp. Med., *How hospitalists add value: a special supplement*, The Hospitalists, (2005).

<sup>27</sup> *Id.*

<sup>28</sup> M.M. Roytman, S.M. Thomas, *et al.*, *Comparison of practice patterns of hospitalists and community physicians in the care of patients with congestive heart failure*, 3 J. HOSP. MED. 35 (2008).

<sup>29</sup> Wachter, *supra* note 22.

be necessary to evaluate and substantiate the same advantages to those practice areas as has been demonstrated in earlier studies.

**Health Law Perspectives (December 2010)**

Health Law & Policy Institute

University of Houston Law Center

<http://www.law.uh.edu/healthlaw/perspectives/homepage.asp>

The opinions, beliefs and viewpoints expressed by the various Health Law Perspectives authors on this web site do not necessarily reflect the opinions, beliefs, viewpoints, or official policies of the Health Law & Policy Institute and do not constitute legal advice. The Health Law & Policy Institute is part of the University of Houston Law Center. It is guided by an advisory board consisting of leading academicians, health law practitioners, representatives of area institutions, and public officials. A primary mission of the Institute is to provide policy analysis for members of the Texas Legislature and health and human service agencies in state government.