

## SIGN OF THE TIMES

## What is a Nonteaching Hospitalist?

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**T**here is no set definition for nonteaching hospitalists. However, it has been connotated to mean a hospitalist who cares for patients without residents. It is also known as attending-only service, attending-directed service, or direct-care hospitalist service. Nonteaching hospitalist services made their debut in teaching hospitals in response to growing patient volumes and coverage problems due to resident work-hour restrictions. The goal was to shift admissions from resident services to a single service allowing for safe, efficient, and effective care. Over the past decade, the number of nonteaching hospitalists in academic institutions has greatly increased—and with it its own growing pains. In a 2011 survey of US academic hospitalist leaders, 77% noted that their hospitalists served as “nonteaching attendings.”

There are many challenges in having nonteaching hospitalist services in academic centers. One source of dissatisfaction amongst nonteaching hospitalists is institutional respect. Even the name “nonteaching” hospitalist has a stigma associated with it. If not designed properly, nonteaching hospitalists may be treated as fourth-year residents and of lower academic rank than teaching hospitalists. Providing 24/7 services requires a large proportion of night shifts and off-hours that are hard on young hospitalists, especially those with growing families. The service can be very busy especially when the resident services have “capped” and all admits go to the hospitalist service. The job may not be fulfilling if the young nonteaching hospitalist has greater desires for advancing in academia as an administrator or teacher rather than a “one-year position” awaiting fellowship or family. Promotion in academics is often based on the traditional mission of clinical care, education, and research. Nonteaching

hospitalists who focus mainly on clinical care may find it difficult to fulfill education and research goals. More than 40% of surveyed hospitalist leaders agreed or strongly agreed that their faculty were not developing sustainable nonclinical activities. Nonteaching hospitalists are “promised” one week on and one week off and are not required to pursue nonclinical activities. Also, some institutions require that physicians start on the nonteaching service to gain experience before starting to teach residents.

Possible solutions to making nonresident work more satisfying include providing ample time off and compensation. However, more important might be to make nonteaching hospitalists feel part of the group by encouraging quality improvement efforts and participatory research. Some groups are moving toward consolidation of nonteaching hospitalists and hospitalist services, such as providing teaching time to nonteaching staff and nonteaching time for teachers. At academic centers, hospitalists often have opportunities for student teaching by presenting at resident noon lectures and participating in faculty meetings and case conference.

In addition, compensation becomes tricky with nonteaching and teaching faculty. For instance, the clinical teaching faculty was found to have higher clinical productivity than nonteaching hospitalist full-time faculty in a study based at the University of Florida in Jacksonville. This was thought to be secondary to the less direct patient time, as residents serve as first-line for patient calls. On the other hand, teaching takes time, and the Medicare teaching dollars fund many of the salaries of teaching faculty. However, because the nonteaching side has large swings in daily census, more paperwork and physical work for the hospitalist to complete, and more night shifts, some acad-

emic centers are paying nonteaching hospitalists salaries similar to those offered to community-based hospitalists. Academic nonteaching hospitalists tend to see fewer patients than community-based hospitalists, but nonteaching hospitalists argue that this is because academic medicine is less efficient than many community-based hospitals. These inefficiencies may include slower turn-around from consultants that need to staff with attendings and calling four people to make sure one patient will get a needed radiological test prior to the weekend.

In short, there is no easy answer on how best to address the needs of nonteaching hospitalists, except that consolidation is more likely to happen rather than less likely to happen. Both nonteaching and teaching faculty have things to gain by being able to do both jobs. Teaching faculty can gain direct patient care and keep up their clinical skills. Nonteaching faculty can sharpen their teaching skills and see a different perspective on how to treat patients. Consolidation also makes providing “backup” coverage for both services easier as the pool of physicians who are capable of covering increases. The academic mission may be threatened in the current state where the focus of nonteaching faculty is solely clinical needs, RVUs, length of stay, and cost. The main fundamental ideals of scholarly work—whether it be serving on hospital committees, quality improvement, teaching, or clinical research—should be embraced by all faculty at teaching institutions and along with it the respect garnered by doing academic work. This may mean coming in on one’s “day off.” However, providing more respect to nonteaching hospitalists likely will increase job satisfaction and decrease turnover.

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### Suggested Reading

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