

## SIGN OF THE TIMES: PART I

**Hospitalist Staffing: To Split or not to Split?**

Dan Hunt, MD; Alfred Burger, MD; Rebecca Harrison, MD; Will Southern, MD, MS; Tony Boonyasai, MD, MPH; and Luci K. Leykum, MD, MBA, MSc

*Dr. Hunt is faculty at Massachusetts General Hospital; Dr. Burger is faculty at Beth Israel Medical Center; Dr. Harrison is faculty at Oregon Health & Science University School of Medicine; Dr. Southern is faculty at Albert Einstein College of Medicine; Dr. Boonyasai is faculty at Johns Hopkins University School of Medicine; and Luci K. Leykum is faculty at University of Texas Health Science Center.*

**H**ospital medicine groups take on many different sizes and structures and many kinds of roles. This diversity is one of the most exciting aspects of the field and one of the most challenging. How to staff and balance housestaff and non-housestaff activities, for example, is a vexing issue. This topic was the subject of considerable discussion at the Hospital Medicine Interest Group meeting at the 2012 SGIM annual meeting. Hence, members of the SGIM Academic Hospitalist Task Force have outlined the potential advantages of each type of staffing model.

**Staffing Advantages**

In this model, faculty staff their separate services, which:

1. *Promotes focus on differing missions.* Having dedicated hospitalists who only work on the housestaff service encourages them to focus on improving their teaching skills and engaging in educational faculty development. Dedicated non-housestaff-affiliated hospitalists focus on other administrative or service-oriented goals.
2. *Fosters professional flexibility.* Each role is delineated in a way that best meets the differing professional needs of each group. The clinician-educator schedule can be created in a way that fosters academic pursuits, while the non-housestaff hospitalists have clearly specified shifts or blocks that also maximize their activities.

3. *Nurtures tighter professional connections and identity.* In larger groups, it is easy to get “lost in the crowd.” Having subunits of hospitalists who share a primary professional interest can help to foster a closer sense of identity and growth.
4. *Facilitates relationship building.* Having faculty dedicated to housestaff education or direct patient care allows them to create strong connections with the residency program and clerkship directors. Because of the focused nature of this job, trainees may view the group on equal footing with dedicated faculty in the subspecialties.
5. *Better defines position expectations.* Clear position expectations are set and maintained over time. Having dedicated subgroups allows more consistency between initial and ongoing job descriptions, thereby promoting greater job satisfaction and faculty retention.

A main challenge in this model is the perception of different tiers of faculty and the challenge of recruiting “lower-tier” positions.

**Advantages of an Integrated Group Model**

In an integrated model, there is a single pool of faculty who perform all roles, which:

1. *Creates a cohesive group of “academic hospitalists.”* Having a combined group in which everyone is involved in both

housestaff and non-housestaff activities creates a greater sense of identity among all faculty. A stable single group avoids the view of the hospitalist as a “PGY-4” doing uncovered clinical work.

2. *Promotes appreciation and understanding.* In a single group, everyone appreciates each other’s jobs and unique skills; in the two-tier system, “the grass is always greener on the other side.”
3. *Utilizes each person’s skills more effectively.* An integrated model with variable job descriptions allows for better utilization of peoples’ skill sets and greater flexibility in meeting career/professional goals over time.
4. *Allows flexibility.* Having all faculty functionally part of the same “larger group” gives greater flexibility in terms of meeting new needs or quickly filling gaps in the schedule. It avoids the “I don’t do that kind of job” mentality by fostering the “we are all in this together” mindset.
5. *Attracts higher caliber applicants.* A single model can provide a competitive edge in recruitment. High-quality applicants do not want to be pigeon holed into single-track jobs where they cannot grow. They may be more willing to accept an initially higher clinical load if they feel that their role and scope of work can evolve.

A main challenge with an integrated model is maintaining the per-  
continued on page 2

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## SIGN OF THE TIMES: PART I

continued from page 1

ception of fairness. People tend to have different schedules, and changes in roles or rotations must be implemented in a way that is fair to all. In some programs, salaries reflect those considerations.

Of course, many programs are hybrids of these models. Some have core integrated groups but bring on dedicated faculty for activities like night-time coverage. Others have a more permeable “barrier” between

groups of faculty. Many of these differences reflect the history of how the groups were started. In either case, continually reassessing division, hospital, and individual needs is critical.

*SGIM*