

Educational Value and Design of Hospitalist-directed Nonteaching Services

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For decades, nonteaching services have cared for patients without residents. In a recent national survey, 90% of hospital medicine groups at teaching hospitals report staffing nonteaching services.¹ A properly designed nonteaching service is both an institutional asset and an important partner to a residency program.

Hospitalist-run nonteaching services have been integral to achieving compliance with Accreditation Council for Graduate Medical Education (ACGME) resident admission and ongoing care patient cap rules and duty hour regulations by offloading volume on the teaching service and by increasing discharges from the emergency department.² Of note, 87% of adult hospital medicine groups staff surgical co-management services, 51.7% staff observation units, and 69.7% provide ICU coverage that would have otherwise required effort from subspecialty faculty or residents.¹

A recent meta-analysis of 108,570 patients admitted to US hospitals between 1987 and 2011 found no difference in mortality, 30-day readmissions, or length of stay between teaching and nonteaching general medical services.³ Similarly, a study of 2,189 patients admitted to a university-affiliated community hospital in 2002 found no difference in overall patient care costs between patients admitted to teaching versus nonteaching services.⁴ In contrast, a hospitalist and nurse practitioner-directed nonteaching service that admitted patients with low-risk chest pain demonstrated statistically significant reductions in length of stay and total hospital charges as compared to the teaching service.²

A 2005 retrospective study found that patient acuity was higher on a teaching service as compared to a nonteaching service. Residents saw more acute renal failure, respiratory failure, septicemia, and HIV and saw less chest pain, cellulitis, alcohol withdrawal, and sickle cell crisis.⁵ Underexposure of residents to common, less complex inpatient cases could negatively affect their clinical competence in the inpatient and ambulatory settings. Overexposure of residents to complex inpatient cases may drive career interest toward medical subspecialties and alter resident perspectives on inpatient resource utilization. If residents only care for complex cases while admission and ongoing care caps and ward team composition remain constant, residents may be overloaded with work. This would upset the balance between service and education, cause duty hour violations, and threaten patient safety.

In contrast, an equal service model in which a nonteaching service delivers the same level of care as a teaching service has multiple benefits. This model can reduce transfers from nonteaching service to a teaching service for the provision of a higher level of care. Furthermore, an equal service model facilitates throughput from the emergency department (ED), which can improve patient satisfaction, and reduces disagreements about patient service assignment from the ED. In this model, patients and faculty are less likely to perceive two care standards, and admitting faculty are less likely to adopt service preferences that could further complicate patient flow.

Nonteaching services that care for specific patient populations (e.g.

low-risk chest pain or observation units) are important to hospitals and are also valuable partners to a residency program. Nonteaching services in this model facilitate patient flow from the ED to the wards; promote efficient management of routine clinical conditions; and have the potential to increase patient satisfaction, improve clinical outcomes, and decrease costs. Cases of particular educational value can still be admitted to the teaching service so that trainees have opportunities to see rare diseases and interesting presentations of common diseases.

Hospitalists commonly serve as teachers for residents⁶ and are highly rated for teaching by residents.⁷ Hospitalists are also ideal faculty to staff nonteaching services in teaching hospitals. Common staffing models include hospitalists delivering care directly or doing so in conjunction with mid-level providers such as physician assistants or nurse practitioners. Training of mid-levels must keep pace with any expansion of a nonteaching service. No matter what the model, clearly defined expectations and support from department of medicine leaders are key to the success of hospitalist services.

Many hospital medicine groups require a faculty member to spend time working on both the teaching and nonteaching services. Some hospitalists prefer to work exclusively on either a nonteaching or teaching service, although many hospital medicine group directors find it difficult or impractical to maintain separate faculty cohorts. Hospitalists who were hired before the start of a nonteaching service may

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be dissatisfied with working on that service, feeling that it "isn't what they signed up for." The first-hand knowledge of hospital care delivery systems gained from working on a nonteaching service can improve hospitalists' ability to supervise and evaluate residents on the teaching service. Having recent graduates work first on a nonteaching service can give them time to adjust to the clinical and administrative responsibilities of being an attending physician before they take on teaching duties. The continued participation of faculty on the teaching service must be approved by the residency program director and based on evaluation data.⁸

If the admitting capacity or the coverage footprint of a nonteaching service is decreased, patient volume on the teaching service may rise, upset the balance between service and education, and jeopardize patient safety. Interruptions in the functioning of a nonteaching service during busy admitting hours is a source of resident dissatisfaction—an unfortunately ironic situation as nonteaching services are often in place to protect residents. If hospitalists working on the teaching service are required to simultaneously cover nonteaching duties, this will impair their ability to teach and supervise residents and medical stu-

dents. The negative impact of staffing shortages will be more pronounced on off hours when coverage is often thinner to start with.

Hospitalists who are trained to perform—and bill for—procedures are an increasingly common solution, with 33% of adult hospital medicine groups reporting that they routinely provide procedural service.¹

In conclusion, with thoughtful design and appropriate support, nonteaching services staffed by hospitalists can help achieve institutional and residency program goals. The value nonteaching services can add to education and patient care will be best realized through an ongoing partnership between hospital leadership, hospital medicine division chiefs, and residency program directors.

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