Revolutions in the Medical System

- Advent of Medicare and Medicaid
- Prospective payment
- Quality and accountability
- Hospitalist medicine
Why did it start?

- Natural outgrowth of prospective payment and pay for performance. Hospitals needed more control.
- Popular demand. Community physicians didn’t want to come in at night. Busy office practices not compatible with sick inpatients for small or moderate size groups. Resident-based teams capped.
Studies of Hospitalists

- Often not blinded
- Often not randomized
- Really asks the question:
  - Are hospitalists ‘better’ or ‘worse’?
    Than what?
  - Should there be hospitalists?
Membership in the Society for Hospital Medicine

![Graph showing membership growth from 1997 to 2004.
In 1997, there were 23 members.
By 2004, the number of members had increased significantly.]
Chair Perspective

- Hospitalist medicine is here to stay
- Most are internists
- Issues:
  - Training/teaching
  - Faculty development/retention
  - Economics
  - Research
Where do Hospitalists ‘fit’?

- Hospitalists are primary care physicians
  - Generalists by training
  - Cover range of specialties
- Hospitalists are specialists
  - No focus on primary prevention
  - No continuity
  - Proceduralists, inpatient specialists
- Not all hospitalists are internists
Department of Hospitalists Medicine

■ Advantages
  ■ Coordination of inpatient needs
  ■ Economics clearly defined
  ■ Faculty could be exclusively hospitalists
  ■ Incorporate multiple disciplines

■ Disadvantages
  ■ Faculty isolated from others in their disciplines
  ■ Cross-cultural differences among specialties
  ■ Training programs may be more problematic
  ■ Probably not enough specialists are hospitalists yet. Those who focus on inpatient consultation are unlikely to leave their current Depts/Divisions
Separate Division of Hospitalist Medicine

Advantages

- Inpatient specialists interact closely with each other
- Economic model not diluted with outpatient medicine or (possibly) teaching
- Prestige? Research? Easier for hospitals?

Disadvantages

- GIM would likely not give up inpatient medicine leaving 2 Divisions doing essentially the same job.
- Fails to take advantage of opportunities for cross coverage, joint teaching
- GIM may be pushed into high-overhead settings. Salaries may fall.
Hospitalists in GIM Division

Advantages

- Teaching and economic model intact. Reduces competition
- Ability to share coverage in teaching and service, reduce burden if one hospitalist leaves
- Broader research setting

Disadvantages

- Hospitalist identity may blur
- Easy to drift into status quo, fail to make important changes
What is the answer?
We are not asking enough questions!

Not just:

- Where can hospitalists fit in our system?

But:

- How should our system change to accommodate hospitalists?
Where should hospitalist ‘fit’?

- Division of General Medicine IF the system can adapt to the needs of the hospitalist
  - Higher salary for increased clinical work, longer hours
  - Change promotion guidelines as needed
  - Mentorship from senior hospitalists
  - Changes in existing faculty clinical practice
  - Willingness to admit current model is not the best model
  - Willingness to change resident education model
Salary

- Inpatient setting has little overhead
- Hospitalists probably devote more total time to the clinical setting, which is where the money is generated
- Hospitalists make more than generalists (MGMA)
- Under most models, hospitalists should earn more than traditional generalists in GIM
Academic Promotion

- Usually pays little attention to clinical accomplishments
- Hospital committee work or quality improvement activities also not sufficient
- Teaching is difficult to quantify
- Guidelines need to change.
- Opportunities for research need to improve
Changing Practice

- Existing faculty
  - May have to cross cover nights and weekends in rotation
  - May have to bring their skill level to that of the hospitalists in some areas
  - May have to spend more time in clinic and less in inpatient settings
  - May have to meet productivity guidelines that are driven by hospitalist-type productivity
Opportunities !!

- Inspire medical students and residents to enter Internal Medicine
- Added economic opportunity beyond the traditional teaching service
- Opportunity for hospital leadership
- Research/Scholarship: How do we make hospitalist medicine a viable career across the physician lifespan? How should we teach hospitalists? How do hospitalist faculty get promoted? Communication between inpatient and outpatient? Tests that come back after discharge?
I want to be in the GIM Division because....
If we split off, I would have to cover lots more nights and weekends

My research program is embedded in GIM

I enjoy teaching. I have inspired IM residents. I think we are a leader in hospitalist training.

I make just as much money here as I would in a separate Division

GIM respects me. I get opportunities for faculty development. They nominate me for awards. They help me get grants/organize conferences.

I am on track for promotion.

Through my Division, hospitalist medicine has a strong voice in the Dept/College
Where will it end up?

- Subspecialty of Internal Medicine
- Distinct specialty like ER medicine
- Will IM residencies no longer train in inpatient settings and instead outsource this to hospitalists?