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The hospitalist movement and family practice—An uneasy fit

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In this edition of the JFP, Peter Smith and colleagues have taken advantage of a "natural experiment" that resulted from a change in HMO rules forcing a group of patients into the mandatory hospitalist model. Their findings again raise doubt about whether hospitalists provide higher quality care at a lower cost. Meanwhile, the hospitalist movement continues to grow, albeit more slowly than initially projected.

During the last 5 years, there has clearly been a trend for family physicians and general internists to focus on office practice and reduce or eliminate responsibility for hospitalized patients. Much of the change has been driven by physician choice rather than managed care mandates like the one that provided a "natural experiment" for the authors. Primary care physicians are generally operating in a business structure that provides a narrow profit margin. Time out of the office to attend hospitalized patients provides for needed continuity of care but is seldom time efficient or cost effective. The hospitalist movement has been a response to this change in focus.

Hospitalists serve as generalists in the hospital, coordinating diagnostic work-ups, and consultations with other specialists, and initiating treatment plans. An important role is facilitating the smooth transition from pre-hospital care to inpatient care and then to post-discharge treatment and follow-up. This key ingredient is a natural for the primary care physician who admits and discharges the patient personally. For all others, systematic communication is necessary between the community physician and the inpatient physician. Every patient who comes to the hospital gets a disease-oriented history and physical, but all too often details about pre-hospital work-up or treatment, family issues, and end-of-life wishes are lost somewhere between the office and the hospital. The American Academy of Family Physicians has developed guidelines for the interaction between community physicians and hospitalist physicians that encourage tight and continuing communication for the best possible patient care (see http://www.aafp.org/x6873.xml).

The best hospitalists are generalist physicians who see the patient as a whole person and not just as the disease problem that precipitated the admission. The hospitalist should not be confused with the intensivist, who is trained and experienced in providing specialized care, specifically diagnostic and monitoring procedures for critically ill patients.

One of the most powerful findings of this study is the higher cost for the mandatory hospitalist model. As with many of the recent studies that have addressed this issue, the authors have only been able to look at in-hospital costs and length of stay. Any analysis of the "true cost" of novel delivery system changes needs to be made by looking at system costs. We have learned that clamping down on health care costs in one sector is like squeezing a water balloon: it just pushes the same costs to another place or time that is not currently under study.

The authors conclude that the assumptions that appear to drive the hospitalist movement need further study. Most would agree, but the study needs to include an analysis of the forces in the larger health care system that are driving these trends. For the most part, managed care organizations have abandoned the mandatory hospitalist model. The far more important driving force is that physicians are choosing not to go to the hospital on a daily basis. The authors attempt to make a policy statement based on their limited research and argue against mandatory hospitalist systems. Although most of us could agree philosophically with this conclusion, it is certainly not supported by this research alone.

Continuity of care is a core value that most of us hold near and dear to our concept of Family Medicine. Abdicating responsibility for a long-term patient's care at a time when he or she needs a trusted physician most cannot possibly be the best care for the patient. The reality, however, is that many patients are hospitalized and do not receive care directly from their personal physician.

Forces in the larger health care arena are likely to make the environment more fertile for the hospitalist model. More primary care physicians will practice in groups with one group member in rotation seeing the hospitalized patients each day for the entire group. It is simply more efficient by

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reducing travel time and by opening up more appointment slots back at the office to enhance revenue for the group.

For various reasons, as many as 1 in 5 family physicians have chosen to focus attention on office practice and not participate in hospital care. These choices may be based on economics, lifestyle considerations, or the perception of reduced competence in caring for the hospitalized patient.

As the hospitalist model develops, some kind of subsidy from the system will be needed to support this activity. It is difficult for a physician to support an adequate salary by charging for 10 to 12 hospital visits per day when most of these visits are inadequately reimbursed through Medicare. The arithmetic simply does not work out. A large group, the hospital system, or a managed care organization has subsidized most successful hospitalist programs.

Hospitalists are here to stay. This new specialization seems to have come about to fill a need rather than from a mandate. As with the other arbitrary divisions of responsibility that have produced our fragmented care system, the hospitalist will be found in urban and suburban hospitals, but not in the rural areas. There will be attempts to exclude those physicians who do not fit the arbitrary definition from hospital care. Physician assistants will be hired to help out with the hospitalist's tasks, thereby negating any argument about training and competence. In the end the hospitalist movement will reach a steady state driven by need and not mandate. Family physicians will choose to work in the hospital or not just as they make other scope-of-practice choices now.

Family physicians will continue to provide continuing, comprehensive, and personal care to most of their patients, in the context of family and community and taking advantage of the important integration of mind, body, and spirit. The specialization that has occurred during the last 50 years has not changed the essence of what we do for our patients. The hospitalist movement is not likely to precipitate that change either.

JFP