Hospitalist Evolution Raises Questions, Challenges

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN FRANCISCO — Hospitalist practice is evolving rapidly into its own specialty, distinct from its largely internal medicine roots.

That process of evolution is bringing up questions and challenges, some of which may have implications for not just the hospitalists themselves but for hospitals and other physicians as well, John R. Nelson, M.D., said at the annual meeting of the American College of Physicians.

Hospitalist practice already meets many of the criteria often used to define a distinct specialty, said Dr. Nelson, a past president of the Society of Hospital Medicine.

In addition to having their own society, hospitalists now have their own continuing medical education courses, a handful of residency tracks, and fellowship programs. Hospitalists are developing some distinct competencies, and plans for a hospitalist journal are in the works.

Hospitalists are going to be pushed to specialize more, or at least to take on responsibilities that they do not often have now.

"We nearly meet all these requirements now, and the ones that we don't meet are coming soon," Dr. Nelson said.

Current estimates suggest that 10,000-12,000 hospitalists are now practicing, up from a few hundred in the 1990s. And there continue to be more hospitalist positions opening than there are applicants to fill them.

A conservative estimate about the future is that there may be 25,000 hospitalists by as soon as 2010, and that the need will plateau with that number, he said.

"I feel that hospital medicine is growing according to Moore's law—the guy who said computers double their power and speed every 18 months," said Dr. Nelson, director of hospitalist practice at Overlake Hospital Medical Center, Bellevue, Wash.

But this rapid expansion of hospital practice is liable to bring some economic issues to the fore, Dr. Nelson noted.

A concern has been raised that insurance companies will discover that hospitalists have greater liability exposure than office-based physicians.

Perhaps more importantly at this time, many hospitalists are subsidized by a health plan or the hospital where they work because their patient mix tends to include a high proportion of uninsured people.

According to a survey conducted by the Society of Hospital Medicine in 2003, the average hospitalist generates fees of $178,471 a year and receives $74,000 in hospital support, for a total that produces an average income of $158,493 plus $28,776 in benefits, after subtraction of costs and overhead.

As the ranks of hospitalists grow, hospitals may need to wean them off of this support, as happened with emergency department physicians as their specialty developed.

The difference, however, was that emergency physicians were able to have their fees raised and corrected in the era before the imposition of rigid fee caps, Dr. Nelson said. That is not possible anymore.

Another economic challenge is that medicine is adopting global fee structures and pay-for-performance strategies. That may put hospitalists in a particular bind, if hospitals turn to the hospitalists to achieve cost savings while the hospitalists are dependent on the hospitals for their practices.

Also, as the field evolves, hospitalists are going to be pushed to specialize more, or at least to take on responsibilities that they do not often have now.

This is occurring already, and one example is the admission of patients with hypertensive intracerebral hemorrhage, Dr. Nelson said. In some places, neurosurgeons are looking at hospitalists and wondering why they have to admit these patients, when in the vast majority of cases, the management will be medical in the hospital, followed by referral elsewhere.

Moreover, patient deaths are more common in the hospital than in outside practice, which probably means hospitalists should develop more end-of-life expertise.

The vast majority of hospitalists still come from the ranks of internal medicine,

but some institutions already have psychiatry, obstetrics, and cardiology hospitalists, Dr. Nelson said. He also noted that in countries such as Germany, hospital and office practice are already largely differentiated.

The specialization of hospitalists is already raising the question of credentialing, Dr. Nelson noted. At this time, hospitalists can and should just be credentialed in their own specialty, he said. The bigger issue, he added, is what to do about hospital credentials for physicians who never go to the hospital anymore.

In his opinion, office-based practitioners can and should still continue to have hospital credentials because knowledge and expertise are not like the technical proficiency needed to perform a particular procedure, for which it has been shown that regular repetition is necessary for competency.

It is a question that hospitals are already asking, Dr. Nelson said. They are also worried about how they will keep doctors loyal to their particular institution, when the doctors no longer go there.

"A lot of people are thinking about ways to keep doctors loyal to a hospital," he said. ■

Hospital Medicine Specialty Firming Up Core Curriculum

BY BRUCE DIXON
Contributing Writer

CHICAGO — The Society of Hospital Medicine has taken a major step toward defining the core content areas and competencies for practicing hospitalists.

Members of SHM got their first glimpse of a draft document at the society's annual meeting. Authors of the curriculum hope that the document, which is considered a crucial part of becoming a bona fide specialty, will be published in early 2006, possibly in the first issue of the Journal of Hospital Medicine, which is scheduled for publication in January.

"The current iteration of the core curriculum that we've developed was really borne from the first education summit that SHM held in September 2002," Michael J. Pistoria, D.O., chairman of the curriculum task force, said during the meeting in Chicago. "The concept of the core curriculum was really one of trying to find who we are and what we are. We know that what we do we do very well, [but] we don't always know how or why, and we don't know maybe how to teach [to achieve] the best possible hospitalists."

The core curriculum will be a valuable resource for adult and pediatric hospitalists and for medical education, said Dr. Pistoria, associate program director at Lehigh Valley Hospital in Allentown, Pa.

The core curriculum will be available to institutions that decide to have a hospitalist track in their residency programs or such a track within a fellowship.

"For example, a program director who wants to design a hospitalist track within his or her residency program, or a hospitalist fellowship, or even simply a class on congestive heart failure—say a lecture series—would have some of the core elements of that training," he said. "And we felt we had significant buy-in from medical education."

The content of the core curriculum will be available to institutions that decide to have a hospitalist track in their medical residency programs, or it could be part of the development of a hospitalist track within a fellowship, said coauthor Syliva McKean, M.D., of Brigham and Women's Hospital, Boston. "For example, some programs have general internal medicine fellowships that take different paths, and they could use this for those people who are interested in doing research in hospital medicine and are eager to go down a hospitalist track."

It's important to note that hospitalists do more than provide inpatient care, Dr. McKean said. They also "have the opportunity to lead, participate, and coordinate quality improvement projects in the local hospital."

According to the American Hospital Association, some 1,200 U.S. hospitals now have hospitalist programs employing an estimated 10,000 physicians. More than 4,000 of these doctors are SHM members.

In addition to Dr. Pistoria and Dr. McKean, the core curriculum authors included: Alpesh Amin, M.D., University of California, Irvine; Tina Budnitz, Society of Hospital Medicine; and Daniel Dressler, M.D., Emory University, Atlanta. ■