

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

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of residency tracks, and fellowship programs. Hospitalists are developing some distinct competencies, and plans for a hospitalist journal are in the works.

"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, hos-

pitals 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,

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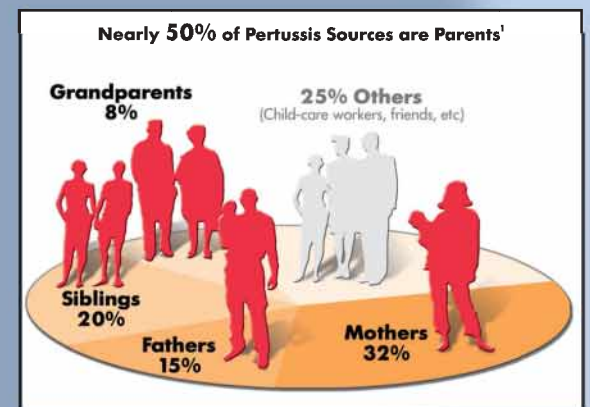
PERTUSSIS transmission

How do infants get
PERTUSSIS?

They get it from their family.

That's right — their moms and **DADS**, brothers and sisters, even grandma and grandpa!

Nearly 75% of the time, a family member is the source of pertussis disease in infants¹



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According to a recent study of pertussis in 264 infants, a family member was identified as the source of the disease in three quarters of the cases. In fact, the infant's mother was positively identified as the source in 32% of the cases. In addition to Mom, other confirmed sources included Dad 15% of the time, Grandma/Grandpa 8% of the time, and a sibling 20% of the time. This study provides clear documentation of the threat of pertussis within the family setting and serves as a window to the growing problem of pertussis in the general population.¹

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 practition-

ers 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.

"For example, a program director who wants to design a hospitalist

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.

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 Sylvia 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."

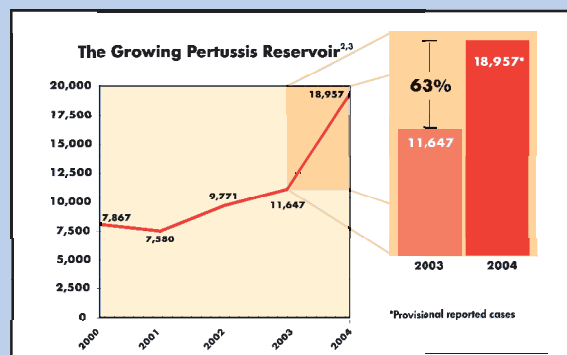
According to the American Hospital Association, some 1,200 U.S. hospitals now have hospitalist programs employing an estimated 10,000 physicians. More than 4,000 of these doctors are SHM members.

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. ■

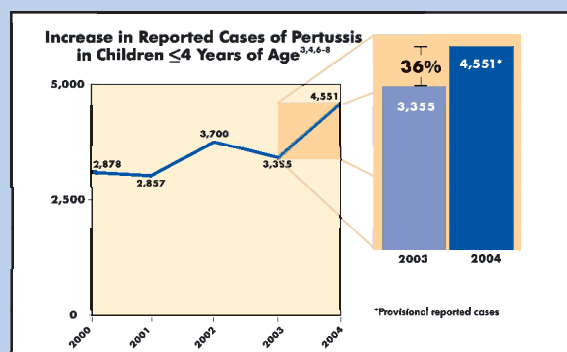
begins at home

The growing threat of pertussis — an often silent disease reservoir

Long thought to be nearly eradicated, pertussis case reports are at a 40-year high.² Today pertussis is the only communicable disease that is on the rise in all age groups for which a routine immunization is available. In 2004 there were 18,957 cases reported to the CDC, a 63% increase over 2003 and a startling 1000% increase from 20 years ago when incidence reached its nadir.^{2,3}



Especially troubling are two facts: first, there has been a 36% increase in reported cases among children ages 4 years or less^{3,4}; second, over the last decade, 80% of deaths attributed to pertussis occurred in infants under 6 months of age.⁵



Among the many explanations on the explosion of pertussis in the United States are better reporting, better diagnosis, and waning immunity. What they all have in common is the acknowledgment that there exists a reservoir of disease among adolescents and adults, and more importantly, from this reservoir pertussis transmission occurs. Pertussis is most contagious during

the first few weeks of illness before it is recognizable.⁹ In both adolescents and adults the disease is often mild in nature, and not associated with the trademark "whooping cough."^{9,10} However, studies have reported significant morbidity including pneumonia, rib fractures, urinary incontinence, weight loss, otitis media, and sinusitis.¹¹ People with pertussis are also at risk of hospitalization and other complications such as seizures and encephalopathy. Beyond the morbidity are the social, financial, and psychological costs of pertussis disease. One recent study reported that 70% of affected adolescents lost 5 to 10 days of school while 49% of afflicted adults were out of work for 5 to 10 days.¹¹ In addition, 49% of adults reported that their sleep was disturbed for more than 21 consecutive nights with 9% reporting disturbed sleep for an astounding 60+ nights.¹¹ It's no wonder the ancient Chinese called pertussis "the cough of 100 days."

Soon pertussis prevention will begin in the home too

Building on the heritage of the proven pediatric acellular DTaP vaccines, acellular Tdap vaccines for adolescents and adults will soon be available. This intervention will allow health-care providers to protect a broad spectrum of people from the morbidity of primary disease, as well as limit the morbidity and mortality in vulnerable infants by curtailing disease transmission.

You can find out more about pertussis by visiting any one of the following Web sites:

www.pertussis.com; www.cdc.gov;
www.nfid.org; www.napnap.org;
www.aap.org

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