'Laborists' Branching Off From Hospitalist Trend

Ten U.S. hospital systems are now hiring physicians whose sole role is managing the patient in labor.

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — The hospitalist movement is now poised to deliver results in the field of obstetrics.

Ten U.S. hospital systems have started or are about to start using "laborists"—physicians whose sole focus is managing the patient in labor—Louis Weinstein, M.D., reported at the annual meeting of the American College of Obstetricians and Gynecologists.

Laborists are expected to improve patient care and ease burnout among obstetricians, said Dr. Weinstein of Jefferson Medical College in Philadelphia.

The laborist profession offers predictable and limited work hours, while offering private ob.gyns. less disruption to their office and operating room schedules.

It also offers women in labor the benefit of prompt, continuous, and efficient care, he said.

Dr. Weinstein said he proposed the laborist model in 2003, modeling it on the rapidly growing hospitalist movement among internists (Am. J. Obstet. Gynecol. 2003;188:310-2). Some criticize the hospitalist movement for disruption of care, but studies have shown a high degree of patient satisfaction, reductions in resource utilization, and good clinical outcomes. Hospitalists report a high level of job satisfaction, a long-term commitment to remaining in the field, and the lowest burnout rates of any medical specialty.

To maintain 7-day, 24-hour coverage by a team of laborists, a hospital would need four physicians, each working four 10.5-hour shifts each week, Dr. Weinstein said.

He reached that estimate by assuming that the laborists would each earn $175,000 per year, and they would be given 1 week of CME time and 3 weeks of vacation annually. The hospital would have to provide a total of 12 weeks' vacation coverage for the time the laborists were away.

Laborists would receive benefits worth 28% of their salaries, and they would be covered under the hospital's liability policy at a cost of about $60,000 per laborist per year. The total annual cost to the hospital would be $1.2 million.

This scenario would make economic sense only in a hospital performing at least 2,000 deliveries per year. If laborists handled half of those deliveries at $1,200 per delivery, that would bring in $1.2 million per year, making the program "revenue neutral" from the hospital's perspective.

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The laborist profession allows the physician to enjoy predictable, limited work hours, said Dr. Louis Weinstein of Jefferson Medical College in Philadelphia.

But hospitals would come out ahead if the use of laborists improved patient safety such that even one lawsuit were avoided every 5 years, Dr. Weinstein said.

Beyond these economic calculations are the benefits to individual physicians and to the profession of obstetrics and gynecology.

Dr. Weinstein cited studies showing a high rate of burnout among ob.gyns., which he attributed in part to their hectic and unpredictable schedules and to work weeks well in excess of 40 hours.

For the laborist model to succeed, there must be buy-in by the medical staff. "Clearly, if everybody says, 'Well, I'm not going to let the laborist do *my* deliveries,' then it won't work," Dr. Weinstein said.

The ideal laborists work hard, respond efficiently but understand that "when it's their time to go [off shift], they go with good handoffs to the next laborist." ■

Evolution of Hospitalist Practice 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.

"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 commented. That is not possible anymore.

Another economic challenge is that medicine is adopting global fee structures and pay-for-performance strategies.

Specialization of hospitalists is already raising the question of credentialing.

DR. NELSON

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, he said.

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 that 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, he 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," Dr. Nelson said. ■