

Virtual Mentor

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HISTORY OF MEDICINE

Evolution of Hospital Medicine as a Site-of-Care Specialty

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Drs. Robert Wachter and Lee Goldman coined the term “hospitalist” in a 1996 *New England Journal of Medicine* article to refer to a physician who assumes the responsibility for managing the care of hospitalized patients [1]. Hospitalists are relative newcomers in the American health care system—internists have been around for over 100 years, and emergency-department physicians, for approximately 50 years. But hospitalists are not an American innovation; they have existed in other countries (e.g., United Kingdom and Canada) for decades. While some physician specialists are defined by the population they serve (geriatricians), the procedures they perform (orthopedic surgeons), or the organs they treat (dermatologists), hospitalists, like emergency-department physicians, are defined by their work location.

Who Are They?

In the late 1990s, the majority of hospitalists were general internists, but a significant number also had subspecialty fellowship training (e.g., in pulmonology, nephrology, etc.). Today, roughly 80 percent of hospitalists are general internists; smaller numbers (about 10 percent) have medical subspecialty training or other postgraduate training (about 5 percent in family medicine and 5 percent in pediatrics) [2]. The average hospitalist is 38 years of age with roughly 5 years or less experience in the field [2]. In academic medical centers, it is common for a physician to work as a hospitalist for one or more years between residency and fellowship training, but the majority of hospitalists view hospital medicine as a career. While most work full time, many do not, since the defined schedule appeals to physicians who wish to spend time with families or in nonclinical activities like research.

How Many Are There?

Since 1996, the number of hospitalists in the United States has grown rapidly. Their numbers predominate on both coasts and in large hospitals but are found throughout the country in hospitals of all sizes. In a little over 10 years, their estimated number has increased more than tenfold—from 2,000 to more than 20,000 [2]. No one is certain how many hospitalists are needed, but some believe that the number will double again in the next 10 years.

What Are Hospitalists' Clinical Roles?

Early in the movement, hospitalists routinely cared for unassigned, hospitalized medical patients, working with the primary care physicians of these patients. Today, in addition to working with primary care physicians, most hospitalists co-manage

inpatients with medical and surgical subspecialists (e.g., nephrologists, gastroenterologists, or orthopedic surgeons), deliver care in hospital short-stay units, provide inpatient medical consults, and lead hospital rapid-response teams. Particularly in community hospitals, they deliver care for patients in intensive care units and post-discharge settings such as transitional-care units and rehabilitation hospitals. A small but growing number work as proceduralists, performing traditional bedside procedures.

In community hospitals, where fellowship-trained, critical-care physicians are often in short supply, hospitalists provide much of the care in intensive care units, either along with or in lieu of critical-care physicians.

What are Hospitalists' Nonclinical Roles?

In teaching hospitals, hospitalists have assumed responsibility for teaching medical students and residents in internal medicine programs, and some participate in the education of allied health professionals (e.g., nurses, physician assistants, and pharmacists). Medical students are typically introduced to hospitalists early in their third year of medical school and become familiar with them as influential teachers during the third and fourth (i.e., clinical) years. In internal medicine training programs, hospitalists teach throughout residency. The role of hospitalist as teacher will only expand.

Hospitalists are often integral care team members and leaders of quality initiatives; they sit on hospital committees and assume leadership roles on committees such as health information management, pharmacy, and therapeutics.

What Is Driving this Growth?

In the late 1990s and early in this century, cost savings was the predominant force behind the development of many hospitalist programs. Hospitals and payers recognized that hospitalist care was linked to decreased length of stays and resource use. Greater patient throughput correlated with hospital revenue, giving managed care and hospital executives reasons to develop hospitalist programs.

Over the past few years, improvements in patient safety and health care quality prompted hospital executives to conclude that safer care does not necessarily mean more costly care. But safer care often requires greater availability and participation by physicians as integrated team members. As a group, hospitalists meet those requirements. They are uniquely positioned to recognize opportunities for improvement and able to develop more effective systems of care, thus helping hospitals comply with the growing number of quality mandates set forth by payers.

The development of the hospitalist model has increased the availability to outpatients of primary care physicians who no longer want to provide inpatient care. Primary care physicians can establish their outpatient practices knowing that hospitalists will care for their patients when they are hospitalized. The number of primary care

physicians who personally coordinate hospital care for their patients has declined dramatically throughout the country.

The Accreditation Council for Graduate Medical Education's (ACGME) resident work-hour restrictions have markedly curtailed the number of hours residents can work in the hospital. Violation of ACGME rules is not an option; a violation puts a program at risk of losing ACGME accreditation, which, in turn, would jeopardize the availability of the relatively inexpensive resident workforce and could mar an institution's reputation.

Most hospitals have relied on hospitalists to fill gaps in patient care and medical student teaching caused by the mandated shorter work week for residents.

What Are Some Adverse Effects of this Growth?

The number of physicians who complete postgraduate physician training programs in the United States has not risen significantly over the past 10 years. During this time, however, a growing number of graduates have chosen hospital medicine positions over traditional practice fields. In many training programs, the number who opt for positions in hospital medicine dwarfs the number choosing positions in primary care and nearly rivals the number who choose to pursue additional subspecialty training. The availability of hospital medicine is cited as one of many reasons why fewer trainees than in the past are selecting careers in primary care.

After cognitive skills, communication is often named as the most important quality for hospitalists. Any system becomes more complicated with each additional step, and the hospitalist model has injected another clinician into patients' health care delivery system. While a primary care physician may "know" a patient for 30 years, the hospitalist typically sees a patient 4 to 5 days. Hence, the model of care demands that the hospitalist and primary care physician transmit patient information in a timely manner at the beginning, throughout, and end of a patient's hospital stay. Patient privacy laws (e.g., Health Insurance and Portability and Accountability Act or HIPAA) and the lack of a uniform platform for electronic medical records make effective, efficient communication a challenge. Without communication and an infrastructure to address these issues, patients are at risk for medical error.

What Does the Future Hold for Hospital Medicine?

The person who set foot in a hospital emergency room 50 years ago was more likely to be greeted by a nurse than a doctor. The role of an emergency-department physician—indeed the comprehensive emergency department itself—was not commonplace. If a patient went to an emergency department today and did not see a physician, he or she would be surprised and outraged. The hospitalist movement, while following this trajectory, is catching on far more quickly. Hospitalists routinely care for the majority of patients in many hospitals across the country, even though most patients are not familiar with the role of hospitalists. In the near future, I think patients will see hospitalists in all of our nation's hospitals.

As hospital medicine matures, research will contribute to the growing literature and body of knowledge that will push hospitalists toward acquiring new competencies. The 2-year-old *Journal of Hospital Medicine* became listed by MEDLINE within the past year, and the American Board of Internal Medicine is developing an examination for a certification in hospital medicine. The internist of the future will most likely be able to receive board certification with a focus on hospital medicine. Whether it is patient care, teaching, or research, the future of hospital medicine is bright.

References

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