Hospitalists and Patient Safety
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This issue of *Forum* focuses on Hospital Medicine and the challenges and opportunities that face this rapidly growing field. Hospitalists are physicians “whose primary professional focus is the general medical care of hospitalized patients.” Over the past decade, hospitalists have quietly replaced primary care physicians (PCPs) as the fundamental provider for patients in many American hospitals. Their presence in the hospital has set the stage for hospitalists to become leaders of patient safety, teamwork, and health care quality.

This paradigm shift has not occurred without challenges or controversy. As a group, hospitalists are young physicians and most hospitalist groups are in their infancy. According to the Society of Hospital Medicine (SHM), the median age of American hospitalists is 37, and most hospitalist programs have existed for five years or less. Concern about inexperience is understandable, but many hospitalists who have practiced full-time for five years or more may have cared for as many hospitalized patients as most PCPs.

Critics of this model of care have lamented the further fragmentation of care: hospitalists cannot replace the understanding and perspective a PCP has built up with a patient during their longitudinal relationship. Clearly, effective communication is vitally important to assure an appropriate transition of care and it is incumbent upon hospitalists to make sure this occurs. Despite some potential disadvantages, hospitalists offer the potential for more “timely” care that most PCPs are unable to fulfill due to their outpatient responsibilities. With an increasing population of medically complex inpatients, our hospitals have readily adopted this model of care.

This issue of *Forum* explores the evolution of the field, the role of the hospitalist, and perspectives about hospital medicine from the view of the patient (through the lens of the Patient/Family Relations Department), the hospitalist, the PCP, and the legal system. One thread which is shared among all of these viewpoints is the importance of health care quality in the hospitalist’s role. Early in the hospital medicine movement, the Institute of Medicine Report focused our country’s attention on health care quality. By serendipity, hospitalists found themselves well positioned to address these concerns. Although the hospital medicine movement was not conceived on the basis of quality improvement, hospitalists are perfectly situated to champion patient safety and quality improvement in their institutions. By focusing their clinical time in the hospital, hospitalists have the ability to spot systems issues that need to be addressed; they are inherently encouraged to synchronize their quality improvement efforts with those of the hospital administration, as both have a vested interest in improving patient care and safety.

References

1 SHM Website: www.hospitalmedicine.org
Robert Wachter: Looking Back, Moving Ahead

by Deborah LaValley, BSN, RN, CPHQ

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Dr. Robert Wachter is the Associate Chair for Clinical Affairs and Chief of Medical Service in the Department of Medicine at the University of California at San Francisco. In 1996, Dr. Wachter authored an article in the New England Journal of Medicine which introduced the term “hospitalist” to describe a new practice model emerging from California and Minnesota. Recently, Forum spoke with Dr. Wachter about the past, present, and future of the hospitalist movement.

Forum: What was the “big bang” of the hospitalist evolution?

Dr. Wachter: Soon after the initial New England Journal article, a number of the early [Hospital Medicine] leaders got together and we asked ourselves, “what happens if this becomes a bona fide specialty?” We looked at other similar site-based specialties: emergency medicine and critical care medicine. Those emerged when the ED and ICU became complex enough that they needed a site-based specialist, someone who lived in that place and took on ownership. We looked at the “playbooks” of those fields, and realized that their growth and maturation was accompanied by a number of activities and products such as a professional society, educational programs, journals, textbooks, and conferences. So we set out to build them.

And, you had to convince the hospitals, the PCPs, and the patients to accept a lot of changes, right?

Yes, but the hospitalist field had to change as well. When our field was very young, it was in danger of being branded as being solely about efficiency and shortening length of stay. That was the main reason that hospitals were so excited about hospitalist programs: if you had hospitalists, you would shorten the length of stay by half a day and cut costs by 15 percent.

Then, three years after the field started, the IOM report on medical errors came out, followed by the IOM report on the quality chasm. While many physicians ran in the other direction from the IOM reports’ recommendations and findings, hospitalists—smack in the middle of these complex and dysfunctional organizations—knew the concerns were well-founded. The hospitalists recognized that hospitals would soon come to care as dearly about their quality and safety scores as they did about their profitability, and they believed that they should be the vanguard of fixing it.

How did hospitalists advance the patient safety movement?

Hospitalists have often pushed hospitals to improve their quality and safety conditions, in part by identifying many of the speed bumps the hospitals didn’t know they had. If you are truly a part-time hospital person, like a primary care doctor who visits the hospital irregularly, or a one month a year ward attending in a teaching hospital, you see glitches all over the place but you can usually ignore them because you will be leaving the building shortly. But if it’s where you work all the time, you’re going to dive in to fix it.

Was the discontinuity of care, when PCPs handed off inpatients to hospitalists (and vice versa), seen as a roadblock to having a hospitalist service?

Part of the magic of the hospitalist idea is that inpatient-outpatient discontinuity buys a tremendous increase in within-hospital continuity by virtue of the hospitalist being there all the time—essentially all day long—able to talk to consultants, talk to the family, react to changes in a patient’s condition, react to lab or radiologic tests that come back at 10:00 a.m. or 2:00 p.m., knowing the nurses, knowing the case managers. All those things create degrees of hospital-focused continuity that cannot be matched in other systems. But yes, the price of that is a cleavage of the care between the outpatient and the inpatient doctor.

How much of a physician’s time should be spent in the role of a hospitalist?

All of it. When the Society of Hospital Medicine defined the specialty, it said that a hospitalist was a physician whose primary professional focus is hospital care. In the community setting, very few hospitalists do anything other than 100 percent clinical hospital medicine (some spend a significant percent of their time doing quality improvement activities or other administrative activities, but still they are spending all of their time in hospital care). For community-based hospitalists, one day a week in the office just doesn’t work.

In academia, we see great variations of job descriptions. In my group, we have people who are only doing inpatient care 20–30 percent of their time, but that’s all they do in their clinical life, and then the rest of their time is in quality improvement, patient safety, or medical education or research. In general, even that part is focused on hospital care.

Does working less than 100 percent of the time as a hospitalist impact the coordination of patient care?

It doesn’t…or shouldn’t. For example, in three days I will start a 16-day period on the wards on which I will be spending virtually all of my 12-hour-a-day shifts taking care of inpatients. Since the average length of stay is 4–5 days, I will admit the vast majority of them to the hospital and see them through to their discharge. When I pick up the service, I will get a very detailed sign-out on all of the existing patients. When I leave the service, I will do precisely the same thing for the person picking up the service. During the 16 days, I’ll be “on” the entire time. The level of care and coordination that I can provide dur-
ing my 16-day shift far exceeds that of the PCP who can only be in the hospital from 6:30–7:15 a.m. en route to the office. I may not come back on service for a month or so, but because hospital care is episodic, that doesn’t carry a cost.

This fits the “practice makes perfect” argument: you want your hospitalist to be clinically active eight or 10 months a year, not two or three. The data support the premise that the key issue is this focus—when you’re on, you’re really on. You’re not distracted by other things, you’re there to do all the care and coordination that patients need. This task of caring for hospitalized patients and making hospital care better is not a marginal activity in your job. If you have those attributes, you’re capable of achieving outcomes both in terms of quality and efficiency that exceed those of people who don’t have that focus.

**Does the physical burden of 16-day shifts counter the benefits?**

In an academic setting where we’ve got smart residents, I can be here until early evening, then go home pretty confident that my team will do what needs to be done taking care of the patients overnight. I’ll speak to them a few times overnight, but I’ll be in bed. In the community setting, without residents, most hospitalist programs have 24-hour inpatient coverage with defined shifts and someone else to cover the patients at night. Since you can’t do that 16 days in a row without burning out, a prevalent model in the community is five or six days of 10 or 12-hour shifts on, with overnight coverage.

To create the maximum amount of continuity for the patients in the hospital, the tradeoff is that we want hospitalists to work as many days in a row as they can muster. I like to say, “let’s figure out how many days in a row one works before you burn out, subtract one, and that should be the length of a shift because that maximizes the chances for any individual patient of having only one doctor during their entire hospital stay.”

**How have patients responded to hospitalist care, that is, to not seeing their PCP during their hospitalization?**

Initially, it was a big surprise for a patient who was expecting to see their regular doctor and didn’t. We (hospitalists) had to let them know why their regular doctor wasn’t there and, interestingly, their response often depended on how we worded it. If you simply tell the patients a physician other than their PCP will be taking care of them, they may balk. If you tell them they’ll be treated by a physician who is a specialist in hospital care, and who can be there all day, partnering with their regular doctors until they leave the hospital, then most people say that sounds fine.

Patients recognized under the old model that, even if they loved their PCP, they were not seeing him or her for the bulk of the day, and a lot of stuff was happening to them without obvious adult supervision. And America is not a very primary care-oriented society. We are used to different doctors doing different tasks, such as in the Emergency Department (look back 40 years to when patients who came to the ED were checked in by a nurse and then waited for their PCP to show up; that would seem ludicrous today). The difference is that in emergency medicine, a Monday-Wednesday-Friday schedule is fine, and in hospital medicine it’s a disaster. You need as much day-to-day continuity as possible.

**How well do hospitalists and PCPs communicate with each other, especially at critical times?**

In general, terrible, but I don’t think it is all the hospitalists’ fault. We have this really broken system and if you look at the research that has been done on improving the discharge process in the last 10 years, much of it has been done by hospitalists. Most systems just don’t have the technological infrastructure to facilitate this communication. Even when there is good technology, some of the person-to-person contact, such as phone calls or e-mails, should remain.

It is just a matter of time before hospitals will only receive partial payment for the initial hospitalization when a discharged patient gets readmitted. Maybe then hospitals will turn to their hospitalists and say “we know you have been moaning about this for years, but now we’re really ready to invest in making this discharge thing work right.” Then things will improve rapidly.

**How are PCPs being impacted by the advent of hospitalists?**

I think it’s a mixed bag. The life of a primary care doctor is almost undoable now—it’s a national crisis. For many PCPs who have become hospitalists, they find the hospital piece more attractive than the office. For those who’ve stayed in the office, the choice of using hospitalists is (usually) voluntary. Most of them who choose to team up with a hospitalist service do it because we make their lives better, and we can give their hospitalized patients more time and attention than they can. Having a good hospitalist program has become a major satisfier for many primary care doctors.

One of the costs for the primary care doctor is the loss of his or her time in the hospital for collegiality or burnishing skills or for maintaining their linkage to the hospital. There have been

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Developing a Hospitalist Program: What You Should Consider

by Adam C. Schaffer, MD, and Sylvia C. McKean, MD

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The primary concern that is raised during the initial development of a hospitalist program, and beyond, is the introduction of discontinuity between inpatient and outpatient care since the hospitalist, not the primary care physician (PCP), is directing the patient’s hospital care. Increasingly, PCPs are removed from the inpatient setting, and hospitalists, many of whom work shifts, have never practiced primary care outside of residency.

The key to addressing this discontinuity is establishing systems to ensure robust communication between the hospitalist and the patient’s PCP. Communication should be bi-directional, with a mutual and realistic understanding of what needs to be done in each setting to ensure patient satisfaction and safety. The goal is to create a collaborative environment and facilitate a seamless transition from the inpatient to the outpatient setting.

The frequency and content of this communication is critical to the quality of care, as well as the satisfaction of the patient, family, and PCP. Ideally, the hospitalist should communicate with the PCP, at a minimum: a) at the time of admission, b) upon any significant change in the patient’s clinical status, and c) upon discharge. In the case of acutely ill patients, or if it is the preference of the patient’s PCP, daily communication is appropriate.

Communication between the hospitalist and the PCP must be standardized. An important component of this standardized communication is the discharge summary, which should be automatically transmitted to the PCP. In one survey, only 33 percent of PCPs reported consistently receiving the discharge summary prior to their patient’s first post-hospitalization visit. With in-house information technology, discharge summary modules can be designed to directly bring information such as medication lists and pending tests from the hospital’s computer systems into the discharge report—enhancing the speed and accuracy of discharge reports. The design of such systems, an area in which hospitalists can often take the lead, benefits the entire hospital.

Highlighting the importance of hospitalist-PCP communication and the development of systems to improve it, the Society of Hospital Medicine has identified communication, transitions of care, and information management as being among the core competencies in hospital medicine. Good communication between the hospitalist and PCP is important for patient care, while poor communication regarding pending tests and required follow-up care is a potential source of litigation.

Additional Responsibilities

Increasingly, hospitalists are called upon to co-manage patients—such as orthopedic and neurosurgical patients—who fall outside their core area of training (usually in internal medicine). In one study, orthopedist-hospitalist co-management of elective hip and knee arthroplasty patients was able to achieve benefits in terms of reducing minor (but not major) complications and in reducing adjusted length of stay. The appeal of having hospitalists—who are already in the hospital—admit surgical patients, especially during off hours, is clear, but the practice is not without potential hazards. Although hospitalists have expertise in perioperative medicine (e.g., the use of beta blockers and venous thromboembolism prophylaxis), they may not be the most appropriate first hospital responders to complex orthopedic and neurosurgical patients who may require emergency surgical intervention. Before any co-management service is launched, there needs to be careful and explicit delineation of the responsibilities of the hospitalist and surgeon, so that the hospitalist is not placed in the position of having to manage a clinical situation he or she does not feel adequately trained to handle. Expansion of the responsibilities of the hospitalist service must be done in a measured way. Broadening the role of hospitalists too rapidly risks physician burnout, and so may jeopardize the stability of a maturing hospitalist service.

Hospitalists are in a good position to take leadership roles in patient safety programs, clinical pathway development, and other systems-level improvement efforts, and these activities are an important part of their professional development. Hospitalists are also well-suited to enhance the patient care provided by (high-revenue-generating) services such as orthopedic surgery, either as medical consultants or in a co-management service. For systems-level quality improvement initiatives to be most successful, the hospitalist must be able to put in a sustained effort over several years. This fact points to an underappreciated nexus between the efficacy of the quality improvement efforts that hospitalists undertake and one of the biggest challenges facing growing hospitalist services: the difficulty in recruiting and retaining hospitalists.

The surge in the number of hospitalists—which now number more than 20,000 and are growing by 10–20 percent annually—signals the high demand. To avoid rapid turnover in personnel that could impede the ability of the hospitalist service to achieve systems-level improvement, hospitalists need to be given schedules that avoid burnout. They also need career development opportunities. Particularly in the academic realm, providing mentorship is important so as to facilitate professional development. Although, ideally, this mentorship should come from within the hospitalist group, there is a paucity of
senior faculty within the ranks of hospitalists. Mentorship may also come from other divisions who have senior faculty whose interests in administration, quality improvement, teaching, or research overlap with those of the hospitalist.

Another challenge hospitalist groups in academic centers are going to be called on to meet is the need to reduce the work hours of residents (a trend likely to accelerate as a result of the recent Institute of Medicine report10). Hospitalists will be asked to provide 24-hour staffing in the hospital to improve resident supervision, and will also need to care for patients without the assistance of residents. Non-resident care by hospitalists can take the form of direct care by the hospitalist or, promisingly, care provided on teams with non-physician clinicians, such as physician assistants.11

Hospitalists are well-positioned to be at the forefront of addressing some of the most pressing challenges confronting hospitals. These include implementing systems-level changes to enhance patient safety and communication among care providers, as well as enabling academic centers to meet the increasingly stringent work hours and supervisory requirements for residents. By helping hospitals solve these challenges, hospitalist programs can ensure that they become integral to the functioning of the hospital, thereby helping to ensure the support from the hospital—both financial and administrative—that hospitalist programs need in order to thrive. ■

References

Dr. Wachter

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compromises for that person, no doubt. But the time pressures for everybody are so intense that hospital care cannot be the way that PCPs achieve satisfying career paths.

Are residents who choose a career in hospital medicine being adequately prepared?

There are advantages to going out in a practice and seeing what that is like before entering hospital medicine. It’s not absolutely necessary, but the hospitalist who happened to have done outpatient medicine beforehand have an advantage. That said, I wouldn’t see that as a common career path.

We, and a few other programs, offer a one-year hospitalist fellowship for people to learn a set of skills that right now most people don’t learn during residency. Those include system improvement skills like quality improvement, patient safety, informatics, communication skills, improving your work as a medical educator, and palliative care. Right now the market is such that if you want to be a hospitalist, you will get a job. When we hire somebody right out of residency, they are immersed in a two-year faculty development program that tries to give them all of those skills.

It has been my belief all along that part of what makes this field so unique is that the good hospitalists will say I have two sick patients—one is the person right in front of me and the other is this hospital system that doesn’t always work well. My job is to make both of them better.

Now that the hospitalist model is maturing, any concerns that it will drift from what you once envisioned?

I couldn’t be happier with the way things have played out over the last 12 or 13 years. We just had 700 people at our annual CME conference and they were so excited by what they are doing, really feeling like they are making a difference and making the system better. Hospitalist programs have evolved so quickly because the system that we are working in is changing so quickly. The minute you think it’s getting static, the job changes and the dynamics of the field change. There is a built-in dynamism to the specialty that is continuously refreshing. If the whole reason the field existed was to cut length of stay and cut costs, it would be very difficult to sustain the enthusiasm. We lucked out when the quality and safety revolutions hit around 2000, because we really took ownership for improving these areas. I think that has led to an incredibly rich and dynamic field that remains extraordinarily exciting to be part of. ■

Reference
The transition towards hospitalist medicine has led to a dramatic transformation in the delivery of inpatient care at many community hospitals. It has redefined the way primary care physicians (PCPs) relate to their hospital and their patients, adjusting longstanding practice patterns and challenging traditional hospital operations.

This has certainly been the case at North Shore Medical Center (NSMC), a multi-site health system with a total of 415 beds at acute care campuses in Salem and Lynn (Massachusetts). A community-academic hybrid, NSMC maintains collaborative clinical programs with both Massachusetts General Hospital and Brigham and Women’s Hospital, and offers its own Internal Medicine residency program. With a challenging payor mix, a competitive market, and a disparate range of owned and affiliated physician practices, NSMC responded to feedback from its PCPs and began to develop a team of hospitalists whose professional focus would be general inpatient care. Over the past five years, NSMC’s establishment of its hospitalist program has helped it identify important areas of focus.

The initial driving force for the development of many hospitalist programs has been the desire of PCPs to focus on office-based practice. At NSMC and elsewhere, challenges associated with the recruitment and retention of PCPs has led to efforts to improve their quality of work life, including the reduction of after-hours coverage. The ability to hand off responsibility for inpatient care to a dedicated team of hospital-based physicians, theoretically, enables PCPs to spend more time with their patients in the office setting and improve the efficiency of their workflow.

In addition to supporting NSMC’s primary care referral base, physician and administrative leadership recognized several additional benefits to the development of a hospitalist program. Adequately staffed, it would provide rapid response to a patient and his or her family. The 24/7, on-site nature of the program would also facilitate prompt access to specialists and provide timely medical consultation for patients from other specialties. With a strong commitment to ongoing performance improvement, NSMC also recognized that its hospitalists would be ideally qualified to drive patient safety initiatives and maintain standards for transitions of care. Finally, the hospitalists would be well-positioned to improve operational efficiencies and support a variety of cost management initiatives, including a reduction in length of stay.

How much benefit a hospitalist program brings to a hospital depends on a number of factors, including the ability to successfully recruit high-caliber physicians. On Boston’s North Shore, the high cost of living and the pressure on the initial hospitalist team to meet the demands of the primary care practices extended the hiring timeframe beyond initial expectations, but today NSMC is managing 85 percent of its admissions (both campuses) with approximately 25 hospitalists and extend FTEs.

The optimal size of the initial core group will vary by institution, and will be partly dependent on hospitalist responsibilities. NSMC based its initial benchmark volume of patients per hospitalist on a clinical model that ensures a focus on patient safety, rewards favorable outcomes, and maximizes high levels of patient and family satisfaction. Though the pressure to accommodate primary care practices quickly was substantial, NSMC offered PCPs access to the hospitalist program in a sequential fashion based on the number of hospitalists and the projected volume of admissions for each of the interested primary care practices.

In addition to recruitment challenges, NSMC encountered other barriers that might have affected the delivery of high quality care within the hospitalist program. In contrast to the PCP, the hospitalist rarely has an established relationship with the patient and his or her family prior to the admission. NSMC’s experience has been that the lack of a pre-existing relationship can pose significant limitations to the rapid assessment of the patient’s past and present history. The establishment of a trusting confidence in the hospitalists can have a major impact on the patient’s outcome during a hospitalization where timely decision making can be critical. NSMC administrators have noted that many PCPs have avoided the topic of hospitalist medicine with their patients, setting the stage for confusion and disappointment when patients are admitted. NSMC learned an early lesson: a clear orientation to the hospitalist program and an endorsement by the referring PCP can go a long way to the establishment of a healthy patient–hospitalist relationship.

As more physicians relied on their hospitalist peers and more hospitalists were added, physicians told NSMC administrators that more was needed to clarify communication preferences. They wanted to create stronger links between the primary care groups, the Emergency Department physicians, and the hospitalists to ensure the safest clinical transitions. For NSMC, models of care that optimize continuity and coordination of care are still evolving and remain a critical success factor for favorable patient outcomes and optimal levels of patient and family satisfaction. Several components of the program have started to emerge as best practices, one is the concept of a seven days on/seven days off staffing model for individual hospitalists.

The program has also benefited from a combination of standardized protocol-based practices, structured communication, and clarification of responsibilities among admitting, attending, and hospitalist physicians.
The ongoing success of a community hospital requires a commitment to patient safety, quality patient care, and high levels of satisfaction among patients, physicians, and hospital staff. Similar to the implementation of certain patient safety technologies at NSMC, the introduction of a hospitalist program has resulted in certain unintended consequences and vulnerabilities, including the most notable challenge of providing personalized and compassionate continuity of care. Although it was difficult to predict the magnitude by which this new paradigm would change the delivery of patient care, it has presented new opportunities to develop a variety of performance improvement and risk management strategies at NSMC. Despite the range of complexities associated with the implementation phase, the hospitalist program has been a success by many measures, enhancing the work life of our primary care physicians and improving the coordination of inpatient care.

In the community hospital setting, the advent of hospitalist medicine has further accelerated one additional trend. At NSMC as in other hospitals across the nation, hospitalist medicine has combined with more outpatient facilities, electronic medical records, computerized order entry, and telemedicine to reduce the need of many physicians to come to the hospital. The result is less time for physicians to connect on a collegial level, and fewer opportunities for the hospital to build relationships with its medical staff. While NSMC’s administration and medical staff share the confidence that each of these major initiatives are yielding profound improvements in patient safety, this less tangible by-product of modern health care represents a challenge its team is determined to meet.
I recently saw a 1952 magazine ad portraying the archetypical physician. Under the picture of a man garbed in hat and overcoat carrying a black bag through a snowstorm, the caption reads, ‘Twas the night before Christmas and all through the house, not a creature was stirring, except for the doctor who was getting ready to make a house call.” This was indeed the accepted image of the family doctor: someone as likely to come to your home as to see you in the office; someone who would offer care throughout the full spectrum of health.

Over time, the underlying structure changed. The burden of medical knowledge increased. The intensity of medical interventions magnified. The luxury afforded by the home visit fell to the wayside in the effort to see more patients and offer more complex care. Even so, the primary care physician (PCP) remained the caregiver who knew and followed a patient through the entire continuum of care. Instead of house calls, the MD was making early morning rounds at the hospital before going to the office. It was the dedicated physician seeing the patient in the intensive care unit. The location changed; the concept remained the same.

Now, with hospitalists on hand, the PCP paradigm is again in flux.

Massachusetts General Hospital (MGH), born, in part, of a rich primary care tradition, currently has a mixed model, employing hospitalists but also permitting internists to round on their own patients. As an academic institution, many of the medical services are covered by resident housestaff backed by their supervising attendings. Side-by-side, PCPs and hospitalists offer in-hospital care. Office-based physicians who do visit their inpatients work alongside peers who no longer make the daily trek to the wards. That highlights some tension in the PCP’s role and exposes the pressures of balancing economics, quality of care, and quality of life. It also speaks to physician identity.

The traditional PCP model adds value to quality of care in several key ways. First, because the PCP knows the patient, and has managed the patient’s care longitudinally, he or she is better positioned to anticipate patient responses and needs. For example, a longstanding PCP might remember that the last time a particular patient was hospitalized, he developed delirium to a specific medication. The PCP might know that another patient typically burrows candy bars in her mattress when hospitalized, making her diabetes deceptively hard to control. PCPs hold information that might not otherwise be available, and can more readily engage familiar patients in difficult conversations (e.g., who better than the longstanding PCP to discuss with patient and family issues around end of life).

All patients risk losing some continuity of care when they transfer into or out of the hospital. PCPs who round on their inpatients might argue that they are better informed about the care plans and medications at discharge than they would be if they weren’t on site: the patient is changing location but not physician. Entrusting their patients to a hospitalist, they might argue, adds a transition in provider care. Even with a vigorous system of communication, information can be lost or missed (and vigorous communication systems are more the exception than the rule).

On the flip side of the quality of care debate, hospitalists point to several benefits for both patients and providers. First, hospitalists are on-site and are available for urgent inpatient evaluation, while the PCP in his or her office is forced to rely on others for triage and feedback. Second, the average hospitalist will manage more inpatients in a given year than the equivalent internist. The hospitalist’s base of experience becomes greater and his or her skill set more focused on the inpatient arena. For an office-based PCP, hospital admission rates are likely to vary—posing a challenge for maintaining a rounding routine and keeping inpatient skills sharp.

Third, PCPs who use the hospitalist service free up time for the patients they see in the office. In a productivity-based primary care reimbursement model, more time for more patients means more income. Even in 1952, physicians with families, mortgages, and student loan debts, had an eye on the bottom line—today probably even more so. While inpatient rounding is appealing and role defining, that bottom line renders it a more difficult decision to make.

Fourth, in an environment that already overburdens PCPs, the decision to transfer inpatient responsibilities to a hospitalist has to consider the PCP’s overall quality of life. Will that extra time (and reduced stress) give him or her an opportunity to be a better spouse, parent, colleague, or caregiver? Or will he or she feel incomplete as a physician, vulnerable to eroding skill?

What defines the PCP? Does it have to be the archetypical doctor walking out into the storm or rounding on his patients until after the children are asleep? Does one MD really need to follow the patient through all stages of health? Where do we as PCPs feel that we are adding our best value to patient care? In the end, the answers to these questions require individual introspection and a broad analysis of our profession. If we are unsatisfied with the answers, then it becomes the individual’s responsibility to change locally and the profession’s responsibility to make changes globally.
Switching to Inpatient Care

by Arthur Kennedy, MD

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The delivery of medical care, at the primary care level has remained the same for generations. As little as 20 years ago, I doubt many of us expected it to change. When I went into primary care in 1976, I assumed that I would care for my patients in both the inpatient and outpatient setting throughout my career.

Since then, of course, primary care delivery has undergone dramatic changes. Out of that upheaval emerged the development of the hospitalist model to help ease the care burdens of outpatient physicians while better coordinating inpatient care. I have had the opportunity to live and work through this transition. After 27 years in traditional primary care, I served two years as a private hospitalist for a nine-member practice. Three years ago, I joined the Newtown-Wellesley Hospital (NWH) hospitalist program.

This significant and rapid shift in the care delivery model occurred for several reasons. On the outpatient side, PCPs are being strained to the limits of safe, high quality care, and a tolerable work life. As more patients seek regular medical care, most primary care practices have been faced with a steadily growing demand to take on new patients (in our community the majority of practices, even the larger group practices, are closed to new patients). This patient population increase is compounded by the low number of medical graduates electing to go into primary care—demand is exceeding the supply. Even among the dedicated physicians in primary care, the ever-growing burdens of documentation, chronic disease management, insurance company requirements, etc., make it impossible to do it all.

For PCPs who wanted to provide comprehensive outpatient care, supportive inpatient care, and have some personal life, something had to give. For most, letting go of the inpatient segment made the most sense. Those who have done so will tell you that they were saddened by the decision, but felt that their best contribution to their patients’ care was in the office. Others, such as myself, were sad to give up an elementary part of what we do, but chose to tackle the inpatient piece of the puzzle.

On the inpatient side of the care system, this trend was likewise driven by a number of factors. With pressure to markedly reduce hospital lengths of stay came a need to “pack” as many studies and treatments as possible into each day. For a physician carrying a full office schedule, being available for their inpatients on such accelerated schedules proved unmanageable. On top of that, PCPs with inpatients were expected to be up to speed with rapidly advancing technology, information systems, and procedures. Meanwhile, the residents and medical students interacting with the PCPs’ inpatients needed to be supervised and educated. Where would he or she find the time (or energy) to work side-by-side with trainees during the day and to cover the occasional night shift? The time for a different model was clearly ripe.

In the mid 1990s, on the west coast, the concept arose of a team of full-time hospital-based physicians for general medical care. The fruition and rapid spread of this approach across the country over just a few years speaks to the pent up stress on the system and the ability of this model to address the problems hospitals and PCPs faced. In just over 20 years, more than half of all hospitals have developed a hospitalist program; more than 20,000 physicians classify themselves as hospitalists, the fastest growing field in medicine.

Most changes involve positives and negatives; the development of hospital medicine programs is no different. The benefits PCPs gained by not having to go to the hospital are offset by separation from the medical staff functions within the hospital. Securing PCP participation on committees and leadership projects is increasingly more difficult as they become more detached from the hospital. This removes an important part of the care delivery team from staff planning.

A hospitalists program may solve many of the difficulties of inpatient management while handling an active office practice, but it adds the complex and crucial problem of transition from one provider in the hospital to the outpatient provider. This communication process has proved more difficult than perhaps many anticipated, due to time and paperwork demands on both providers, varying computer systems, and the redundancy in the discharge process. Smoother transitions will require increasingly efficient and interconnected information systems. Indeed, a daunting task.

Patient Response

Fortunately, patients have responded to these changes surprisingly well. When I first made the switch to inpatient care, I was covering only for my previous practice; so to the patients, it wasn’t too different from typical vacation or weekend coverage. But even when we merged with the hospital system, the acceptance was remarkably high. Certainly patients were a little confused about the change initially (one proudly announced that she knew I was “the hospitalizer”), and that confusion was partly related to inadequate education before admissions. Once patients understood the reasons for the change, however, most have reported being quite satisfied. They seem to appreciate the fact that their in-hospital attending is able to be more focused on their immediate problems and is available all day if problems...
Pediatric hospital medicine has grown rapidly over the past decade, expanding into the dominant model of inpatient pediatric care in academic centers and non-academic centers. From a handful of practitioners in the early 1990s, the number of pediatric hospitalists has grown to 1,000–2,000 nationwide.

In both community and academic hospitals, pediatric hospitalist positions were initially established to streamline care and reduce variability in clinical practice. Over the past several years, however, hospitalists have increasingly taken on administrative and quality improvement positions, and have found themselves serving as key educators in academic health centers. By optimizing clinical care, studying care quality, and leading implementation of systemic improvements, pediatric hospitalists have the potential to substantially improve the quality and safety of care for hospitalized children.

Most studies of pediatric hospitalist systems have found that hospital costs and length of stay (LOS) have decreased following implementation of hospitalist systems. A systematic review found that in six of seven studies, LOS and costs decreased by an average of 10 percent apiece. The majority of the decrease in cost appears to be the product of reduced LOS, but some limited data also suggest that hospitalists may use fewer inpatient resources than community-based providers. Ogershok et al. found in a study of 2,177 patients that there were fewer radiology, hematology, and chemistry tests ordered per patient in a hospitalist system than on a traditional ward service (p<0.005). A second study found a reduction in pharmacy and radiologic charges for children admitted for asthma in the hospitalist service.

In addition, referring provider, house staff, and patient and family satisfaction has generally been high in hospitalist systems. Parental experience of care has been improved or unchanged in hospitalist systems and policies within their hospitals.

To change. A study by Conway et al. found that variation in care was lower in hospitalist than in traditional systems of care, and that hospitalists had higher rates of adherence to evidence-base care standards and national guidelines than community-based pediatricians who provided inpatient care. Another study, however, found that variation even among hospitalists was high, largely due to the lack of data and consensus regarding best practices in the care of many common inpatient conditions.

Rigorous research comparing therapies used in the care of children hospitalized with common conditions will be needed if reduction in undesirable variation and measurable improvement in care quality is to occur. Many hospitalist researchers have begun to address these questions, both through studies of care in individual hospitals and through multi-center studies. The PRIS (Pediatric Research in Inpatient Settings) Network was formed several years ago with the support of the American Academy of Pediatrics, the Academic Pediatrics Association, and the Society of Hospital Medicine to facilitate such studies, with the goal of improving the quality and safety of care. Currently, more than 300 pediatric hospitals nationwide are participating in this collaborative effort.

In addition to studying and improving the care of specific conditions, pediatric hospitalists have the potential to improve the quality and safety of “non-disease specific” processes of care. The Institute of Medicine has called for measurement and improvement in the safety, efficiency, effectiveness, timeliness, equity, and patient-centeredness of care. With respect to safety in particular, serious medical errors may occur up to three times as often in inpatient pediatric as in adult inpatient settings.

Efforts to reduce the incidence and consequences of medical errors in pediatric hospitals have included implementation of computerized order entry systems, hiring of clinical pharmacists to monitor drug ordering, prevention of nosocomial infections, and the implementation of work hour reductions. While many of these efforts have led to safety improvements in individual centers, not all such efforts have proven beneficial, and dissemination of successful interventions has been slow. Consequently, inpatient pediatrics (as other fields) has far to go to optimize patient safety.

Pediatric hospitalists have the opportunity to bridge this gap between knowledge and implementation of safety and quality improvement efforts both through the conduct of ongoing research, and leadership in the development of improved care systems and policies within their hospitals.
References


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Switching to Inpatient Care

General pediatrics has bifurcated into two overlapping specialties, office-based primary care and hospital-based acute care. Upon completing a pediatric residency program, the pediatrician is well trained in inpatient medicine. Even residents in primary care tracks spend a majority of their training in the hospital setting. In this regard, there is a natural fit between many pediatric residency graduates and hospitalist careers. Pediatric hospitalist clinical services vary, but most include caring for in-house pediatric patients, attending high-risk deliveries, caring for high-risk neonates in the special care nursery, and consulting in the emergency room. With the advent of hospitalist programs, as with any model of care, we have learned of both costs and benefits to the medical system, and risks and benefits to patients and providers alike.

Analyses have demonstrated reduced length of stay and reduced cost per admission when hospitalists assume care of hospitalized pediatric patients. The reduction for each of these factors is approximately ten percent. Cost reductions may be linked to more efficient utilization of services such as laboratory testing, radiologic imaging and pharmacy. The reduced length of stay might be attributable to better adherence to clinical guidelines as well as to having a physician on site to make incremental adjustments in care toward discharge and to assess and discharge the patient as soon as is appropriate.

Most hospitals with hospitalist groups allow primary care physician (PCP) groups to choose whether to manage their own hospitalized patients or refer them to the hospitalist group. Many PCPs who refer their admitted patients to hospitalist services feel that their outpatient practices are more manageable and efficient. A majority feel confident that their hospitalized patients are well cared for and that they will be informed about their patients’ conditions, management plans, and follow-up needs. Unlike in adult medicine, communication between the outpatient physician and the inpatient physician is usually straightforward as most children admitted in the community hospital setting have short problem lists and, often, uncomplicated hospital courses. The PCPs who prefer to care for their hospitalized patients do so for the sake of continuity of care, to keep their acute-medicine skills honed, for economic concerns, and sometimes for their own career satisfaction.

Benefits

Outcome studies comparing pediatric hospitalist and traditional PCP systems of care are needed, but the perceived benefits to patient care of hospitalist systems are many. The most obvious is the presence of a pediatrician on-site 24/7. This is no small matter in community hospitals where there would otherwise be no pediatrician on-site after the PCPs complete morning rounds. The hospitalist is there in real-time to respond to changes in a patient’s condition, laboratory and radiology results, and consultants’ recommendations. The in-house physician can respond to patients’ and families’ concerns in person and usually more promptly than an office-based provider. In traditional systems of inpatient care, families often need to wait until rounds the next day to talk with their physicians. Of course, hospitalists must perform triage throughout their shifts, since they can be called to address more than one patient issue in more than one area of the hospital at a given time.

Hospitalist pediatricians are in a unique position to drive quality, efficiency, safety, and utilization improvement. As integral members of the inpatient team, hospitalists are on the frontlines to witness, or actually take part in, systems failures. They have a greater understanding of the workflow and the multiple components and players in hospital systems of care. With credibility, they can influence the awareness and buy-in of both hospital administrative and patient-care staff of the need to re-design systems and implement new quality measures.

Armed with evidence, an integral patient-care role, and (often) administrative responsibilities, the hospitalist team should be an agent of change.

The inpatient team of doctors, nurses, and ancillary staff drive improved usage and implementation of evidence-based practices and decreases in variation of approaches to common pediatric conditions seen in hospitals. Through centralization, leadership, and focus on inpatient care, standards are developed and evidence-based guidelines are presented to and adopted by pediatric departments consisting of hospitalists, PCPs, and inpatient units. This should decrease over utilization of resources, variation and individualization of practice patterns, and confusion among nursing staff who try to accommodate the practice preferences of each physician group. Furthermore, when hospitalists bring current knowledge and standards to the common conditions of pediatric hospitalized patients, decision making is streamlined not only for themselves, but also for the busy, office-based PCPs who choose to care for their hospitalized patients.

Risks

So what are the risks of the current pediatric hospitalist system to patients and physicians? A factor that is usually discussed in terms of patient satisfaction is also a significant source of risk to the hospitalist. While some studies have demonstrated that patient satisfaction is preserved in hospitalist systems, the long-term relationship and earned trust between a patient and the PCP is absent in a patient-hospitalist relationship. It is well understood that a caring, trusting relationship between a physician and his/her patients goes a long way in reducing the risk of litigation when things go wrong or the outcome is...
simply not what everyone hoped for. This difference cannot be eliminated, but the risk can be mitigated by strong communication skills, a compassionate demeanor, and taking time to listen and talk with the patient.

The delivery room poses further risks. Hospitalists in community hospitals often attend high-risk deliveries when maternal-fetal transport to a tertiary care hospital is not prudent or feasible, or when unanticipated peripartum complications and emergencies occur. Hospitalists usually are not neonatologists and do not have in-house neonatology back-up. Yet, in these circumstances, the hospitalist must be prepared to resuscitate and provide intensive neonatal care upon delivery of the infant. Historically, pediatricians had substantial delivery room and NICU experience during residency, but compared with tertiary care centers, there is simply a lower volume of neonatal emergencies in community hospitals, so the hospitalist and the rest of the delivery room team, including nursery nurses and respiratory therapists, are by necessity less experienced than those working in the NICU of a tertiary care hospital. Recent changes in residency requirements have aimed to better prepare pediatricians to fill primary care roles, and in so doing, they have decreased the amount of neonatal resuscitation and NICU experience gained in pediatric training. Therefore the pipeline of new pediatricians seems even less prepared for this hospitalist role than in the past, and hospital models for obstetrics and neonatal care or residency curricula might need to be revamped.

One pitfall of hospitalist systems—handoffs—deserves particular attention because it can and should be reduced with education, awareness, research, and the re-design of systems. Patient care is fragmented when physicians work in shifts. In recent years, limits have been placed on consecutive work hours for housestaff due to medical errors attributable to long work hours and sleep deprivation. Some have argued that the safety gains from this policy change have been offset by an increased number of handoffs. On one hand, hospitalist groups tend not to regulate work hours as stringently as residency programs are required to, raising risks associated with fatigue when they cover shifts longer than those allowed for residents. On the other hand, breaks in continuity of care are part and parcel of the hospitalist system. A potential consequence of fragmented care is a decreased sense of “ownership” of the patient. The responsibility for providing excellent care and for doing no harm must extend beyond the doctor’s shift.

The key to fulfilling this responsibility is careful communication. Root cause analyses of medical errors reported to the Joint Commission between 1994 and 2006 have shown that a vast majority were due to communication failures, and another study of 150 post-operative sign outs in a pediatric intensive care unit revealed errors in 100 percent of exchanges. Factors that contribute to communication errors include: the lack of a universal, systematic hand-off method; fatigue; high patient volume; devaluation of rigorous hand-off practices; and the short-cuts that experts tend to take in thinking and problem solving after years of practice. A culture that stresses the value of proper communication and establishes parameters and techniques to diminish the human factors in hand-off errors must be inculcated at the training level, expected throughout medical practice, and practiced repeatedly. Awareness of the errors due to communication failures must be raised, and systems must be designed to make it easier for practitioners to do the right thing.

The trend toward hospitalist medicine as a branch of pediatrics has demonstrated value in cost effectiveness and efficiency of hospital-based care. The trend supports career satisfaction among pediatricians by making office practice more manageable, hospital care more efficient, and by creating options for pediatricians to concentrate on inpatient medicine, ambulatory medicine, or both. It represents a cultural shift for pediatricians and it should propel further cultural shifts that will enhance quality, safety, and teamwork. We hope that future outcomes studies will bear out these benefits for our patients.

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The specialty of Hospital Medicine (hospitalists) is relatively new, having first come into existence in 1996. Today, somewhere between 20,000–30,000 physicians practice as hospitalists, yet within the specialty there are significant differences in perception and practice. From the legal perspective, one issue of interest is defining the specialty and clarifying the hospitalist’s role and obligation.

Based on a very unscientific survey in Massachusetts and Rhode Island, even among hospitalists the definitions and answers vary. One school of thought is that the hospitalist performs a service for the hospital (as opposed to for the patient). Hospitalists may (and often do) assume the care of patients who have no primary care physician (PCP), or whose PCP is from out of the network or from out of state. Most often, the hospitalist has no prior relationship with the patient, and therefore may feel he or she does not work directly for the patient. This is analogous to a patient choosing the hospital emergency department (ED) he or she wishes to go to, but having no choice of ED physician. Other hospitalists perceive their role as a specialist, similar to a cardiologist or orthopedic surgeon, with a narrow obligation to the patient.

In terms of exposure for liability, this larger role for the hospitalist poses higher risk.

With expanding numbers and greater exposure, hospitalists have recently become targets in lawsuits.

Among these hospitalist scenarios are subtle but significant differences. Unlike the Emergency Medicine specialist, who is only responsible for the patient while he or she is in the ED, the hospitalist follows the patient throughout the entirety of the hospital stay. And unlike the cardiologist, who sees and treats the patient within the narrow prism of cardiology issues, leaving other specialists to take care of and coordinate treatment for other medical, surgical, and psychiatric conditions, the hospitalist typically oversees (or at least has knowledge of) all the care and treatment a patient receives. One evolving legal definition positions the hospitalists as the overseer of the inpatient’s care, similar to a commanding general directing several different forces in the field.

The Patient Population

With significant oversight and direction by health insurance companies, and advanced medical technology, the medical demographics of today’s hospitalized patients have changed. Due to decreased hospital stays and utilization committee oversight, the population of patients who qualify for an extended stay is more complex, both medically and socially. PCPs, already pressed for enough time to adequately attend to their outpatients—including patients who in days gone by would have been deemed sick enough to be hospitalized—have less time to oversee the care of patients who are admitted to the hospital. Given these changes in hospital populations to an increasingly common scenario in which a patient’s care team might involve multiple specialists, the time demands for overseeing a patient’s inpatient care have multiplied, creating gaps in patient monitoring and continuity of care.

The Inpatient PCP

Into this void stepped the hospitalists, serving as the 21st Century PCP for the hospitalized patient, overseeing and coordinating care, including ordering consults with subspecialists as appropriate. Clearly, a major difference from the 20th Century is the absence of any pre- or post-hospitalization relationship with the patient (i.e., longitudinal care). The role of the hospitalist is “limited” to providing timely and comprehensive care during an episode of acute or chronic illness necessitating hospitalization (i.e., vertical care). Of course, this necessitates adequate communication between the hospitalist and a patient’s PCP or referring physician to effectuate a functional transfer of care, at both admission and discharge, and during the hospitalization itself. In this fashion, the “longitudinal” and “vertical” axes intersect, benefitting the patient. In this model, the hospitalist is both communicator and team leader. In terms of exposure for liability, this larger role for the hospitalist poses higher risk.

As a team leader, the hospitalist is expected to be knowledgeable about the patient’s overall condition and treatment, and is responsible for directing the engagement of specialist consultants and testing for the patient. Thus, his or her “exposure” for legal liability is concomitantly enlarged. With expanding numbers and greater exposure, hospitalists have recently become targets in lawsuits. The following are some typical situations that can lead to malpractice allegations against a hospitalist.

- After several days in a community hospital without relief from severe pain, the patient is transferred to a tertiary teaching hospital. Upon arrival late in the day, the patient is worked up by a hospitalist whose differential diagnosis includes infection. Following numerous exams, tests, and
consults with four specialties, imaging reveals an abscess causing the pain, but the patient has sustained permanent neurological deficits. In a malpractice action, the plaintiff might claim that the hospitalist should have obtained imaging and a neurosurgical consult sooner.

- A patient hurt in a motor vehicle accident is discharged from the hospital after a short stay with “minor injuries.” Ten days later, the patient returns with significant pain. During her second admission—due to scheduling coincidences—the patient is seen by several hospitalists over several days. The patient’s condition fluctuates (initially improving then declining) and, ultimately, a hospitalist orders a neurology consult. Specialized imaging reveals previously undetected injuries and the patient dies shortly thereafter. The hospital, and its hospitalists might be accused of negligence for not ordering the neurology consult sooner.

- A hospitalist is monitoring an elderly patient with stroke-like symptoms, but whose initial imaging and neurology exams (by several providers, including neurology consult) are negative. When follow-up imaging and neurological examination the next day reveals a debilitating stroke, the patient may be inclined to sue the hospitalist for allegedly failing to notice and treat changes in the patient’s status during her hospitalization and not ordering timely consults.

- By pre-arrangement, a patient is admitted to the hospitalist service at a hospital where his specialist does not have admitting privileges (i.e., the specialist will serve as the co-attending and direct his patient’s care for the specific problem). The attending hospitalist who formally admits the patient and—along with the specialist and a consultant specialist in a related field—examines the patient on several occasions, making notes for each visit, and including suggestions for general medical care and treatment in the chart. The patient ultimately sustains severe vascular complications, with resultant disabilities. In addition to pursuing a malpractice case against his specialist, the patient might also name the hospitalist, alleging—as his doctor—he should have initiated more aggressive treatment.

Each of these scenarios calls into question the (still hazy) definition and expectation of the hospitalist’s role, responsibilities, and limits—both vertical and longitudinal—across the patient’s continuum of care. Assessment of those interpretations of the hospitalists role and responsibilities will, no doubt, be further explored by judges and juries in pending and future malpractice cases.
As we lament the challenges facing providers, patients, and family members navigating today’s health care system, we’ve all heard “Gone are the days of house calls….” But are they?

According to representatives from the Patient/Family Relations Department at Boston’s Brigham and Women’s Hospital (BWH), the growing roles of hospitalists in our complex hospitals may serve to put the feel of the “house call” back into complicated, long-term, or frequent medical admissions. These impressions are the result of anecdotal information from patient or family member encounters and comparative patient complaint data over the last three years.

In the absence of their familiar primary care physician (PCP), patients admitted under the hospitalist service appear to find comfort in the knowledge that their assigned hospitalist will be available throughout their admission. Of particular importance to patients is the great sense of relief that their hospitalist will be responsible for communicating the details of their admission to their PCP after discharge.

Further, the hospitalist’s daily presence in “the house” leads to advantages not otherwise available to community PCPs. Patients enjoy the increased efficiency of care that is delivered by a physician with established relationships with nurses and consultants, and their availability for acute emergencies. From the perspective of both patients and their family members, such availability and perspective from having overseen a patient’s entire hospitalization is extremely valuable during interdisciplinary family meetings and discharge planning. At the point of discharge from the hospital, and the transition away from the hospitalist, a robust system for alerting PCPs to their patients’ discharges, and access to a unified electronic medical record system, can make the handoff between hospitalists and PCPs be quite seamless.

The Patient/Family Relations Department also tells us that patients and their families seem to have strong relationships with hospitalists involved in their care. This may be a byproduct of familiarity through chronic illness and repeat hospitalizations, but it also appears to be linked to increased continuity and communication with hospitalists throughout their admissions.

The data maintained by the BWH Patient/Family Relations Department support this. With between 300–400 concerns being reported annually regarding the Department of Medicine, the hospitalist service certainly receives its share—most often about “overall attitude” and “customer service.” While complaints of rudeness and disrespectful demeanor are by no means good news, hospitalists take some solace that their service is subject to fewer patient safety-related complaints (i.e., about overall quality of care, communication with patients and their families regarding the care plan, and coordination of care) than physicians in other major services.

According to the patient/family representatives with whom we spoke, patients seem to view their hospitalists as “gatekeepers” to the myriad consultants often involved in long and complicated admissions. Their hospitalists serve as buffers for and translators of specialists’ opinions, absolving patients of the responsibility to translate such complex information to their PCPs during and after their admissions.

Of course, hospitalists have a number of potential pitfalls through which to navigate. Despite the convenience of their ongoing presence throughout a hospitalization, a hospitalist runs the risk of misunderstanding or not being as aware of family dynamics affecting the course of a patient’s care as is his or her long-term PCP counterpart. Further, at least within BWH, hospitalists rotate through various services, so patients with longer admissions still may see multiple hospitalists. With some effort and trust born through increased continuity and better-defined care plans established by hospitalists, these transitions can be made less difficult.

Finally, it is critical that the hospitalist’s role be clearly articulated and reinforced to patients during and towards the end of the admission in order to avoid claims of abandonment at the end of the hospitalization. Some of the representatives with whom we spoke indicated that the presence and support of a hospitalist gives the patient the sense that such communication and continuity is “too good to be true.” As long as patients understand, however, that their hospitalists will not follow them after discharge, they should be able to rest assured that the benefits they glean from the hospitalists’ involvement is just as good and true as it seems.
The following additional resources related to hospitalists were selected from the PubMed (Medline) database of indexed biomedical literature published from 2000 through March 2008. Links are provided to abstracts and full text, where available.


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