

A Surgical Surge

Hospitalists specializing in surgery are poised for huge growth



In every institution I have made contact with, the medical and surgical hospitalists have a good working relationship. Each is available to the other for consults, and they work together so frequently that they can begin to build a greater sense of teamwork.

Many or most specialties in medicine are adopting a hospitalist model, at least to a limited extent. In fact, hospital care of adult medical patients wasn't even the first place the idea was adopted.

In talking with people from hundreds of institutions it seems clear the idea appeared earlier and grew more quickly in pediatrics than adult medicine. And in the past 10 to 15 years, fields like obstetrics ("laborists"), psychiatry, gastroenterology, and many others have slowly begun to

adopt the hospitalist model.

One of the most recent disciplines to join the parade is general surgery. And when comparing the forces in play for hospitalists in the early 1990s to the current situation for surgical hospitalists, I think we may be close to a surge in surgical hospitalists similar to what we've seen with medical hospitalists in the past 10 years.

When I say surgical hospitalists, I'm referring to surgeons with a nearly exclusive inpatient practice. Other terms such as surgicalist, acute care surgeon, and traumatologist overlap to some degree but have ambiguous meanings.

Generalizations

For some months I have contacted all the surgical hospitalist practices I can find to learn what forces led to their creation and how they are structured. Several common themes are emerging:

Prevalence: There are probably no more than 20 to 40 surgical hospitalist practices, but many institutions are considering the idea. This is similar to the situation for medical hospitalists in the early to mid-1990s.

Driver to start program: In every program I've found, the main impetus to start it was to address the burden of emergency department (ED) call for existing general surgeons. Like primary care, ED call is regarded as unattractive because it is unpredictable (lots of night and weekend work), usually has a poor payer mix, and many general surgeons have seen the "center of gravity" of their practice move away from the hospital toward an ambulatory surgery center over the past 10 years

or so. Additionally, many general surgeons are increasingly uncomfortable caring for trauma patients because of recent changes in that field. (For an excellent discussion of the changing nature of general surgery and trauma care see "The Acute Care Surgeon" in *The Hospitalist*, May 2006, p. 25.)

Case volume: General surgery case volume tends to go up at a hospital that puts a surgical hospitalist program in place. When existing surgeons are relieved of ED call they increase their volume of (mostly elective) surgery. The availability of surgical hospitalists may mean fewer emergency cases presenting to the ED are referred elsewhere (which may happen when non-hospitalist surgeons are required to take ED call). These changes in case volume and the timing of the operations (e.g., volume of night surgeries may go up) may require adjustments to operating room staffing and scheduling. Presumably this increased volume would not occur in an area oversupplied with surgeons.

Economics: Like nearly all medical hospitalist programs, surgical hospitalist practices are not viable without financial support in addition to collected professional fees. In all cases I am aware of, this support comes from the sponsoring hospital.

While the cost may be similar to what the hospital might have paid for existing surgeons to take ED call, hospitals seem to be getting a better return on that investment with surgical hospitalists. A small group of surgical hospitalists can handle the increased volume and all ED calls, improving clinical and service quality. Some institutions report that surgical hospitalists are much more attentive to billing for nonoperative work than their predecessors.

Structure: Programs should have an outpatient clinic where the surgical hospitalists can provide post-operative follow-up. In most cases, each surgeon spends only half a day a week in the clinic.

Scope of practice: All surgical hospitalist practices take most or all ED general surgery calls. In some institutions, the surgical hospitalist also leads the trauma team. Other duties at a few institutions include things like managing a wound-care clinic and being on-call to place lines.

Opinion of other surgeons: Community private practice surgeons tend to support these programs, but most institutions limit or prohibit surgical hospitalists from accepting elec-

tive referrals. Community surgeons are still offered the option of remaining on the ED call schedule—as might be the case for surgeons new to the community. At least one institution reported that the presence of surgical hospitalists improved recruitment of non-hospitalist general surgeons. However, I am also aware of one program put into place largely at the insistence of the existing surgeons. Those same surgeons later insisted it be dissolved because they saw it as unwanted competition.

Staff needs: Surgical hospitalist practices nearly always require fewer doctors than a medical hospitalist practice in the same institution. This can lead to a tension between having the right number of surgical hospitalists for the case volume (often just one or two doctors) and enough to provide for a reasonable call schedule. Existing groups have adopted a number of strategies.

Groups with only two doctors often have each work seven on/seven off. The doctor on-call for that week takes all night call him/herself. In some practices that have a medical hospitalist in-house all night, it could be reasonable to have routine calls on the surgical patients (e.g., sleeping pills, laxatives, low urine output, fever) first paged to the medical hospitalist, who refers the call to the surgical hospitalist only as needed.

At least one practice has hired enough surgeons so the call burden on each is reasonable. This might be more staff than required for the patient volume: Four surgical hospitalists each work 12-hour shifts in a seven on/seven off schedule. During the seven consecutive night shifts (worked by each surgeon one week in four), patient volume is low.

Some practices hire community surgeons as moonlighters or consider using nurse practitioners or physician's assistants as first responders at night.

Demographics: Surgical hospitalists are usually midcareer doctors, not surgeons who have recently completed their training. Many say they have gotten burned out with the stress of operating a private practice and prefer hospital work to office work.

Where Will It All Lead?

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frequently that they can begin to build a greater sense of teamwork. It is important that both groups jointly develop guidelines, such as who admits which type of patients.

If, like primary care doctors, general surgeons and a handful of other specialties with significant hospital volume (such as obstetrics and gastroenterology) move largely to a hospitalist model, U.S. healthcare will have made a remarkable transformation. In the span of my career we will have gone from a system of most doctors seeing patients in and out of the hospital to a division of physician labor such that most doctors practice almost

exclusively in only one setting or the other.

I can see how this could be a good thing for patients and medical professionals, but that isn't a given. For it to turn out we must preserve the elements of the earlier system that worked well and mitigate new problems and complexities. We will need well-designed research to show the economic and quality effects of the hospitalist model on non-primary care fields such as general surgery. We face growing challenges in ensuring excellent communication between inpatient and outpatient caregivers—something that doesn't work ideally in all medical hospitalist practices.

Let Me Hear From You

I'd like to hear about any surgical hospitalist program you know of so I can add it to my database of information about such programs. And if you're thinking about becoming a surgical hospitalist or you're an institution thinking about starting such a practice, feel free to contact me so we can compare notes. I can be reached at (425) 467-3316, or by e-mail: john@jnelson.net. **TH**

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