HOSPITALIST CARE DESTINED TO BECOME DOMINANT MODEL OF INPATIENT CARE IN THE U.S., SAY UCSF RESEARCHERS

The rapidly growing hospitalist model of inpatient care has now achieved many of the attributes of other medical specialties and seems destined to become the dominant model of hospital care in the United States, according to a study published in the January 23, 2002 issue of the Journal of the American Medical Association (JAMA).

“The Hospitalist Movement Five Years Later,” by researchers at UCSF Medical Center, says that the hospitalist field appears to be living up to its promise to improve the efficiency and perhaps the quality of hospital care.

“Even skeptics now concede that it is here to stay,” said Robert Wachter, MD, associate chairman of the UCSF department of medicine, lead author of the JAMA article, and the physician who first coined the term “hospitalist” in a 1996 issue of The New England Journal of Medicine (NEJM).

According to the UCSF study, hospital care provided by physicians (typically internists), who focus exclusively on hospitalized patients and are available throughout the day, is less costly. In addition, “hospitalists may provide a higher quality of inpatient care than that provided by many primary care physicians who have few hospitalized patients and can generally see patients only briefly once a day,” said Wachter.

“The model appears to have achieved its minimum goal of improving efficiency without adverse effects on quality, teaching, or patient satisfaction,” said Lee Goldman, MD, chairman of the UCSF department of medicine and co-author of the article.

Fifteen of the 19 studies reviewed by UCSF researchers found significant decreases in both hospital costs (average decrease 13.4 %) and lengths of stay (average decrease 16.6%). Two other studies demonstrated lower lengths of stay, but no decreases in costs. The researchers noted that if the average American hospitalist cares for 600 inpatients yearly and generates a 10% savings over the average medical inpatient cost of $8,000, the nation’s 5,000 hospitalists are safely reducing inpatient costs by approximately $2.4 billion per year.

“Thus far, there is little to suggest that hospitalist-generated savings come at the expense of quality,” said Wachter. He explained that most studies found no change in quality measures. Two larger studies (averaging 1600 hospitalist patients per study) found significant decreases in inpatient and short-term mortality associated with hospitalist care.
The researchers noted that these results are insufficient to support an unqualified statement that hospitalists improve quality. They suggest that future studies must use more refined measures of quality.

Despite initial concerns regarding patient acceptance of hospitalists, surveys of patients show high levels of satisfaction, equivalent to that of similar patients cared for by their own primary care physicians or by traditional academic ward attendings. “Patients appear to be willing to trade off the familiarity of their regular doctor for the availability and acute care expertise of hospitalists,” said Wachter. “Most hospitalists are at the hospital at all times and thus accessible to the patient and family, while primary care physicians spend most of their day at their offices with outpatients, and are therefore less available.”

Recent physician surveys also indicate acceptance of the model. “As primary care physicians get used to the system, many are choosing to partner with hospitalists to care for their inpatients,” said Wachter. “Concerns about discontinuity have diminished as hospitalists have found ways to communicate effectively with primary care physicians and coordinate all aspects of care. At a time when hospital patients are more acutely ill than ever before, more doctors appear to believe that it makes sense to have these patients managed by physicians specializing in hospital care.”

Moreover, some medical staffs see hospitalists as a solution to the long-standing struggle to find physicians to care for patients admitted from the emergency department who have no primary care provider, explained Wachter.

A recent analysis projected that the hospitalist workforce in the United States will grow by the end of this decade to about 19,000, up from 5,000 presently, making it comparable in size to cardiology. “Physicians are drawn to the hospitalist field because it allows them to be generalists and still have the excitement and gratification of acute care medicine,” Wachter said.

Currently, there are hospitalist programs in 12 of America’s top 15 hospitals (as ranked by US News and World Report) as well as early training, residency track and fellowship programs at major universities nationwide. At UCSF, 15 faculty hospitalists now staff about two-thirds of the inpatient general medical service and all medical consult months. Preliminary evidence indicates that resident teaching evaluations of hospitalists are significantly higher than those of traditional ward attendings. In addition to their clinical and teaching roles, academic hospitalists are also making important research contributions in reducing medical errors, improving end-of-life care, and finding new ways to care for patients with common inpatient diseases.

Wachter is also chief of medical service at UCSF Medical Center and was the first elected president of the National Association of Inpatient Physicians (NAIP), the premier professional organization representing nearly 2,500 hospitalists nationwide.

Goldman is a Julius R. Krevans professor of medicine and also associate dean of clinical affairs in the UCSF School of Medicine.

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