The Emerging Role of Hospitalists—Will Family Physicians Continue to Practice Hospital Medicine?

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Should I continue to treat my patients when they are admitted to the hospital? You can probably imagine my surprise when I first faced this question. Like most of my family physician colleagues, my training taught me how to care for all aspects of my patients' health regardless of illness, organ system, age, or setting. Today, as a family practice educator, I teach the concepts of comprehensive care, sometimes referred to as womb-to-tomb or cradle-to-grave care. Soon, however, our family practice department will discuss proposals for a new inpatient care model that challenges this family medicine paradigm. Instead of managing my patients in the hospital, I might be transferring them to physicians who practice only inpatient medicine. There is an intensifying national debate centered on who is most appropriate to provide inpatient medical care: the patient's personal physician (family physician or other primary care physician) or an inpatient specialist. What is driving this debate, and what is the potential impact on family physicians and family medicine?

Inpatient specialists, or hospitalists, are physicians who spend 25 percent or more of their time in the hospital setting working as the physician-of-record of hospitalized patients.[1] Although there are several variations of inpatient-only practice arrangements,[2,3] the basic concept is that the inpatient specialist accepts patients from community physicians and manages their in-hospital care. The inpatient specialist keeps the primary physicians up to date on their patients' progress and transfers care back to those physicians upon a patient's discharge. Although the concept of a house physician is not new, hospitalist groups are becoming increasingly common in managed care organizations, larger hospitals, and some large physician practices. The National Association of Inpatient Physicians was founded in 1994 and now has approximately 2000 members nationwide. They are mainly internists and include critical care and pulmonary specialists and a few family physicians.

The goals of the hospitalist approach are to increase the efficiency of inpatient care while decreasing its costs. Because hospital stays are shorter than in the past, inpatient conditions are more acute and require more of the attending physician's time and personal attention—time that many ambulatory-based physicians no longer have. Inpatient specialists, then, can give more personalized care to hospitalized patients because they spend most of their time in the hospital rather than in the office. Their in-hospital availability allows them to see patients several times a day, adjust therapies more efficiently, better coordinate care among consulting specialists, and respond to patient problems or complications quickly. Proponents argue that this intensive care shortens hospital stays, decreases medical costs, and improves the quality of care.[1] Some note that patients are highly satisfied in this new system and that family physicians enjoy having more time to see patients in the office without the often competing demands of hospital work.[4,5]

Those who oppose the hospitalist model argue that the decreased cost of inpatient care does not necessarily equal more cost-effective or high-value care. Inpatient specialists, likely to be unfamiliar with the patient's history and current psychosocial milieu, might order more aggressive work-ups and interventions than would the patient's personal physician[6]—thus increasing the cost of care in both the short and long term. Some feel that the family physician who cares for the patient in the hospital is the one most qualified to continue the outpatient management after discharge.[7] Hospital stays have become shorter and the problems more complex. Physician-patient re-

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lationships and continuity of care, then, are more important than ever before. They improve patients' recovery from illness and strengthen their trust in their physician. The personal physician's deeper knowledge of the patient likely results in fewer tests, shorter lengths of stay, and better long-term outcomes. To some physicians it seems to be quite inconsistent to be preaching continuity of care but "abandoning it at the hospital door as an unnecessary burden."[8]

The arguments on both sides of the issue, although convincing and passionate, are based on anecdotal data and personal experience. Solid data to support either view do not exist. Some particulars, such as costs and lengths of stay, are currently being studied by some inpatient specialist groups. It is immensely difficult, though, to assess the cost-effectiveness of different models of health care (and then to generalize the findings) when there are so many unique variables, such as geographic location, institutional characteristics, access to care issues, professional relationships, and the personal preferences of physicians. How does one define high-value care, much less measure it?

Current managed care pressures to decrease health care costs are creating an atmosphere of economic credentialing of family physicians. Although in some settings family physicians generally enjoy more responsibility and higher incomes than they have in the past, their outpatient load continues to increase, leaving little time to care for their hospitalized patients. There are diminishing financial incentives (and increasing financial disincentives) to spend time in the hospital.[5] As hospitalists assume more of the inpatient care, family physicians could find they have less contact with colleagues, miss more learning opportunities, and face deteriorating inpatient skills. They risk no longer being cost effective enough—or comfortable enough—to care for hospitalized patients.

Although decreasing costs and standardizing care are priorities in the current health care climate, restricting how family physicians practice might not be the correct method for accomplishing these goals. A reasonable alternative might be directing more efforts and graduate medical education dollars into training more family physicians. With more family physicians, efforts can then be focused on establishing more equitable practice arrangements where the ambulatory patient load is not so large and there is time to provide the comprehensive care—including inpatient care—that patients deserve.

Primary care physicians' continual learning and skills enhancement might decline as they are further removed from hospital medicine. What organization, then, can replace the interactions with specialist colleagues that occur most commonly within hospital walls and are a large source of this continuing education? Intuitively, it does not seem likely that many of the inpatient diagnoses can be separated from the outpatient ones. Will deterioration of inpatient skills lead to deterioration of outpatient skills? Will the short-term monetary savings, then, be negated or reversed as a result of a theoretically global decline in the quality of medical care?

The evolution of inpatient specialists challenges family medicine's holistic, cradle-to-grave approach to patient care. Although some see the hospitalist model as an opportunity to increase efficiency in health care delivery, others view it as a fragmentation of care and the deterioration of a founding philosophy of family practice. What is the role of the personal family physician in this era of medical consumerism? Is the current paradigm of the family physician caring for all realistic in a medical climate that is driven by economic efficiency? Is having a personal physician important to patients today? Where does the balance lie between treating patients with biomedical and biopsychosocial ailments and providing service to insured lives? The introduction of hospitalists, then, challenges family physicians to examine their role in today's new health care delivery systems.

Still, the original question remains: Will I continue to practice hospital medicine? I will because there are neither data nor convincing arguments that show the hospitalist model is superior to traditional family practice. In fact, most family physicians currently choose to continue to provide inpatient care in their practices and enjoy doing so.[9] Some recommend that the "shape of our health care system be guided by measuring clinical outcomes, costs, and satisfaction rather than by following passion or tradition."[10] Although most family physicians and inpatient specialists agree, the shape of the health care system is changing even in the absence of these measurements. The hospitalist concept creates many challenging questions - the answers to which will likely affect most

family physicians. Until solid data are obtained, though, I will continue to provide hospital care to my patients based on a passion for the holistic traditions of family medicine.

References

1. Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. N Engl J Med 1996;335:514-7.
2. Henry LA. Working with hospitalists. Fam Pract Manage 1997;4(10):32-4, 37-42.
3. Gipe B. A Pennsylvania model for in-house acute care physician services. Improving inpatient performance and relieving outpatient stress. Cost & Quality 1996;2:6.
4. Brandner J. Will hospital rounds go the way of the house call? Managed Care 1995;4(7):19-21, 25-8.
5. Henry LA. Will hospitalists assume family physicians' inpatient care roles? Fam Pract Manage 1997; 4(7):54-6, 58-60, 65, 66, 69.
6. Epstein D. The role of "hospitalists" in the health care system. N Engl J Med 1997;336:444.
7. Guttler S. The role of "hospitalists" in the health care system. N Engl J Med 1997;336:444-5.
8. Ryan CW. Writer questions the inevitability of FPs' declining role in inpatient care. Fam Med 1997;29: 382-3.
9. Stadler DS, Zyzanski SJ, Stange KC, Langa DM. Family physicians and current inpatient practice. J Am Board Fam Pract 1997;10:357-62.
10. Wachter RM, Goldman L. The role of "hospitalists" in the health care system. N Engl J Med 1997;336: 444-5.