

The Hospitalist Model: Perspectives of the Patient, the Internist, and Internal Medicine

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The use of hospitalists has implications for patients, for internists, and for the specialty of internal medicine. For patients, the greatest concern is interrupting the continuity of a supportive relationship with their regular physician. For many internists, the hospitalist model is attractive, but they are concerned that health plans will compel physicians to transfer their patients to a hospitalist at the time of admission to the hospital (mandatory hand-off). Thus, the hospitalist could become the means to exclude internists from hospital care and deprive them of an important source of professional satisfaction. The specialty of internal medicine is very concerned about the mandatory hand-off because it threatens the internist's identity as the physician who can care for the sickest patients in any venue, making it harder for patients and health plans to distinguish the internist from family physicians and nurse practitioners. The hospitalist movement has much to offer internal medicine. To enjoy the benefits and avoid the harms associated with the hospitalist model, internal medicine must resist the imposition of the mandatory hand-off and use the hospitalist's focus on excellent inpatient care to improve the practice of medicine by all internists.

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This article considers the hospitalist in relation to several factors, including the interests of the patient, the professional identity of the internist, and the physician workforce. I write as an internist who is concerned about my patients, my practice, and the future of my field.

The Changing World of the Internist: The 1970s and the Present

An internist entering practice today would hardly recognize the life of the internist of 20 years ago. The Mendenhall Study (1), a careful observational study of the daily life of physicians, described the conditions of practice in the late 1970s. At that time, the general internist averaged 50 hospital encounters and 51.4 office visits per week. He or she spent 5.6 hours per work day in patient care activities, which included 2.4 hours per day doing office examinations and 2.0 hours in the hospital. The average length of an outpatient encounter was 18.4 minutes. From today's perspective, the life of the

general internist of the 1970s sounds relaxed and altogether enviable.

Although no methodologically similar observations of the current internist's work day have been done, the pace of that day has quickened and the locus of care has shifted. The typical internist's hospital service is small, but hospitalized patients require more intensive effort because they are sicker, because care has become technically more complex, and because the physician feels constant pressure to minimize hospital stays. Many illnesses that were once an occasion for hospital admission are now managed successfully in the office, the home, and the nursing home. Office practice is much busier; anecdotal reports indicate that 20 to 30 patients per work day is the norm for internists in areas where managed care is well established.

The shift in the locus of care may have several consequences, all currently unproved. Because internists spend much less time caring for inpatients, they could lose some of their inpatient care skills. Interruptions in a full, tightly scheduled day in the office could be much more stressful. Inpatient care, an important part of the professional identity of most internists, could become an unwelcome distraction. Reduced numbers of inpatients may mitigate some of these effects because fewer inpatients may mean fewer interruptions in the office. The magnitude of these effects is still unknown because little research has been done on the current conditions of practice.

The Hospitalist Model

According to the hospitalist model, when a patient is hospitalized, the patient's regular physician transfers complete responsibility for patient care to a hospital-based physician (2). This model is a proposed solution to the conflicts engendered by the internist's shrinking hospital census and expanding office practice and by the increasingly technical content of hospital care.

Two principal models of hospitalist care exist. In the most prevalent, several physicians practice as a group and work full time in inpatient hospital practice. The term *hospitalist* applies to these physicians, who have chosen inpatient care as their professional calling. The second model is simply an extension of

“sharing call” for nights and weekends. In this model, office-based physicians rotate responsibility for inpatient care. For 1 week, 2 weeks, or 1 month, one physician cares for all of the group’s hospitalized patients while the others work full time in the office. This system has many attractive features, including the opportunity for physicians to maintain their skills in caring for hospitalized patients.

The transfer of responsibility for patient care to a hospital-based physician has a second dimension: It can be voluntary or mandatory. Many physicians voluntarily relinquish their responsibility for care to hospitalists, cardiologists, or specialists in intensive care medicine. However, the most troubling aspect of the hospitalist model is the mandatory hand-off, through which managed care organizations require office-based physicians to transfer responsibility for patients whom they admit to the hospital to a hospital-based physician. The mandatory hand-off relegates the patient’s personal physician to the role of a bystander who is permitted to visit the patient in the hospital but not to write orders. Because a managed care organization can remove a physician from its panel, it has the leverage to force physicians to give up inpatient care. Some managed care organizations purchase community hospitals and control admitting privileges. Physicians in southern and northern California and Kansas have reported this variant of the hospitalist model.

Internists specializing in intensive care have long cared for patients admitted to the intensive care unit by primary care internists who were not fully confident of their intensive care skills. Geriatricians working largely in nursing homes have often admitted patients to the care of hospital-based colleagues. Thus, the hospitalist model is not new, but it is growing rapidly as a result of the role of managed care organizations, the increasing complexity of inpatient care, and the pressures of busy outpatient practices.

Potential Consequences of the Hospitalist Model

The Patient’s Perspective

All forms of the hospitalist model, as well as most “on-call” coverage arrangements, have one potential problem: They necessitate a break in the continuity of care for a sick patient. Implicit in a long-term patient–physician relationship is the physician’s promise to “be there” for the patient in times of duress. Hospitalist models can endanger this fiduciary relationship.

Little is known about the effects of interrupting a relationship when a patient enters the hospital. The following hypotheses are among those that require

testing: 1) Continuity of care is especially important when patients become very sick and confront the prospect that they will someday die; 2) costs will increase because the hospital-based physician doesn’t know how the patient responds to illness; 3) there will be confusion about advance directives; 4) end-of-life care will be prolonged; 4) patients subject to the mandatory hand-off will be angry about losing the freedom to choose a physician; 5) patients may be unhappy about having several physicians in charge of their care (hospitalists usually work in shifts and rotate in-hospital responsibilities); and 6) hospitalists will focus on day-to-day problems and fail to confront long-term concerns because they can be relatively isolated from what happens before and after hospitalization. The potential advantages of receiving care from a hospitalist also require evaluation; these include quicker physician responses at moments of crisis; a fresh point of view; more time to talk; and greater, in-depth knowledge of inpatient care.

The Physician’s Perspective

Many physicians with a large and growing outpatient practice will welcome a system that frees them from twice-a-day hospital rounds and the threat of interruptions in the office. However, their responses to the various hospitalist models will depend on the value that they place on providing inpatient care. Physicians who want to provide inpatient care will see many advantages to the practice of rotating responsibility for inpatient care among colleagues; this system allows each physician to maintain inpatient care skills.

Physicians who want to provide inpatient care will be very concerned about the mandatory hand-off. They will deeply resent any outside force coming between them and their hospitalized patients. They want to keep their implicit promise to be there when their patient needs them, regardless of the venue of care. They fear the loss of their autonomy, self-esteem, patient care skills, and professional identity. At some point in their careers, they may voluntarily relinquish some of their inpatient skills, but they won’t easily accept a mandate that deprives them of the opportunity to maintain those skills. A requirement to admit one’s patient to the care of another physician strikes at the very core of the internist’s identity. Internists will also be concerned about the effects of the mandatory hand-off on their outpatient skills. As one internist wrote to me, “. . .familiarity with critically ill patients in the hospital makes internists more facile in handling complex, ill but stable problems in the outpatient setting.”

The hospitalist model will be attractive to many general internists, except in so far as managed care

organizations need hospitalists to implement the mandatory hand-off. The hospitalist model is less threatening to the subspecialist internist. Some subspecialists (such as those in cardiology, pulmonary-critical care, and nephrology) depend on hospital technology and spend substantial time in the hospital. Many are, in effect, hospitalists with outpatient practices. Other subspecialists deal with diseases that seldom require hospital technologies and have hospital practices that are smaller than those of general internists.

The Perspective of Internal Medicine

Although internal medicine is the largest specialty in the United States, internists are concerned about its future. To remain vital, internal medicine (like any other field) needs to attract future internists and patients. Internal medicine is just emerging from a crisis of confidence about its attractiveness as a career choice for medical students. The specialty is in the midst of a campaign (the Internist Today Program) to increase public awareness of the internist. Internal medicine has recently reexamined and reaffirmed the role of the internist (3). At the center of its definition of the internist is the following statement (3):

Caring for the most complex patients has always been the internist's special role in the community. Patients with advanced chronic disease require medical knowledge, judgment, and experience, as well as patience and skill in working with community resources. . . . Managing sick patients efficiently in the hospital and immediately before and after hospitalization is a focal point of the internist's training.

Internal medicine recently completed a 3-year project intended to define the content of the internal medicine residency. The central goal of this project was to come to a consensus about the skills necessary to the general internist (4). The listed competencies include many that are required in the care of seriously ill hospitalized patients. Thus, internal medicine has recently reasserted itself as a specialty whose practitioners can care for the sickest patients in all venues.

The hospitalist, as one of the participants in a mandatory hand-off, may indirectly undermine the ability of the general internist to compete for patients. Adults seeking a primary health care practitioner can choose an internist, a family physician, or a nurse practitioner, and the three types of providers compete for patients. The mandatory hand-off may make the general internist more vulnerable in this competition. Deprived of the opportunity to care for sick inpatients, general internists will have less to distinguish them from nurse practitioners, family physicians, and independent practice nurses. Patients who are choosing a physician will be even

more confused about how the work of the internist differs from that of other practitioners. In addition, a reduced role for internists in hospital care may give managed care organizations fewer reasons to choose internists when they assemble physician panels.

It is difficult to predict the effect of the hospitalist model on the appeal of internal medicine as a career choice. The role of the hospitalist will appeal to some medical students, who choose internal medicine partly because it is so difficult (5). However, even if all hospitals large enough to support a hospitalist practice adopt one, the number of hospitalists is estimated to be small in relation to the current number of internists in the United States (6, 7). If mandatory hand-offs to hospitalists become the norm, students may feel that the lack of inpatient care responsibilities makes general internal medicine a less attractive career option.

An additional reason for concern about the hospitalist model is the experience of many countries in which hospital-based internists (generalists or subspecialists) perform all adult inpatient care and outpatient care is the exclusive province of family physicians. Internal medicine is a much smaller specialty in these countries.

Conclusions and Next Steps

The hospitalist model has much to offer internal medicine. It broadens the choice of careers in internal medicine; it is a good solution for internists who want to limit themselves to office practice; and, most important, it could improve care for some patients.

However, patients and internists have reasons for concern about the hospitalist model. Three principal problems are evident. First, all hospitalist models interfere with continuity of care. For some patients, this shortcoming may outweigh any benefits. Second, managed care organizations are implementing a form of the hospitalist model that includes a mandatory hand-off. This hand-off is likely to be harmful to patients because it interferes with their free choice of a physician. Third, implementation of a hospitalist model that includes the mandatory hand-off could harm the specialty of internal medicine.

Patients, internists, and professional organizations have a common stake in ensuring that the good accomplished by the use of hospitalists is not offset by harm resulting from these three core problems. Above all, internal medicine must remain unified. It must also find common cause with the public. Internists, both hospitalists and primary care physicians, must work with each other and with their patients and community leaders to improve

the hospitalist model, preserve the patient's freedom to choose a physician, and strengthen internal medicine for the future.

Improve the Hospitalist Model

Measurement of the risks and benefits of the hospitalist model, which are as yet unknown, requires carefully designed, controlled clinical trials. This research should measure the effects of different degrees of interruption in continuity of care during hospitalization, including effects on satisfaction, psychological adaptation, length of stay, discharge planning, postdischarge follow-up, mortality, and morbidity. The balance of benefit and harm will probably differ among patients, among hospitalists, and among physicians. Therefore, clinical trials should be large enough to have sufficient power to detect important differences between subgroups.

What can we do right now? Internal medicine should strive to raise the standard of care for inpatients. Hospitalists can play a central role in providing high-quality training. We must measure the quality of inpatient care and provide feedback. We need systems that support effective communication between the primary care physician and the hospitalist.

Preserve the Patient's Freedom To Choose a Physician

Managed care organizations have learned that patients want complete freedom in choosing a personal physician. The hospitalist movement may teach another lesson: Patients want their personal physician to be meaningfully involved in their hospital care. They want a personal physician who takes a deep, abiding interest in their well-being. Our profession's code of conduct requires loyalty to the patient. The two-way relationship between patient and physician has been at the heart of good medical care since earliest times. The medical care system should enable physicians and patients to keep their fundamental commitment to each other. Patients should have the right to receive care from their personal physician. Patients and physicians should actively resist administrative actions that interfere with this right.

We draw a sharp distinction between voluntary arrangements and mandatory transfers of responsibility for patient care. Voluntary transfers are part of current practice and are seldom a source of concern. Mandatory transfers are not helpful to patient care.

The form of the hospitalist model that includes a mandatory hand-off must not become accepted practice. The following five actions may help.

1. Communities should retain control over community hospitals, lest community members lose the

freedom to designate their personal physician as their care provider in the hospital.

2. The law should require managed care plans to tell potential enrollees about any restrictions on their freedom to designate their personal physician as their care provider in the hospital.

3. Contracts between managed care organizations and physicians should specify that a physician can provide hospital care to patients who designate him or her as their care provider. Employers and other purchasers of health care should insist that contracts so specify.

4. Office-based physicians and hospitalists have common cause in resisting mandatory hand-offs. Hospitalists should join office-based physicians in confronting managed care organizations that try to impose mandatory hand-offs.

5. When a hospital wants to implement a hospitalist system, local internists should strongly consider forming a group that shares responsibility for full-time inpatient care.

Strengthen Internal Medicine for the Future

The rapid rise of the hospitalist model is a reminder of the speed with which change which can occur. To retain their valued place in society, internists, especially general internists, must adapt to new conditions of practice and the changing needs of the health care system. For the sake of their patients if not themselves, internists must resist the mandatory hand-off. But it is much more useful to adapt to change than to resist it, and it is important that internists seek out the best in the hospitalist model. In addition, internists must identify short- and long-term trends and acquire the skills that they need to provide value.

In the near-term, patients will be older and burdened with diseases that we cannot cure. This scenario plays to the strengths of internal medicine. A short-term view would place greater emphasis on training in geriatrics and preparation for practice in the office, the home, and the nursing home. To maintain an identity distinct from those of other health care providers, internists must be able to deal confidently with increasingly sick patients in these settings.

It is difficult to envision internal medicine 50 years from now, in the era of chemoprevention of cancer, gene transplantation, xenotransplantation, and drugs designed to capitalize on an intricate understanding of molecular mechanisms of disease. What will be the major health problems of society? What practice skills will be needed? These questions help to put the hospitalist movement into a broader context, in which the changing content of practice will determine the role of the internist to a

far greater extent than will changes in the organization of practice.

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