

The Hospitalist: A New Medical Specialty?

Mark A. Kelley, MD

Economic forces have stimulated a growing role for physician “hospitalists” in caring for patients hospitalized by other physicians, and the question of whether hospital care constitutes a new medical specialty has been raised. Three recently recognized specialties—emergency medicine, family practice, and critical care—originated from trends in medical practice. All three fulfill the major criteria for a medical specialty: scientific legitimacy, the development of new training pathways, and the existence of academic departments. The hospitalist movement is currently underdeveloped in each of these areas. By training, most hospitalists are internists who are well prepared to care for inpatients. Internal medicine must determine how this new movement fits into the traditional framework of general internal medicine and medical subspecialties. Until it does, the future of inpatient medicine as a recognized specialty will remain uncertain.

Ann Intern Med. 1999;130:373-375.

From the University of Pennsylvania Medical Center, Philadelphia, Pennsylvania. For the current author address, see end of text.

Since the advent of the “hospitalist” in the delivery of inpatient care, many questions have been raised about the appropriate training and career path for this new role. As the hospitalist movement gains momentum, it is important to ask whether it will evolve into a recognized specialty. Although it may not currently meet the nationally recognized criteria for a specialty, hospital care is evolving in such a way that a specialty designation may be in its future.

Definition of a Medical Specialty

In the United States, most recognized specialties are developed under the auspices of the American Board of Medical Specialties (ABMS), a national confederation of the most commonly recognized specialty boards. The specialty board that awards the most certificates and the most types of certificates is the American Board of Internal Medicine (ABIM).

In the early 1990s, as new areas of knowledge and advanced technology stimulated interest in new specialties, the ABIM sensed that U.S. medicine was in danger of fragmentation. In 1993, the ABIM’s Task Force on Recognizing New and Emerging Disciplines in Internal Medicine (NEDIM) issued a policy statement (1) that provides criteria for deciding whether to award an ABIM certificate in a new medical field. For a discipline to receive ABIM certification, it must 1) have a distinct and unique

body of knowledge, 2) have clinical applicability sufficient to support a distinct clinical practice, 3) generate new information and research, 4) require a minimum training period of 12 months, and 5) have a substantial number of trainees and training programs nationwide. In addition, it must not have a negative impact on any other specialty. The NEDIM report emphasized that medicine is a constantly evolving discipline and that new technologies and knowledge should, ideally, be incorporated into existing specialties or subspecialties. These principles are similar to those embraced by the ABMS (2).

In analyzing the role of the hospitalist, it is useful to understand how specialties other than hospital care have been formed. Most fields have traditionally focused on procedures and technology, a specific population, or a particular organ system. The procedure-based specialties are largely surgical disciplines that concentrate on specific parts of the body, such as thoracic surgery and orthopedics. The population-based specialties include pediatrics, obstetrics and gynecology, and geriatrics. The medical subspecialties, such as cardiology and gastroenterology, focus on disorders related to specific organ systems. A more recent stimulus for specialization has been location of practice; two notable examples of such specialties are the hospital-based specialties of emergency medicine and critical care.

Changes in Medical Practice

Evaluating the role of the hospitalist requires a historical perspective on medical practice over the past 30 years. Through the 1970s, most primary care was provided by a community physician, the general practitioner. This physician had some postgraduate training but usually was not board certified in any discipline. He or she provided a wide range of services, which was often influenced by practice location. At one end of the spectrum, general practitioners engaged only in office practice; at the other, they performed general surgery. At that time, most medical care was administered in the hospital, where the general practitioner was often assisted by a consulting general internist who was trained in organ-based disease and was comfortable with inpatient medicine. Medical subspecialists were few, and consultant internists had large inpatient services.

By the 1980s, this situation had changed markedly. Family practice had emerged as a specialty,

legitimizing the role of the general practitioner. The internist's value as a consultant had been diluted by the emergence of medical subspecialties. Intensive care and emergency medicine were evolving into major disciplines. Consequently, the internist began spending more time on office-based practice.

Now, in 1999, most family physicians have large office-based practices, most general internists have a small role in the care of inpatients, and critical care medicine and emergency medicine are entrenched in the hospital. Having certified intensivists staff intensive care units is a growing trend because it may improve outcomes (3). The role of emergency medicine is stronger than ever because some U.S. states require emergency departments to be staffed by board-certified specialists in emergency medicine.

Three new specialties—family practice, critical care, and emergency medicine—have emerged and thrived in this 30-year period. The reasons for this are linked to demand for care, and they provide important lessons for the hospitalist movement. Family practice addresses common diseases from the pediatric through the geriatric populations and fits nicely into the managed care paradigm. Critical care physicians have met a demand for complicated postoperative care and advanced life support. Emergency medicine has filled a need to have trained persons staff a major portal of entry to the hospital: the emergency department. Critical care and emergency medicine have shown the benefits of organizing physician-administered care in specific areas of the hospital. Bringing this trend to the hospital ward could provide the necessary clinical niche for the hospitalist.

The Hospitalist as Specialist

Should hospitalism be a specialty? In analyzing the new “specialties” of family practice, emergency medicine, and intensive care, it is clear that they have met the criteria advocated by the ABMS and the ABIM. With thousands of successful practitioners and many training programs, all three have made important contributions in practice and education. In science, critical care has focused on sepsis, trauma, and cardiopulmonary physiology; emergency medicine has concentrated on resuscitation, cost containment, and screening technology; and family practice has focused on prevention and outcomes research. These specialties have their own journals and professional societies. Therefore, they seem to fulfill the criteria for a specialty.

Is hospital care a medical specialty according to the ABIM's criteria? Hospitalists have formed a national specialty society, the National Association of Inpatient Physicians. Small residency and fellowship tracks are in the early stages of development or

implementation, as are textbooks, journals, and continuing medical education courses focused on inpatient medicine. Currently, however, hospitalists can claim no unique medical knowledge or skill. Leaders of the hospitalist movement have indicated that the traditional internal medicine residency may be ideal (or at least adequate) training for a future hospitalist. If internal medicine training remains the same, then hospitalists will not meet the training-related criteria for specialization.

On the other hand, training in internal medicine is in the midst of a major transformation (4). It is clearly shifting from a focus on inpatient care to a balance between ambulatory and hospital practice. Although some worry that this shift is simply a reaction to competition from family practice, the average general internist spends less than 20% of his or her time in the hospital (5). At the same time, internists have felt poorly prepared with respect to some of the skills required in the practice of ambulatory internal medicine (4).

With this educational shift toward ambulatory medicine, the practice pendulum seems to be swinging back and forth between the outpatient and inpatient venues. However, this instability is more apparent than real. The recent reconfiguration of the education of internal medicine residents (which, among other things, increased the minimum amount of time spent in ambulatory practice during a residency from 20% to 33%) was more of an adjustment than an overhaul. New content was required to reflect modern care, and committing 33% of a residency to ambulatory care is hardly a retreat from hospital-based training. The benefit of the shift is that residents now receive a more balanced education and will be better prepared for a wide range of clinical roles. Furthermore, enough elective flexibility remains to allow training to be designed to fit various job requirements.

Therefore, the current educational framework can be easily tailored to train residents who are interested in becoming hospitalists, essentially “specializing” training through well-chosen electives that build needed competencies. In addition to the general internist's knowledge base, these competencies might include procedural skills; resource management and quality improvement techniques; and detailed knowledge about nutrition, rehabilitation, and palliative care. This increased skill set could also justify additional training. As in geriatrics and critical care, new fellowship programs for hospitalists would test the specialty waters, but funding these fellowships will be problematic in this era of reduced postgraduate subsidies. As was seen with general medicine fellowships, the existence of postresidency training alone does not inevitably lead to specialty status if this training is unimportant to practice.

Because the criteria for specialty designation depend so heavily on the development of a definable body of knowledge, distinct training programs, and a research agenda, academic medicine may ultimately determine the viability of the hospitalist movement as a specialty. Recent data (6) suggest that academically based hospitalists contribute to the educational experience and can also reduce costs. Therefore, many academic centers are hiring hospitalists to foster teaching and efficiency and to cover the inpatient services abandoned by residents who are being reassigned to ambulatory rotations. These academic hospitalists will be motivated to carve out an academic niche to support their role. If this leads to fellowships or even separate residency tracks, hospitalism will have taken a major step toward recognition as a distinct field. This is precisely the pathway that was followed by other new areas in internal medicine, such as critical care, geriatrics, and clinical electrophysiology.

Hospitalists can engage in scientific inquiry to legitimize their field as a specialty. Their research would probably focus on quality and efficiency of care. Not coincidentally, these research areas have also been embraced by both family practice and emergency medicine. If hospitalists extend the scope of their research to include postacute care, a wealth of research opportunities is available, especially because the aging of the population will increase the prevalence of chronic disease. Therefore, it seems that hospitalists will be able to pursue several potential areas of scientific investigation.

Is there a permanent practice niche for hospitalists? Based on the growth of this field to date, the answer seems to be yes, but several questions need to be answered before this "yes" is certain. First, is the hospitalist role simply a temporary position for clinicians before they establish their practices? This question is impossible to answer, given the short track record of the hospitalist movement. Second, will hospitalists develop "burnout"? Concern about burnout has been leveled at both emergency medicine and critical care medicine, but no convincing evidence indicates that burnout affects these fields more than others. It is noteworthy that in a recent survey of 372 hospitalists (7), about 80% expected that they would still be hospitalists in 3 years.

Third, will the hospitalist role be filled by others, especially hospital-based specialists in such fields as emergency medicine and critical care? Ironically, any competition for the hospitalist role will probably come from physicians in internal medicine subspecialties. Most board-certified intensivists were trained as internists. Some medical subspecialists—those in cardiology, gastroenterology, pulmonary, and critical care—devote at least 30% of their practices to in-

patient care (5). However, at least for physicians in pulmonary medicine and critical care, almost all of this inpatient time is devoted to subspecialty care (Schmitz R. Personal communication).

These practice patterns pose an interesting paradox. Some inpatient subspecialty care may be siphoned off by generalist-hospitalists. Alternatively, medical subspecialists themselves could assume the hospitalist role. This has already happened in the Philadelphia region, where one insurance company has designated medical subspecialists to serve as hospitalists. Turf conflicts between the generalist-hospitalist and the hospital-based subspecialist will probably be settled by the vagaries of physician reimbursement.

Conclusions

Hospital care does not constitute a new medical specialty, at least not yet. However, there is little doubt that hospitalists play an important and evolving role in certain sectors of the U.S. health care system. Physicians who take on this role should be clearly identified and nurtured. The National Association of Inpatient Physicians serves a vital function, allowing such groups as the ABIM, the ABMS, and the American College of Physicians–American Society of Internal Medicine to work with hospitalists to properly evaluate their contribution to U.S. medicine. Because the designation of the hospitalist field as a new specialty by the ABMS will depend on whether hospitalists create new knowledge and require unique training, the granting of such a designation may well depend on the enthusiasm of academic internal medicine for this new field.

Current Author Address: Mark A. Kelley, MD, University of Pennsylvania Medical Center, 34th Street and Civic Center Boulevard, 21 Penn Tower Hotel, Philadelphia, PA 19104.

References

1. Final Report of the Advisory Committee on Recognizing New and Emerging Disciplines in Internal Medicine. Philadelphia: American Board of Internal Medicine; 1993.
2. Annual Report and Reference Handbook. Evanston, IL: American Board of Medical Specialties; 1997.
3. Carson SS, Stocking C, Podsadecki T, Christenson J, Pohlman A, MacRae S, et al. Effects of organizational change in the medical intensive care unit of a teaching hospital: a comparison of "open" and "closed" formats. *JAMA*. 1996;276:322-8.
4. Ende J, Kelley M, Ramsey P, Sox HC, eds. Graduate Education in Internal Medicine: A Resource Guide to Curriculum Development. The Report of the Federated Council for Internal Medicine, Task Force on the Internal Medicine Residency Curriculum. Philadelphia: American Coll of Physicians; 1997.
5. Medical Group Management Association and Center for Research in Ambulatory Health Care Administration. Physician Compensation and Production Survey. Englewood, CO: Center for Research in Ambulatory Health Care Administration; 1996.
6. Wachter RM, Katz P, Showstack J, Bindman AB, Goldman L. Reorganizing an academic medical service: impact on cost, quality, patient satisfaction, and education. *JAMA*. 1998;279:1560-5.
7. Lindenaer PK, Pantilat SZ, Katz PP, Wachter RM. Hospitalists and the practice of inpatient medicine: results of a survey of the National Association of Inpatient Physicians. *Ann Intern Med*. 1999;130:343-9.