The hospitalist: a US model ripe for importing?

Australia must consider carefully the implications of developing a specialty of hospital medicine

A HOSPITALIST IS A CLINICIAN who safely manages a patient's acute hospital course and who specialises in hospital medicine, free of any compelling priorities of ambulatory care.[1,2] Hospitalists work only with inpatients, taking over care from primary care physicians after admission to hospital. They are site-defined specialists with skills in general internal medicine,[3] who care for patients with a wide range of organ derangements, illnesses (and ages) within the specific location of an acute hospital.

The hospitalist movement is most active in the United States, with adherents soon to be comparable in numbers to cardiologists.[4] Many leading US hospitals now have active hospitalist programs,[5] and, in this setting, the hospitalist is usually a specialist physician. About half are general physicians rather than single-system specialists; the others are often specialists in intensive care.[6] The US movement is establishing its own credentials as well as its own areas of research and teaching.[5]

The major "driver" for this trend in the US was initially related to funding. Hospitalists represent a rationalisation of the medical workforce within an acute hospital, appealing to a cost-oriented, managed-care model. The evidence for the impact of hospitalists is so far unconvincing, although there is some evidence that patient length of stay is decreased when hospitalists manage care.[5] The evidence for improved quality of care and patient satisfaction is equivocal.[5]

What possible advantages would the hospitalist bring for Australian medicine in the new century?

Those in favour of the concept suggest that a physician with specific training in acute hospital medicine would be more appropriate than the existing system in Australia, whereby the patient's admitting physician is usually trained as a single-system specialist. This is because a hospitalist has skills and training in general medicine, particularly acute medicine on a background of chronic complex conditions. Not only do they consequently have a more holistic approach to patients with complex, chronic problems, but they are also specifically trained in caring for the seriously ill and resuscitation. This set of skills may be especially relevant in Australian hospitals, where there is evidence of an alarming incidence of potentially preventable deaths and serious complications.[7,8] Hospitalists may bring extra skills and expertise in acute medicine and resuscitation as a way of addressing this problem.

In the US model, hospitalists also have skills in the organisational aspects of the hospital stay, including communication with all other inpatient services required by the patient, as well as in discharge planning and end-of-life care. Hospitalists in the US are also involved in the acute medical aspects of surgical and obstetric inpatient management.

How does the US hospitalist concept "fit in" with current Australian hospital medicine?

From an Australian perspective, considering the concept of a hospitalist may assist us in focusing on the changing patient population in our hospitals and re-examining what the role of an acute hospital is exactly. The US concept of the hospitalist suggests that hospital medicine can now essentially be viewed as a general specialty, with system specialists consulted as required. This would seem to require a radical departure from the current Australian model.

However, in Australia, it is already common for single-system specialists to hand over care to more general acute-care physicians in the emergency department and intensive care unit. The complexities of acute medicine now demand its own specialists with general training and experience, such as those who practise emergency and intensive care medicine. This is because understanding not only how each organ is affected in acute insults, but also how the affected organs interact with each other, is crucial to the practice of acute medicine. A similar generalist approach is now being demanded in specialties such as geriatrics and rehabilitation.

Further, with the increasing comorbid complexity of patients in acute hospitals, management by multiple referral is often required, especially in large teaching hospitals, with a potential danger of there being no generalist to pull it all together.

Australian rural hospitals and smaller metropolitan hospitals resisted the move that occurred in the latter part of the last century to increased physician specialisation, often more by default than choice. The US hospitalist model represents a trend back to this "general physicians" concept and using single-system specialists as they once used to be — referring a patient only when the generalist requires an opinion. Perhaps geriatricians in Australia would consider that this concept is already incorporated into their own model of care.

Single-system specialists in America seemed willing to forgo control of hospital care because it was interfering more and more with their professional life.[4] Increasingly, specialist physicians are practising ambulatory medicine in outpatient settings or performing specialised procedural skills, often in non-hospital settings. With this change in practice arose the very practical issue of the amount of time left to manage increasingly ill and complex patients in an acute hospital setting. Similarly, surgeons spend much of their day either in an operating theatre or an outpatient setting. However, in the US, just as important in allowing professionally non-threatening expansion of the hospitalist model were the relatively low fees that non-procedural hospital inpatient care attracted.

Do we need to develop site-specific acute hospital specialists in Australia?

Is there a call for a hospitalist in Australia, similar to the US model: one whose training and skill covers acute medicine and resuscitation medicine, chronic and multisystem problems, as well as aged care and end-of-life care — a coordinator of admission and discharge planning, a clinical

governance coordinator and a communicator between all the service providers involved in patient care?

The current system of clinician responsibility in Australian hospitals has evolved over many years. This evolutionary process has been influenced by many factors, including accountability of the individual clinician, the patient–doctor relationship and continuity of care. Changing this system by replacing existing hospital specialists with hospitalists would radically change the way we deliver healthcare and, at this stage, the advantage of the hospitalist, even in the US setting, is speculative.

Potential benefits to patients and the cost of this change would need to be carefully evaluated in the Australian setting — in the same way we would evaluate the relative cost–benefit of a new drug or procedure. Just as importantly, a well-informed debate is needed about important issues raised by the hospitalist concept. These include the future role of acute hospitals, the population of patients who may be managed in such hospitals and their expected needs, and how to set the balance between ambulatory and hospital-based care. In addition, if single-system specialists continue to play a central role in this environment, we need to think about how they will maintain their skills across a broad range of ambulatory and acute hospital care.

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