Debunking Myths about the Hospitalist Movement

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The hospitalist movement, first described in 1996 (1), has grown from several hundred practitioners to more than 4,000 today. The movement's 2-year-old professional association, the National Association of Inpatient Physicians, enjoys a membership of more than 1,500, and is probably the fastest growing medical society in the United States. A manpower analysis published in **The Green Journal** last year projected an ultimate workforce of 20,000 American hospitalists (2), comparable in size with the field of cardiology.

In this issue of **The Green Journal**, Davis and colleagues (3) provide useful new data that enhance our understanding of the effects of hospitalists on health systems. In their study of a voluntary hospitalist system at a large rural nonteaching hospital in Mississippi, they found that patients cared for by hospitalists had adjusted hospital stays that were 25% shorter, and costs that were 12% less, than patients cared for by nonhospitalist internists. For patients in the highest severity group, these savings were even greater. Annualized, the authors extrapolate that the hospitalists would have saved $2.5 million had they cared for all of the internists' patients. As with prior studies that found similar reductions in resource use (4–7), these substantial savings were achieved without diminishing quality or patient satisfaction. Nor was there evidence of cost shifting: hospitalists' patients were no less likely to be discharged to home (instead of another institution such as a skilled nursing facility) than were patients of primary care internists. We can now state with considerable confidence that hospitalists markedly decrease inpatient costs and lengths of stay with no compromise in quality or patient satisfaction.

As important as these data are, the descriptive elements of the Davis study are as telling as its quantitative findings. The paper addresses, and helps to dispel, several widely held myths about the hospitalist movement: that hospitalists work only in urban or suburban settings; that hospitalists are an "invention" of managed care, and are always employed by either hospitals or managed care organizations desperate to slash inpatient costs; and that hospitalists must always overcome the resistance of primary care physicians reluctant to relinquish hospital care.

It is important to recognize that hospitalists are not simply an urban phenomena. Although many hospitalist programs are located in urban and suburban areas, this distribution may simply reflect the location of most US hospitals. In fact, one of the key drivers of the hospitalist movement is the distance that primary care physicians have to travel to see their patients in the hospital, a major concern in rural areas.

Rural hospitals tend to be smaller than their urban counterparts. Initial speculation was that a hospital of less than 100 beds would not be able to sustain a hospitalist program, as programs generally require a medical-surgical inpatient census of at least 50 to support three hospitalists (2). This theory has given way to experience, which has taught us that even hospitals of 40 to 70 beds can support a successful hospitalist program. Of course, many rural hospitals are not small, and the rural hospital described by Davis et al is a 647-bed referral center, large enough ultimately to support a 10- to 25-person hospitalist program.

The study also confirms that hospitalist programs are not the invention of managed care organizations. Most early programs were formed by medical groups or by individual physicians, often in regions with relatively little managed care. The first reports of hospitalists hired by health maintenance organizations (HMOs) did not reach the literature until about 1997, several years after the movement began to grow in earnest. In a survey of 372 hospitalist-members of the National Association of Inpatient Physicians, only 14% worked directly for managed care organizations and only 4% were paid on a per-member, per-month basis (8).

During the past few years, most managed care organizations have become fans of the hospitalist model (9,10). Through a variety of arrangements, many now contract with hospitalists to care for inpatients whom primary care practitioners choose to hand off. In a few cases, HMOs have mandated this arrangement, leading to a substantial backlash and even some threatened legislation (11–13). Although HMO-mandated hospitalist programs are worrisome, they represent only a tiny fraction of the national hospitalist movement: one recent study of internists found that only 2% were mandated to hand their patients off to hospitalists (A. D. Auerbach, personal communication).

As noted above, relatively few hospitalists are employed directly by managed care organizations. Although a larger proportion (23%) are employed by hospitals, this proportion is smaller than the percent who are employed by a medical group (35%) or are self-employed (12%) (8). Relatively few hospitalists support their salaries and expenses based on professional fees alone, and therefore even those who are not direct hospital employees often depend on some support from the hospital. Although

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Davis et al do not describe such their hospitalists' fiscal and organizational arrangements in detail, the Mississippi hospitalists are said to be employed by the primary care clinic system. Nevertheless, because the hospitalists' decrease in inpatient costs led to actual hospital savings of $250,000, the hospital is likely already supporting the program, or will be asked to do so soon.

Dispelling widely dispersed perceptions to the contrary, Davis et al also confirm that many primary care providers are now proponents of the hospitalist model. Several years ago, my colleagues and I were often invited by hospital or medical group leadership to visit institutions to convince physicians of the clinical, financial, and lifestyle advantages of the model. However, recent reports and my own anecdotal experience convince me that primary care practitioners now frequently drive the creation of hospitalist programs. Although some still strongly prefer to provide their own hospital care, others now find that managing their ambulatory care practice has become so challenging that they will choose which hospital to use based in part on the presence, and quality, of a hospitalist program.

Without question, much of the growth of the hospitalist movement has been generated by hospitals anxious to cut inpatient costs. However, the Davis study's findings regarding the diverse motivations for these programs are typical. For example, in the Mississippi hospital, the motivations included a desire to improve outpatient efficiency (and ambulatory care efficiency did increase by 56%), a motivation shared by many other large multispecialty groups. The availability of primary care providers to their outpatients probably improved as well (although these results were not reported). Freese (14) found that a similar desire to make certain that primary care providers were predictably available to their office patients was a major driver of the hospitalist program at the Park Nicollet clinic, and the program did lead to improved outpatient satisfaction. Other common motivations include the desire to improve physician availability to inpatients, to have hospitalists care for unassigned patients admitted through the emergency department, to invest physicians in hospital quality improvement activities, and to allow primary care practitioners to have more predictable lifestyles (15).

All in all, the study by Davis et al strengthens the case that the use of hospitalists improves inpatient efficiency without compromising quality or patient satisfaction. The paper is also an interesting case study that debunks some myths and increases the sophistication and accuracy of our perceptions of the nation's fastest growing specialty.

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