

At Home in the Hospital

New breed of physicians always nearby

It's 7:30 on a Tuesday morning, and the medical staff on the sixth floor of University Hospital is starting the transition into a new day. In a windowless conference room, two interns, two medical students, a nurse practitioner and the senior resident are squeezed around a table. On one wall, a whiteboard is covered with scribbles recording vital statistics for each patient admitted overnight.

Taking over as attending physician is assistant professor of medicine Vikas Parekh, M.D. (Residency 2002). A tall, slender man of 33 and a graduate of the Harvard Medical School, he has been reviewing patients' records since 6 a.m. Now he squints up at the first name on the whiteboard and begins a 90-minute discussion of the new cases, which range from a 56-year-old man awaiting diagnosis of neurological symptoms to a wheelchair-bound woman whose leg has swelled up after she dropped a carton of 7-Up cans on it.

After two hours, Parekh says: "All right, let's put on our walking shoes." The members of the team follow him to each of the patients' rooms, listening as he asks and answers questions, offers reassurance, and tells each patient what to expect next. By 10:30 a.m., rounds are complete.

It is an uneventful hand-off, more or less typical of a general medicine floor in any major academic medical center. But one thing about it marks a major change in the delivery of health care at the U-M and across the United States.

The change lies in what Parekh does next: He stays put. He'll remain here in the hospital all day, looking in on these patients again, consulting with nurses and specialists, never far away if a crisis arises. He has no practice outside the hospital, so he won't drive off to a clinic or an office or a laboratory. And he'll be here tomorrow and the next day and the next.

Parekh stays on the floor because he belongs to the newest and fastest-growing specialty — hospital-based medicine — and he is a hospitalist — that is, a general medicine physician who devotes all his time and attention to hospitalized patients. Parekh treats the patients of clinic-based primary-care doctors from admission through treatment and discharge, and he'll speak by phone with the patients' own doctors. But as long as a patient is in the hospital, he is the primary physician.

That's good for the patient, who gains by having a doctor who's always just down the hall. And studies show that it's good for the health-care system as a whole.

Hospitalists Find a Home at the U-M

The hospitalist movement, only a decade old, came to the U-M with the hiring of four hospitalists, Parekh among them, in 2002. By mid-2007 there will be 28 U-M hospitalists working under Scott Flanders, M.D., associate professor of medicine and director of the hospitalist program.

This fast expansion mirrors the explosive growth of the subspecialty nationwide. Unnamed and virtually unknown only 10 years ago, hospitalists in the United States now number some 15,000.

For Parekh, like many other young physicians who have chosen the new subspecialty, hospital-based practice offers the chance not only to help develop a new field, but to treat medical problems across a wide spectrum.

"Specialty medicine just didn't appeal to me because it was too narrow," says Parekh, assistant director of the hospital-

ist program. "I've always liked to know a lot of stuff. Then, I really liked the acute-care aspect of general medicine more than I liked outpatient primary care. I like making sick people feel better and getting them fixed up and out of the hospital.

"Taking care of 600 or 700 hospitalized patients a year, you get a good sense of what you need to do and when you need to do it," he says. "And I think that translates into better care for patients."

The hospitalist movement is affecting a sea change in the treatment of sick patients. Twenty years ago, if you were sick enough to be hospitalized, you would have called your primary-care doctor, who would have sent you to the emergency room of a local hospital. Once admitted, the doctor would drop by to examine you — though probably not

"This attending physician would spend two to four weeks a year caring for hospitalized patients — acting as a hospitalist, but on a very part-time basis," Flanders says. "Once a day, the 'attending' would come by, meet with the residents, would hear everything that had transpired overnight, would usually go and see several of the patients — ideally, all of them — would discuss their management with the residents, and then go back to the clinic or the lab. They would do their 14 or 30 days and not do it again for another year."

So the typical patient would be treated mostly by residents — young physicians laboring under workloads that often exceeded 100 hours per week, a regimen that increasingly came to be seen as bad for residents and patients alike.



Scott Flanders, Vikas Parekh and Laurence McMahon Jr., M.D., chief of the Division of General Medicine

until the next morning — write orders, then return to her office outside the hospital. She'd visit you and her other patients — perhaps 15 or 20 in all — once a day. Otherwise, she'd manage your case via phone calls with hospital staff.

In academic hospitals such as University Hospital, you would have been treated by a team of medical residents led by an attending physician — a faculty member who spent most of his or her time in an off-site clinic or a lab.

Need for Speed Drives Demand

In the 1990s, with costs rising through the roof, insurance companies began to insist that hospital admissions meet a higher threshold of illness and that hospital stays be reduced. So, on average, hospitalized patients became sicker. They needed consultation and treatment more often and more quickly. Pressure for quicker discharges heightened the pace ➤

of care. The old system of managing a patient's treatment by pager and phone was straining at the seams.

In the outpatient clinics, the average level of acuity also rose, since only the sickest patients now went to the hospital. So here, too, treating patients was requiring more time and care. Driving to and from the hospital to see only two or three patients was becoming an intolerable drain on doctors' time.

"It was no longer possible, or at least easy, to manage hospitalized patients remotely," Flanders says, "and the role

of the office doctor was becoming increasingly complex."

In the early 1990s, a piecemeal response to these pressures emerged. Here and there, groups of physicians realized it would save money and stress if just one member of the group saw all of the practice's hospitalized patients. Some doctors began to form their own hospital-based practices. In 1996, in a seminal article in *The New England Journal of Medicine*, Robert Wachter, M.D., of the University of California, San Francisco, coined the term "hospitalist" to describe the new trend.

Just a decade later, half of all hospitals with more than 250 beds use hospitalists. In larger hospitals they're even more common. By the year 2010, the number of hospitalists in the United States is expected to reach 30,000 — more than cardiologists.

In the teaching hospitals, another factor tipped the balance toward hospital-based medicine — new rules that residents could work no more than 80 hours per week. Hospitals would have to fill a critical gap in care, and many turned to hospitalists.

Today, if you're admitted to a general medicine floor at University Hospital, you're likely to be treated by a hospitalist. On subspecialty floors — say, oncology or cardiology — hospitalists are less common. In most cases the hospitalist is assisted by residents. But some patients will be seen only by hospitalists, who soon may manage post-surgery cases, too.

Hospitals Benefit as Care Improves

The statistical results are heartening. At Michigan, as elsewhere, studies have shown that hospitalists save 10 to 15 percent of the average hospital stay. By one estimate, a hospitalist team that manages 3,000 cases per year can save its hospital more than \$2 million.

They're also improving the quality of patient care. Some studies show in-hospital mortality rates declining where hospitalists practice. And patients treated by hospitalists appear slightly less likely to make return trips to the hospital.

At first, some internists opposed the new specialty. But many critics changed course when it was shown that an internist who turned over his rounds to hospitalists could earn an extra \$47,000 per year.

Nurses enjoy dealing with a single physician who has primary responsibility for a patient. Residents say hospitalists tend



Scott Flanders checks on a patient.



Hospitalists and physician assistants gather in front of University Hospital.

to make good teachers, since they're so familiar with the hospital's complex systems. And administrators see hospitalists as allies.

"As the hospital is now their home, hospitalists are increasingly focusing on all the problems in hospital care that upset patients and doctors and nurses when things break down or don't work well," Flanders says. "Hospitalists are working to try to fix those things. Hospitals like this, because someone now gives a damn about improving hospital care."

Critics say the new specialists interrupt the continuity of care. But Flanders says his program and others are working harder to encourage communication

between hospitals and clinics. And hospitalists appear to be improving the continuity of care within hospitals, helping patients move efficiently from intensive-care units to testing areas to operating rooms and back to the floors.

"When the hospitalist movement started," Flanders says, "there were a lot of people who thought this was a bad idea, who said, 'Who better to take care of a hospitalized patient than someone who has been seeing this patient for the last 15 years?'"

"But what we're finding is that with current health insurance plans, there isn't a lot of allegiance to family physicians. Patients often hop around to different

doctors. You say, 'Who's your doctor?' and they say, 'Oh, gosh, I've got 15 of them.' So I think those lines have blurred."

Flanders says some still pine for the idealized image of the television character Marcus Welby, M.D. — the family doctor of bygone days who would shepherd each patient through a lifetime of minor and major illnesses.

"There are doctors out there who say, 'That's the way it should be,'" Flanders says. "But, frankly, that era is gone." [m](#)