

FROM THE EDITORS' DESK

Evolution of Hospital Medicine and the Impact on Residents' Career Choices*Lori A. Bastian, MD, MPH^{1,2} and Roy Sittig, MD, SFHM¹*

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Since its inception in the 1990s, the practice of hospital medicine has grown rapidly and is considered the fastest growing specialty in the history of medicine.¹ The initial impetus for developing hospital medicine was to localize clinical practice to the in-patient setting to improve the efficiency of care, and these efficiency gains have been demonstrated by reductions in length of stay and total hospital costs.^{2,3} The next phase in the evolution of hospitalist practice has focused on improving the overall value of care, with value being defined as the quality of care divided by the cost.⁴ The common inpatient quality measures that hospitalists can influence include readmissions, patient safety and patient satisfaction. To further improve the overall value of in-patient care, many programs are testing new models of care delivery, such as adjusting provider schedules, incorporating advanced practitioners, and localizing hospitalist teams to specific nursing units. As the field of hospital medicine matures, it is important to understand how these new models of care delivery may influence internal medicine resident career choices.

Moving forward, one of the challenges will be to better understand how to “recruit” residents into hospital medicine while retaining excellent providers. Little is known about how internal medicine residents choose careers in hospital medicine and understanding how residents develop their career plans is important for planning to meet the current and future workforce needs of in-patient medicine. In this issue of *JGIM*, Ratelle et al. examined the survey associated with the internal medicine in-training examination across three years (2009–2011) in order to identify which internal medicine residents chose careers in hospital medicine and to determine how this career choice changed over the course of their residency training.⁵ In their third year of training, 9.3 % of residents reported hospital medicine as their career choice. However, a much smaller percentage of residents

maintained hospital medicine as their career choice across all three years of training. The majority of residents selecting hospital medicine (> 90 %) did not finalize this decision until their last year of training. Women and those doing primary care residencies were less likely to choose hospitalist careers. Reasons for making decisions about hospital medicine in the last year of residency are unknown, but might be related to positive experiences they gain working with hospitalists on teaching services, or because of an inability to make a decision about which subspecialty they want to do and/or match into their chosen subspecialty.

Also in this issue of *JGIM*, Singh and Fletcher evaluated the impact of the aforementioned changing models of care delivery and undertook a qualitative exploration of the impact of geographic localization of hospitalist teams to specific nursing units.⁶ Investigators led five focus groups with six hospital medicine physicians, three hospital medicine physician assistants, and 29 nurses. Both nurses and providers reported a positive impact of co-localizing hospital medicine teams to nursing units, mediated by improved communication. The focus groups also identified four potential unintended consequences of co-localization: 1) increased communication interruptions; 2) admission flow problems, with patients often arriving in boluses, which tended to overwhelm nursing resources; 3) the teams were generalist teams and this could potentially disrupt wards with nursing units that are specialized; and 4) there was the potential for perverse incentives to increase length of stay, as found in previous work.⁶ This study only included one nursing unit and did not include residents, because the team under investigation was a non-teaching service.

In another article in this issue of *JGIM*, Turner et al. evaluated the effect of hospitalist discontinuity on cost, readmission and patient satisfaction.⁷ Discontinuity was measured by modifying two tools: the Usual Provider of Care Index and the Number of Physicians Index. The authors found that discontinuity was associated with increased costs, had no impact on patient satisfaction and trended toward fewer readmissions. The authors proposed that the discontinuity associated with a “second look” by another provider may prevent readmissions, by offering a

means to enhance the post-discharge plan or by allowing the next provider to not be anchored by the initial diagnostic impression. This study is helpful to understand how discontinuity impacts patient care and it would be useful to know if continuity of residents on a teaching service has a similar impact.

These examples highlight the innovative approaches being applied to improve the value of hospitalist practice. These changes may affect both quality and cost metrics, but also may affect residents' career decisions. Increases in the efficiency of hospital practice that are associated with improved provider satisfaction and more opportunities to augment clinical practice with an academic niche in quality improvement may lead to increased interest in hospitalist careers. On the other hand, some practice changes have the potential to decrease the appeal of the field. It is important for the future of hospital medicine to ensure that these practice changes continue to make hospital medicine a viable choice for trainees. While value is an important hospital metric, we need to be mindful of the how these changes affect career choices, and we encourage our colleagues to evaluate how these practice changes impact resident satisfaction on teaching services.

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