Meeting 24/7 demands

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I am a hospitalist. I did not start out to be one nor, quite frankly, did I even know what one was when I was in training. Hospitalists—usually internal medicine doctors—specialize in the care of hospitalized patients. We go to work each day in a hospital rather than in an office-based practice or a clinic. We work in community hospitals and in tertiary academic medical centers like Dartmouth-Hitchcock Medical Center. We don't take care of hospitalized patients all by ourselves—we coordinate their treatment with a whole health-care team. In addition, hospitalists are essential components in the process of educating medical students and residents.

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But why has hospitalist medicine developed? For centuries now, haven't physicians seen patients in the clinic as well as in the hospital? At one time, patients were admitted to the hospital for therapeutic confinement and were discharged when their illness was resolved. Some illnesses, like pneumonia or heart disease, could keep patients hospitalized for weeks. Each day, the patients' own physicians had "rounding time," during which they visited the hospital—usually in the morning and again at the end of the day—so they could coordinate the care of their patients. When they weren't rounding, physicians were seeing other patients back at the office.

Changes: The American health-care system has been undergoing enormous changes. We now find ourselves with sicker hospitalized patients, more complex and expensive medical technology and interventions, and 24/7 demands coinciding with rising numbers of uninsured patients and decreasing Medicare reimbursements.

Hospitalized patients are definitely sicker today on average than they were even a decade ago. Many illnesses that once sent people to the hospital are now routinely treated on an outpatient basis. Cancer, HIV, and congestive heart failure, for instance, have migrated from the hospital ward to specialized clinics, infusion suites, and outpatient centers. Even diagnoses like uncomplicated deep venous thrombosis—a blood clot in the deep veins of the leg—have disappeared from inpatient wards. Nowadays, patients are being hospitalized only for really complicated conditions such as deep venous thrombosis with pulmonary emboli—clots that have traveled to the lungs—in patients who also have metastatic cancer. Simply stated, we are caring for inpatients today who might not have survived to this point years ago. So clinic physicians' twice-a-day rounds to care for their hospitalized patients are no longer enough. Inpatient care is more complex and occurs all day long: the health-care team is planning interventions and therapies, scheduling and interpreting imaging studies, coordinating consultations, attending family meetings, and more.

Hospitalists coordinate all this care for each inpatient by collaborating with nurses, social workers, physical and occupational therapists, and nutritionists, as well as with a vast array of medical and surgical consultants. We also work with clinical resource coordinators, who help patients make the transition from the hospital to home or to skilled-nursing or rehabilitation facilities.

We strive to get to know our patients, too. It can be daunting to assimilate a stranger's entire health history and to understand his or her personal beliefs pertaining to health care. There is certainly the risk of not knowing patients as well as their primary-care physicians do. Coordinating with the physicians who refer patients to the hospital is absolutely essential to avoid a "voltage drop" in information.

Passion: Nevertheless, physicians drawn to hospital medicine thrive in this environment. Many of us have found that the transition from office-based to hospital-based care has reinvigorated our passion for medicine. We play a vital role in the care of very ill patients and their families. Studies show that hospitalist-based care can ensure patient satisfaction, reduce the length of hospital stays, reduce medical costs, and even reduce morbidity and mortality.

There are enormous benefits for hospitals as well. Coordinated care and better care is, ultimately, more efficient. In a busy hospital, it means there is room for the next patient waiting for admission. In our experience at DHMC with our Hospital Medicine Program, we have begun to see these improved outcomes and benefits.

And finally, the hospitalist plays a vital role in training medical students and residents. The inpatient wards are the proving ground for medical students and the core training area for residents. We have embraced the role of educating and mentoring trainees at all levels. It is clear that the doctor who is available to provide patient care throughout the day is also more available to the learner as well.

Paradigm: At DHMC, we not only serve as the attending-physician-of-record on our housestaff medical teams, but we also care for patients on our own, on units without resident support. Often, the last time an attending physician at an academic medical center provided direct patient care to an inpatient was during his or her residency. But we have created a new paradigm that has honed our skills and provided a model of excellent and efficient care.

The evolution of hospitalists and of our Hospital Medicine Program has occurred at a time of increasing complexity and transition in inpatient care and medical training. We have seen this as an opportunity to improve patient care, better coordinate hospital services, and rededicate ourselves to inpatient medical education. What better way to further the mission of an academic medical center? ■

The "Grand Rounds" essay covers a topic of interest to the Dartmouth medical faculty. Merrens graduated from Dartmouth College in 1988 and DMS in 1994; he's an assistant professor of medicine at DMS and director of DHMC's Hospital Medicine Program.