LETTER FROM THE EDITOR

This issue of Seminars in Medical Practice addresses two emerging trends in health care delivery that will likely affect clinical practice well into the 21st century. The first is the rapidly expanding use of hospitalists. Primary care physicians entering private practice will probably face increasing pressure to hand over their hospitalized patients to physicians whose clinical practice is primarily devoted to inpatient care.

It has been just over 5 years since Robert Wachter and Lee Goldman published their seminal JAMA article describing a new concept in inpatient care they termed the “hospitalist model.” Since then, the number of hospitalists practicing in the United States has exploded. This rapid growth can be attributed to at least two factors: the increasing demand for higher quality, more cost-effective care and the realization by some private-practicing physicians that time spent rounding on their shrinking inpatient panels could be better spent (and possibly more lucrative) seeing more outpatients.

In January 2002, Wachter and Goldman published a follow-up to their first JAMA article in which they reported on the current state of the hospitalist movement. While they stressed the lack of well-controlled, randomized studies examining cost and quality in hospitalist programs, the authors found the data reported to date to be promising. We have had a similarly positive experience with the use of hospitalists at Lenox Hill Hospital. In November 2000, the hospital’s sole sponsored multispecialty group practice instituted a select group of inpatient rounding physicians to cover all of its patients who are hospitalized at Lenox Hill (typically 25 to 35 patients on any given day). Preliminary results indicated a reduced length of stay for those practice patients who were hospitalized at Lenox Hill, compared with those practice patients who were admitted to other hospitals—without a sacrifice in quality of care. As hospitalist programs continue to grow nationally, there will be a need for further studies on their value. Meanwhile, for those physicians who may wish to consider a career in this growing field, the article by Drs. Chakrapani and Diamond on page 20 of this issue will serve as a useful introduction.

The flip side of the hospitalist movement is the simultaneous emergence of a cohort of physicians who exclusively care for outpatients. Much less is known about this group of physicians; however, the study by Dr. Saint and colleagues on page 5 of this issue reveals some interesting details about the work characteristics and practice profiles of exclusively outpatient internists. While considerably less well studied, the “officist” or “ambulist” movement appears to also be stimulated by demands for efficiency and by a preference of certain physicians for a focused clinical practice that allows them to be more efficient and to cultivate skills in outpatient medicine while leaving inpatient medicine to full-time hospitalists. Other factors that may influence this interest in outpatient medicine are the desire for part-time employment or job sharing and for more control over work hours. It will be interesting to study this group of physicians in greater detail and to monitor its growth in parallel with the hospitalist movement.

The second important trend highlighted in this issue of Seminars in Medical Practice is the systematic effort to address the problem of medical errors. Those trainees who go on to practice in hospital-based systems can anticipate demands to participate in system-wide efforts to improve patient safety. Hospitals are already feeling pressure to meet safety standards. For example, the Leapfrog Group—a growing consortium of more than 90 Fortune 500 companies and other large private and public health care purchasers—has begun to recognize and reward hospitals that implement minimum safety standards, such as the use of computerized order entry systems for intercepting medication prescribing errors before they occur.

The Institute of Medicine’s 2000 report on medical errors raised the national consciousness about patient safety and sounded the alarm for health systems to place error reduction at the top of their quality improvement agendas. As Dr. Sorokin and colleagues describe on page 12 of this issue, while fixing the problem will not be easy, a critical first step is to create a blame-free environment in which physicians can discuss and learn from errors.

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