

# The Changing Face of Hospital Medicine

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Gone are the days of Marcus Welby, where the primary care physician makes house calls, sees all patients in the hospital as well as the office. In Welby's world, the world of a small town doctor, patients were seen wherever they needed to be seen, the hospital, the office, the nursing home, or even the grocery store. People connected with their doctor and counted on him/her to be present for major life milestones and health changes. Doctors were on call 24/7. Patients were satisfied but many doctors got burned out.

The idea of a hospitalist, ie, someone who exclusively sees patients in the hospital regardless of who their primary care clinician is, was born in the early 1990s. The hospitalist movement was a product of changes in reimbursement for primary care clinicians rounding in the hospital and changes in the desire for outpatient only practices for many graduating internists and family physicians. Since the mid-1990s the hospitalist movement has drastically changed the landscape of American medicine.

Prior to the 1990s, the vast majority of hospitalized patients were seen by their primary care physicians or a designee (their partner or someone in the call group). The benefits of this arrangement included continuity since the physician knew the patient, their history, and what was going on in their family. The continuity greatly improved both the in-hospital experience (the patient saw their regular doctor or their doctor's partner) and the continuity of follow-up (the in-hospital doctor was able to facilitate follow up without a lot of sign-outs). Downsides of this hospital rounding model included (1) decreasing reimbursement for hospital visits, making physicians less inclined to do rounds since they could earn more by

increasing their outpatient visits; (2) lifestyle issues—doctors could not predict if and how many patients they needed to see in the hospital each day, which made their clinic start times variable; and (3) many physicians only

hospital clinician whom they do not know and who does not know them.

Many fellowships are now available to train physicians in hospital medicine. They focus on leadership, quality improvement, and hospital

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saw patients in the hospital infrequently, which could lead to unfamiliarity with hospital procedures, personnel, and updated clinical guidelines.

The concept of physicians specializing in caring for people in the hospital was a new one 20 years ago. Traditionally physicians had specialized based on clinical concern or organ system. Hospitalists were the first to specialize based on place of care. From being nonexistent 2 decades ago, the hospitalist movement has grown exponentially, now encompassing almost 50,000 physicians in over 75% of all US hospitals.<sup>1</sup>

The hospital care provided by hospitalists is excellent. Hospitalists are responsible for shorter lengths of stay, improved outcomes, and equivalent patient satisfaction.<sup>1</sup> Many hospitalists are integrally involved in hospital policy making and quality improvement efforts. It is unclear, however, how the hospitalist movement has affected longitudinal relationships between patients and their primary care clinician.<sup>2</sup> Being hospitalized is often a major life event, and now many patients around the country are experiencing this event with a hos-

systems in addition to more in-depth training on high acuity hospital medical conditions.

The paper in this issue by Hyder and Amundson describes an innovative hospital medicine fellowship in North Dakota.<sup>3</sup> The fellowship described aims to both train physicians in hospital medicine and encourage the graduates to stay in North Dakota or other rural areas. Sixty percent of the graduates of the fellowship have remained in North Dakota.

This fellowship is innovative because it is located at a rural, critical access hospital but the fellows also have appointments at the University of North Dakota School of Medicine and Health Sciences. The premise behind this joint appointment is that if physicians had an academic appointment and a relationship with a tertiary care center, they would be more likely to stay at the rural site. The fellowship has been a very successful part of the Workforce Initiative program led by the University of North Dakota focused on staffing rural hospitals with hospitalist physicians.

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tions for successful outcomes, the threat of litigation, and the effect of their professional obligations on the quality of their lives, and their families' lives. As medicine evolves to address the changing dynamic of healthcare in America, we must find ways to address these pressures.

UAB expects to recruit an expert in the field of physician wellness who can implement well-designed interventions to enhance a sustainable culture of physician wellness and provide tools and resources to manage stress and burnout. They plan to make these resources available throughout the nation, resulting in more engaged physicians who can provide the highest-quality care to their patients.

In order to ensure that the research is broadly applied, ProAssurance also expects to give an additional \$500,000 to UAB to fund the dissemination of these initiatives in support of physician wellness. The company's Chief Medical Officer, Hayes V. Whiteside, MD, views such programs as a logical extension of ProAssurance's role as a trusted partner with physicians and the nation's health care community. He said, "Assisting physicians has always been a high priority for ProAssurance. Now more than ever, we need to ensure that today's physicians maintain their commitment to our high calling, and that future physicians are equipped to deal with the realities of our vital chosen profession." ProAssurance looks forward to collaborating and coordinating our physician wellness efforts with the Society whenever possible.

As Wisconsin continues to lead the nation in the delivery of cost-effective, high quality healthcare, we work with your Society, advocating for you and providing a Member Benefit Plan tailored to address your liability challenges. The ProAssurance Endowed Chair for Physician Wellness takes our commitment to you—and all US physicians a step further—it's one of the ways we strive to treat you fairly now and into the future.

To learn more about the Member Benefit Plan, contact your Wisconsin Medical Society Insurance & Financial Services Agent at 866.442.3810 or visit [www.wisconsinmedical-society.org/insurance](http://www.wisconsinmedical-society.org/insurance).

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Medicine is challenged to find the correct balance between relationship-centered care and maintaining satisfied physicians. Divisions of responsibilities may go a long way in preventing burnout among primary care physicians.

Also in this issue are 2 papers describing violent injuries. The first looks at firearm mortality in Wisconsin between the years 2000 and 2014.<sup>4</sup> Most firearm deaths (72%) in Wisconsin are related to suicides, and firearms accounted for over 70% of all homicides in 2014. The second looks at accidental spine and spinal cord injuries in people falling from hunting blinds between 1999 and 2013.<sup>5</sup> One hundred seventeen people were seen at the emergency department during the allotted timeframe and 25 patients (38%) required surgical fixation of their injuries.

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## Antibiotic Stewardship in the Outpatient Setting

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(<https://projects.propublica.org/checkup/states/wisconsin>), clinicians can search by their name to find additional information on prescribing practices in the antibiotic category. Adult and pediatric treatment recommendation resources are also available on the CDC's website at <https://www.cdc.gov/getsmart/community/for-hcp/outpatient-hcp/index.html>.

The Core Elements of Outpatient Antibiotic Stewardship provides a framework for outpatient clinicians and facilities that routinely provide antibiotic treatment. They were developed through a combination of consolidating evidence-based antibiotic stewardship practices and building on or adapting known best practices for antibiotic stewardship across other clinical settings. More information is available at [https://www.cdc.gov/mmwr/volumes/65/rr/rr6506a1.htm?s\\_cid=rr6506a1\\_w](https://www.cdc.gov/mmwr/volumes/65/rr/rr6506a1.htm?s_cid=rr6506a1_w).

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**WMJ**

*WMJ* (ISSN 1098-1861) is published through a collaboration between The Medical College of Wisconsin and The University of Wisconsin School of Medicine and Public Health. The mission of *WMJ* is to provide an opportunity to publish original research, case reports, review articles, and essays about current medical and public health issues.

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