Safety, Salary, and Saints

Or, things I learned in San Diego

I just returned from the SHM annual meeting, and I am brimming with new knowledge. While we've tried to capture the essence of the meeting in this edition of The Hospitalist, it's hard to describe in print the excitement, energy, and edification I encountered during those three days in San Diego.

Nearly 1,600 hospitalists descended on the Grand Hyatt on the San Diego Harbor for the six pre-courses April 3 and the two-day meeting April 4-5, marking the biggest and widest-reaching hospitalist meeting to date. Here's just a smattering of what I learned in southern California.

I learned that Don Berwick, MD, is a healthcare visionary. In his plenary address the founder of the Institute for Healthcare Improvement and national leader of the patient safety movement gave his insights on the quality of the healthcare system and offered a challenge for hospitalists. He started by deftly outlining how Americans pay $3,000 more per capita for healthcare than other industrialized countries only to receive less access, worse care, and higher mortality rates. Clearly, more money does not equate to better care.

After noting that every system is perfectly designed to achieve the results it gets, Dr. Berwick challenged hospitalists to debunk the romantic view of the "individual as the cause of excellence" in favor of creating multidisciplinary teams and systems of care whose results do not depend on the heroism of the individual.

I learned that hospitalists are getting paid more today for the same amount of work they provided in 2005. At the same time that the average salary is up 13% to $193,300 (compared with 2005) the average number of annual encounters per hospitalist is down 4% from 2,558 in 2005 to 2,447 in 2007.

I've seen several interpretations of these data. The most cynical take, generally from non-hospitalists, is that this is further proof that hospitalists are overpaid compared with our non-hospitalist generalist colleagues in internal and family medicine. While these changes obviously represent a free-market response to a shortage of hospitalists, I firmly believe these higher salaries are a more accurate valuation of the work hospitalists do—and the more appropriate interpretation is that we've been underpaid in previous years. Now it's time for our healthcare system to more appropriately reward our outpatient colleagues as well.

I also learned that academic hospitalists are struggling with similar issues across the country. Drs. Adrienne Bennett, Brian Lucas, and Bob Wachter, led an enthralling but sobering session surveying the challenges facing academic hospitalist groups. In many cases the vision of developing a sustainable academic model around the core tenets of research, scholarly activity, and education is being undermined by the service mandate of non-teaching clinical work.

These tensions lead to profound challenges come promotion time, a topic that Drs. Scott Flanders, David Meltzer, and Sankey Williams covered in an afternoon session.

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As a director of an academic program who recently went through the promotion process, I view these two issues as critical to the health of all segments of hospital medicine, not just academics. Community hospitalist groups will encounter even larger workforce deficiencies if future hospitalists (i.e., current residents) shy away from the field because they see academic hospitalists devalued as unpromotable resident extenders and academic second-class citizens.

Speaking of workforce shortages, I learned that several highly respect leaders in hospital medicine believe this to be one of the most significant factors threatening the field. In a plenary panel discussion, Drs. Ron Greeno, John Nelson, Mike Guthrie, and John Laverty, commented that overcoming the current and future hospitalist shortage requires rethinking the current model. Dr. Greeno highlighted the need to build more efficient care models whereby hospitalists could see more patients in the same time by reducing the high levels of busy work and administrative minutiae.

Other ideas centered on the development of midlevel provider hospitalists and limiting our scope of practice. To the latter point, there was a lively debate about just how much of the traditionally "non-medical" piece of the pie hospitalists should bite off. Eric Siegal, MD, tackled this issue in a later session challenging hospitalist groups to rethink the value of further expanding the co-management model to more surgical patients while we struggle to care for the patients for whom we currently care.

I learned that Drs. Nelson and Win Whitcomb, co-founders of SHM, showed tremendous vision in their founding of this society. I had the chance to have lunch with John, and I asked him if he ever imagined that the tiny group he brought together in San Diego 11 years ago would ever grow to this—20,000 hospitalists, 6,000 SHM members, an annual meeting with 1,600 people, and a hospitalist (Russell Holman, MD, past president of SHM) seated at the table of the most influential healthcare policy meetings in Washington, D.C.

Rather than being awestruck by the development of this field and SHM, he simply noted this is exactly what he and Win foresaw more than a decade ago; this is the reason they founded SHM. That's the kind of vision that explains why the field of hospital medicine is the fastest-growing medical specialty.

I learned that the future of hospital medicine is being defined today. Nearly 200 posters were presented at the Research, Innovations and Clinical Vignettes (RIV) Competition. When we look back 10 years from now, we will see a mature field and wonder how we got there so quickly.

That future is being constructed today by folks like Ken Epstein, MD, who presented fascinating data on the effects of fragmentation of hospitalist care, and Param Dedhia, MD, who showed that a formalized discharge toolkit could reduce emergency visits and hospital readmissions in elderly patients.

Finally, while I was away in the city named after a saint, I learned that my wife, too, is a saint. Unable to travel with me, she was landlocked in Denver with our 6-month-old son. I, like many attendees, acknowledge the families who sacrificed so their loved ones could attend the meeting. While I was socializing, learning, networking, and teaching a session, my wife was home soothing tears, changing diapers, cleaning chinfuls of cereal, and answering 3 a.m. wakeup calls. On behalf of all attendees I say thanks to all the saints who enabled us to be away charting the course of hospital medicine at Hospital Medicine 2008. TH

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Have a Key Clinical Question?

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