

ORIGINAL ARTICLES

Health Care Market Trends and the Evolution of Hospitalist Use and Roles

Hoangmai H. Pham, MD, MPH,¹ Kelly J. Devers, PhD,² Sylvia Kuo, PhD,³ Robert Berenson, MD⁴

¹Center for Studying Health System Change, Washington, DC, USA; ²Department of Health Administration, Virginia Commonwealth University, Richmond, VA, USA; ³Brown University, Providence, RI, USA; ⁴The Urban Institute, Washington, DC, USA.

OBJECTIVE: To describe local health care market dynamics that support increasing use of hospitalists' services and changes in their roles.

DESIGN: Semistructured interviews in 12 randomly selected, nationally representative communities in the Community Tracking Study conducted in 2002–2003. Interviews were coded in qualitative data analysis software. We identified patterns and themes within and across study sites, and verified conclusions by triangulating responses from different respondent types, examining outliers, searching for corroborating or disconfirming evidence, and testing rival explanations.

SETTING: Medical groups, hospitals, and health plans in 12 representative communities.

PARTICIPANTS: One hundred seven purposively sampled executives at the 3–4 largest medical groups, hospitals, and health plans in each community: medical directors and medical staff presidents; chief executive and managing officers; executives responsible for contracting, physician networks, hospital patient safety, patient care services, planning, and marketing; and local medical and hospital association leaders.

MEASUREMENTS AND MAIN RESULTS: We asked plan and hospital respondents about their competitive strategies, including their experience with cost pressures, hospital patient flow problems, and hospital patient safety efforts. We asked all respondents about changes in their local market over the past 2 years generally, and specifically: hospitals' and physicians' responses to market pressures; payment arrangements hospitals and physicians had with private health plans; and physicians' relationships with plans and hospitals. We drew on data on hospitalist practice structures, employment relationships, and productivity/compensation from the Society for Hospital Medicine's 2002 membership survey. Factors that fomented the creation of the hospitalist medicine movement persist, including cost pressures and primary care physicians' decreasing inpatient volume. But emerging influences made hospitalists even more attractive, including worsening problems with patient flow in hospitals, rising malpractice costs, and the growing national focus on patient safety. Local market forces resulted in new hospitalist roles and program structures, regarding which organizations sponsored hospitalist programs, employed them, and the functions they served in hospitals.

CONCLUSIONS: These findings have important implications for patients, hospitalists, and their employers. Hospitalists may require changes in education and training, develop competing goals and priorities, and face new issues in their relationships with health plans, hospitals, and other physicians.

KEY WORDS: hospitalists; hospital medicine; health care markets; patient safety.

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Address correspondence and requests for reprints to Dr. Pham: Center for Studying Health System Change, 600 Maryland Avenue SW, Suite 550, Washington, DC 20024 (e-mail: mpham@hschange.org).

See editorial by Auerbach, p. 208–9.

In 1996, Wachter and Goldman described the emergence of a new model of hospital care in which “hospitalists” provided care in place of community physicians or academic attendings.¹ They noted several factors fueling the movement, including cost pressures on health plans and hospitals, time pressures on primary care physicians (PCPs), and increasingly complex inpatient medicine. Since then, the number of hospitalists has rapidly increased, with hospitalists now numbering over 8,000 nationally.² Their prevalence grew despite the decline of tightly managed care (e.g., HMOs), whose emphasis on efficiency was central in earlier predictions of growing demand for hospitalists.¹

Rising numbers of hospitalists, most trained as internists, may seek new opportunities and roles.³ However, their success will also depend on whether market conditions make health care organizations more receptive to them. Most research on hospitalists has focused on their effects on costs, length of stay, and clinical outcomes.^{4–7} Much less data are available on the reasons for hospitalist use or the structure of hospitalist care models (e.g., who employs them and what their primary responsibilities are).⁸ Physicians and policymakers need to understand these issues because they have implications for quality of care, medical education, hospital management, and hospitalists' relationships with other physicians and health care organizations.

The purpose of this paper is to fill this literature gap by describing local health care market trends that are increasing demand for hospitalist use and shaping the hospitalist care model. We describe trends in hospitalist use between 2001 and 2003; provide examples of local health care markets illustrating variations in rationales for their adoption (particularly emerging reasons), hospitalists' employment and contractual relationships, and their clinical functions; and discuss policy implications.

METHODS AND DATA

We use qualitative data from the Community Tracking Study (CTS), a longitudinal study of 12 nationally representative markets. We also draw on the Society for Hospital Medicine's (SHM) member survey for additional information on hospitalist prevalence and to corroborate some of our findings. These mixed methods and data provide a rich source of information on local market dynamics and their impact on hospitalist use and roles.

Since 1996, the CTS has conducted 4 rounds of site visits in the same 12 randomly selected U.S. metropolitan areas (Boston, Cleveland, Greenville, Indianapolis, Lansing, Little Rock, Miami, Northern New Jersey, Orange County, Phoenix,

Seattle, Syracuse).⁹ These sites represent communities of different population sizes, geographic regions, and levels of managed care penetration. Further details about design of the site visits have been previously published.¹⁰ During the fourth round of visits, 1,000 semistructured interviews were conducted between September 2002 and May 2003. Over the course of these interviews on local trends in the financing, organization, and delivery of care, changes in hospitalist use and the reasons for their adoption emerged as an important theme.

We focus on 107 Round 4 interviews with leaders of the 3–4 largest medical groups, hospitals, and health plans in each market. We purposively sampled organizations and respondents best suited to provide the fullest descriptions of trends in their markets and how physicians, hospitals, and plans responded to them.¹¹ Interviewees included medical directors and medical staff presidents; chief executive and managing officers; executives responsible for contracting, physician networks, hospital patient safety, patient care, planning, and marketing; and local medical and hospital association leaders.

We designed semistructured interview protocols to ensure comparability of data across different rounds and sites. They contained primarily open-ended questions, including both core questions repeated from previous rounds, and new questions addressing special study topics, and were tailored to specific respondent types (e.g., medical group CEO). We asked plan and hospital respondents about their organizations' competitive strategies, including their experience with and responses to cost pressures, hospital capacity constraints, and hospital patient safety efforts (e.g., intensivist or hospitalist staffing). We also asked all respondents about changes in their local market over the past 2 years generally, and in specific areas: hospitals' and physicians' responses to market pressures; the predominant payment arrangements hospitals and physicians had with private health plans; and physicians' relationships with plans and hospitals. All interviews were recorded in Microsoft Word templates by the primary interviewer, then managed and coded (by two researchers) in *Atlas.ti* software.

We took several steps to ensure data reliability and validity. Two researchers took notes at each interview and reviewed transcripts to corroborate accurate data recording. We triangulated interview data^{11,12} by comparing responses from different respondent types (medical directors vs CEOs), organizations (e.g., different medical groups), and sectors (e.g., medical groups vs hospitals) to corroborate respondents' assertions and document disagreements. We report here only assertions that were corroborated by multiple respondents or not refuted by other respondents. Two researchers independently reviewed coded data and compared interpretations. All authors then reviewed and discussed differences of opinion about interpretations. We analyzed data to identify patterns and themes within and across study sites, and further verified conclusions by examining outliers, testing rival explanations not offered by respondents, and drawing on corroborating or disconfirming secondary data.

To corroborate some of our findings, we drew on data on the prevalence of hospitalist practice structures, employment relationships, and their productivity/compensation structures from SHM's 2002 membership survey. The survey had a response rate of 25%, but is the only available source of national data on hospitalists.

RESULTS

Market Changes Contribute to Increased Hospitalist Use

In 10 of 12 site-visit markets, respondents across different sectors concurred that use of hospitalists had grown over the past 2 years. Sponsors (entities that initiate a hospitalist program for their own benefit or that of their clients) had initiated new hospitalist programs in at least 6 markets (Little Rock, Syracuse, Indianapolis, Seattle, New Jersey, Orange County). They also increased the number of hospitalists in existing programs in 11 markets. Secondary data were consistent with respondents' views. Between 1996 and 2000, the latest year cited in the literature, national estimates of the number of hospitalists grew from several hundred to over 8,000.^{1,2}

Yet the intensity of hospitalist use varied dramatically across communities and types of sponsors. In all 12 markets, hospitalists were present in at least 1 of the 3–4 largest hospital systems, and in some markets such as Boston, most medical groups used hospitalists for the majority of their admitted patients. However, in others such as Syracuse, hospital medicine programs were newer to both hospitals and medical groups, and only slowly expanding. Interviewees' reports of the number of full-time hospitalists in individual hospitals ranged from none or 1, to 17. Respondents' estimates of the percentage of inpatients cared for by hospitalists ranged from 5% at one Miami hospital to 50%–75% of members in an Orange County health plan, and 100% of floor patients at a Phoenix hospital. This reported wide variation in hospitalist use for clinical care was also consistent with national data from SHM's 2002 survey of its members, who reported individual hospitalists in their medical groups completing from 105 to 5,500 admissions and consultations a year.

Respondents explicitly cited, and we also noted, several health care market trends that underlay increased hospitalist use and diversification of their sponsors, employers, and clinical roles. Although these trends were often not the primary impetus for new hospitalist programs, respondents reported that they contributed to program expansions.

Most prominently, financial pressures from reimbursement rates that did not keep pace with rising practice costs helped increase physicians' support for hospital medicine programs, as cited by respondents in 10 of 12 sites. Primary care physicians under financial pressure avoided inpatient care in favor of increasing outpatient visit volume because they could bill for more outpatient visits in equivalent amounts of time.¹³ A few chose to close struggling practices to become hospitalists. Specialists' ability to completely avoid inpatient care was more limited, although some felt that hospitalist care would improve efficiency over rounding on their own patients or referring admitted patients to PCPs who were increasingly avoiding hospital care.

Second, accelerating growth in health care costs increased interest in hospitalist use.¹⁴ Many plan and hospital sponsors reported using hospitalists as an important component of their general competitive strategy because they believed hospitalists decreased costs. This was consistent with our observation that hospitalist use appeared to be related to the predominant hospital payment method. Boston, Greenville, and Orange County had the greatest level of hospitalist use. (We considered respondent reports of program expansions over the previous 2 years, hospitalist presence at most

interviewed hospitals, and hospitalists caring for the majority of inpatients at the 3–4 largest hospitals in the market.) In these markets, plans reimbursed hospitals primarily under fixed payment methods (capitation, case-rates such as diagnosis-related groups or per diems) rather than by percent-of-charges. Fixed payment methods, such as those used in Medicare, generally provide stronger incentives for hospitals to control costs than do discounted fee-for-service methods (although the mix of capitation or case-rates vs per-diem payments could affect hospitals' emphasis on lowering length of stay vs lowering per-day costs). Communities with lower levels of hospitalist use were more varied in the predominant type of payments to hospitals.

Plans and hospitals in markets experiencing hospital capacity constraints used hospitalists to improve patient throughput,^{13,15} and the same concern underlay a few hospitals' plans to place hospitalists in outpatient departments to provide follow-up care to prevent readmissions.

Malpractice cost pressures in some markets also made hospitalist programs attractive to hospitals and medical groups, by contributing to physicians' avoidance of inpatient care and emergency department (ED) call because of the perceived increased liability risk associated with these settings.^{13,16} Hospital respondents also asserted that malpractice concerns made physicians more likely to refer complicated or acutely ill patients to EDs, increasing admissions and making the need for improving patient flow more acute.^{15,17}

Finally, hospitals used hospitalists to respond to growing interest in patient safety improvement, which respondents in Indianapolis, New Jersey, Orange County, and Seattle cited as a facilitator. In response to the Leapfrog Group's recommendations for intensivist staffing,¹⁸ they used hospitalists as substitutes in intensive care units (ICUs) when they could not hire intensivists, despite the lack of literature supporting such substitutions.¹⁹ They also saw hospitalists as "captive audiences" for adoption of new information technology such as computerized physician order entry, because hospitalists practice in a single institution—unlike physicians admitting to multiple hospitals with different information systems—and their higher patient volume could help them learn new technology more quickly. They are also employed or contracted, potentially making them more receptive to information technology initiatives. More generally, hospital sponsors believed that hospitalists would provide more timely communication with ancillary staff, and ultimately better clinical outcomes.

Community Profiles

We examine three CTS communities to illustrate the range of conditions that affected hospitalist use, employment arrangements, and roles.²⁰ While financial pressures on physicians encouraged hospitalist use in all three, each community exhibited other distinctive and illustrative market dynamics, which are further detailed in Table 1. These markets are described more generally elsewhere.^{21–23}

Orange County. Orange County was particularly active in terms of hospitalist use. The major market facilitators were acute interest in cost control among both health plans and medical groups, hospitals' desire to accommodate their med-

ical staffs' need for more outpatient care time under reimbursement pressures, and the entry of several for-profit companies employing salaried hospitalists, allowing hospitals and medical groups to contract for hospitalist services.

Phoenix. Pressures affecting traditional hospital-physician relationships also drove increased hospitalist use in Phoenix. There, the major facilitators were a deepening physician shortage worse than in other communities, and physicians' growing interests in other sources of revenue besides inpatient care or ED consultations, which allowed both PCPs and specialists to grow less dependent on hospital privileges.

Miami. Hospitalist use also grew in Miami, but was driven by a different set of factors than in Orange County or Phoenix, and the volume of hospitalist services in Miami remained constrained. The major market trends facilitating hospitalist use were physicians' focus on increasing outpatient visit volume as in other markets and a malpractice insurance crisis leading physicians to avoid inpatient care, and the resulting exacerbation of already significant hospital bed capacity constraints.

Varied Employment Relationships Create Diverse Practice Structures, Priorities, and Roles

Hospitals sponsored hospitalists more often than did plans or medical groups, usually by directly hiring hospitalists. This was the case at most hospitals with hospitalists in 10 markets. Less commonly, hospitals contracted for hospitalist services with medical groups, vendors, or individual physicians. Although medical groups and health plans were less likely to sponsor programs, they demonstrated similar employment preferences when they did, preferring to hire hospitalists directly. These site-visit findings were consistent with SHM data showing that in 2002, 38% of hospitalists were employed by hospitals, 17% by multispecialty medical groups, 19% by hospitalist-only groups, and only 9% each by universities/medical schools and plans/vendors. Practice profiles submitted by hospitalist practices posted on SHM's website in 2003²⁴ describe a similar range of practice structures.

Sponsors of hospital medicine programs had diverse motives (Table 2). For example, respondents reported that health plan sponsors were most often motivated to start programs to control costs, while respondents most commonly cited convenience for physician staffs, care of unassigned patients, and quality/safety improvement as reasons for hospitals sponsoring hospitalist programs (although we note that improving patient throughput, cited by 24% of respondents addressing hospital sponsors' motives, may have indirect impact on costs if hospitals are reimbursed on capitated or case-rate basis, as mentioned previously).

Sponsorship and employment relationships also steered hospitalists' allegiances and priorities. (As noted, sponsors were often also hospitalists' employers.) Hospitalists hired by hospitals or plans to improve UM primarily had a mandate to lower length of stay and costs. For example, some sponsors explicitly made hospitalists accountable for cost performance, as a Miami health plan did by sharing cost savings with its hospitalist group. In contrast, in programs begun primarily to relieve community physicians of inpatient care or to improve patient flow, hospitalists were under more pressure to accept large patient loads. And hospitalists hired by vendors had

Table 1. Factors Affecting Hospitalist Use and Practice Models in Three Communities

Market Characteristic	Orange County	Phoenix	Miami
Extent of hospitalist use	<p>Hospital medicine was the dominant inpatient care model</p> <p>Plan respondents estimated that hospitalists cared for 50%–75% of their patient admissions</p> <p>Hospitals often had multiple hospitalist teams present, working for different medical groups</p> <p>The model was so successful that vendors contemplated expanding it to postacute care settings (e.g., skilled nursing facilities)</p>	<p>Hospital medicine was the dominant inpatient care model</p> <p>One hospital executive estimated that “8 of the 10 top admitters” at any given hospital were likely to be hospitalists</p> <p>One group medical director reported that all but 6 of 180 PCPs in his practice used hospitalists</p>	<p>Hospitalist use increased in Miami but remained constrained relative to demand for hospitalist services</p> <p>One hospital executive estimated that hospitalists were assigned over 50% of patients admitted through their ED</p> <p>A plan reported fluctuating coverage, with its percentage of admitted patients covered by hospitalists rising one year 50%, then falling to 25%</p>
Most common sponsors of hospitalist programs	Medical groups/IPAs/Hospitals cosponsored programs with medical groups, less commonly developing their own programs	Hospitals and health plans	Health plans and hospitals less commonly
Most common employers of hospitalists	<p>Hospitalist vendors</p> <p>By 2003, one vendor had become dominant, with 70% of the market for hospitalist services (as estimated by plan respondents)</p> <p>Some medical groups</p>	<p>Hospitals and health plans</p> <p>A growing number of hospitalist physicians worked as independent contractors</p>	Hospitalist vendors
Distinguishing market trend facilitating hospitalist use	<p>Medical groups’ and health plans’ interest in cost containment (Plans still paid most physicians under capitation arrangements for professional services. But in 2000–2001, they began entering shared risk contracts with medical groups, in which both bore financial responsibility for hospital care costs and had incentives to reduce length of stay and increase efficiency.)</p>	<p>Physician supply shortage</p> <p>Phoenix had annual population increases of 100,000 or more for several years,²⁶ which strained hospital bed capacity, especially in EDs. Hospitals’ strategies to improve patient throughput included greater hospitalist use.</p> <p>At the same time, Arizona’s physician supply of 172 per 100,000 ranked it 32nd among states in 2001.^{27,28} Shortages affected many specialists and PCPs, leading to sponsors’ greater reliance on hospitalists.</p>	<p>Physicians’ medical malpractice concerns</p> <p>Escalating malpractice insurance costs led physicians to avoid providing acute care in their offices, or accepting new patients admitted through EDs, because they perceived higher liability risks in these situations.¹⁷</p> <p>As a result, respondents concurred that EDs were overcrowded with patients requiring admission, whose care defaulted to hospitalists</p>
Other facilitators of hospitalist use	<p>PCPs’ shifting focus to outpatient care and billing</p> <p>Health plans’ encouragement of hospitalist use</p> <p>One plan executive reported sharing data on hospital costs and outcomes with medical groups, and that “hospitalist programs seem[ed] to sell themselves . . . both in a clinical and an economic sense, [and] for physician convenience</p>	<p>PCPs’ shifting focus to outpatient care and billing</p> <p>Specialists attraction to ambulatory surgical care centers,²⁹ other revenue sources besides inpatient care</p> <p>Specialists also believed ED patients were more often uninsured, and that consultation time would be poorly compensated. They tried negotiating extra pay for ED call, but often preferred to drop admitting privileges.</p>	<p>PCPs’ shifting focus to outpatient care and billing</p> <p>Pressures on hospital bed capacity and patient flow. Higher ED patient volume exacerbated worsening hospital capacity constraints. Hospitalists offered one solution, by admitting unassigned ED patients and potentially increasing patient throughput because of their “specialization” in inpatient management.</p>

(Continued)

Table 1. (Continued)

Market Characteristic	Orange County	Phoenix	Miami
Hospitalists assumed roles beyond general medicine wards	Pediatric NICU	Adult ICUs Specialty services (e.g., neurology)	Generally no
Major market barriers to growth of hospitalist use	Plans for hospitalist coverage of overnight ED patients and in postacute care settings Few	Somewhat limited hospitalist physician supply	Very limited hospitalist physician supply. Plans commonly sponsored hospitalist programs but were shielded from the immediate effects of hospital capacity problems, and so were not motivated to add hospitalist staff. Local hospitalist services vendors were hampered by low supply of hospitalist physicians.

IPA, independent physician association; NICU, neonatal intensive care unit; ED, emergency department; PCP, primary care physician; ICU, intensive care unit.

multiple responsibilities to their employers and to the hospital, plan, or medical group contracting for their services.

Partly as a result of diverse sponsorship and employment arrangements, hospitalists provided care in a range of hospital service areas. At hospitals in each market, they were still most commonly responsible for general medicine patients on floors. But increasingly, hospitalists also provided care in ICUs, short-stay units associated with EDs, or specialized medical floors.

Hospitalists' clinical roles had also diversified. Although they still most commonly took on care for patients who did not have a physician with admitting privileges, or whose physician preferred not to provide inpatient care, hospitalists also substituted for intensivists in ICUs; teamed with subspecialists to care for complicated patients; functioned as primary attendings in skilled nursing facilities; and cared for nursing home patients admitted at night.

DISCUSSION

These recent trends in hospitalist use have implications for clinicians, health care organizations, and policymakers. First, the diversity of hospitalists' sponsors, employers, and roles

poses challenges for hospitalists themselves in terms of education, training, and professional identity. Rapidly rising demand for hospitalists and the new conditions under which they practice suggest that new hospitalists will not lack for opportunities, but that hospitalists may need more diverse training (e.g., in critical care medicine beyond the exposure typical for internal medicine residencies) than in the past. An earlier study of hospitalists' perceptions found that even the most recently trained graduates considered their training inadequate in some areas relative to their clinical responsibilities.²⁵ Because most hospitalists are internists, internal medicine training programs may want to consider ways to provide elective supplemental training for graduates interested in hospitalist careers. In addition, conflicting priorities in patient care might develop. For example, hospitalists charged with increasing caseloads and patient throughput may find that at odds with providing more focused care for complicated patients. Further research on how diverse hospitalist practice arrangements affect quality, cost, and care coordination is needed to inform education and training efforts.

Second, Leapfrog and other organizations promoting quality and patient safety improvement did not explicitly anticipate hospitals using hospitalists as substitutes for board-

Table 2. Frequency of Respondents' Mentioning Sponsors' Reasons for Initiating Hospitalist Programs

Primary Reasons	Hospital Sponsor n (%)	Medical Group/IPA Sponsor n (%)	Health Plan Sponsor n (%)
Cost containment	8 (16)	7 (50)	5 (71)
Convenience/support for community physicians	19 (38)	6 (43)	3 (43)
Assume care for unassigned patients	15 (30)		
Provide specialty care/complicated care	3 (6)	5 (36)	
Substitute for intensivists	10 (20)		
Improve patient flow/relieve capacity constraints	12 (24)		
Improve quality/safety	14 (28)		3 (43)
Competitive strategy (entering a niche market)		3 (21)	
Total respondents addressing motives of different types of hospitalist program sponsors, N	50	14	7

Data from the Community Tracking Study Site Visits, Round 4 interviews, September 2002–May 2003 and are expressed as number (percent) of respondents who discussed sponsors' motives in initiating hospitalist programs (50, 14, and 7 respondents discussed hospital sponsors', medical group sponsors', and health plan sponsors' motives for starting hospital medicine programs, respectively). In total, sponsors' motives were mentioned in 71 of 107 interviews discussing hospitalists at all. Column percentages do not necessarily add up to 100% because respondents could mention more than one reason for hospital medicine programs. Percentages should not be interpreted as population estimates because questions were not close-ended, and respondents were not drawn from a random probability sample.

Empty cells indicate combinations of sponsors and primary motives that were not mentioned by respondents. IPA, independent physician association.

certified intensivists, or that the proportion of inpatients cared for by hospitalists would continue to rise. However, this may afford some hospitals that cannot recruit intensivists some benefits and may facilitate other quality improvement efforts. Research should be targeted at the effects of hospitalist use on both the implementation of quality and patient safety improvement initiatives and on specific safety outcomes, and Leapfrog may need to reconsider its recommendations accordingly.

Third, growing hospitalist use could dramatically change hospitalists' relationships with other physicians, and physicians' relationships with hospitals. What are the implications for medical staff governance, when hospitalists come to care for the majority of inpatients? Would PCPs be largely excluded from medical staff leadership? And if so, how will their absence affect follow-up ambulatory care or hospitals' community outreach and patient education efforts? (At teaching hospitals, the loss of PCPs would also present challenges in teaching implications of inpatient medical decision making for outpatient management.) Conversely, hospitals could lose valuable input from PCPs about emerging needs and trends in care in the community. And if current trends continue, hospitals may become populated with hospitalists with different employers, goals, and incentive structures. How will hospitals and other physicians adapt to accommodate these changes?

Finally, future research should include tracking of market dynamics shaping hospitalist use and roles, and the effects on care outcomes, including patients' experiences of care. If outcomes are affected by changes in hospitalist roles, policymakers need to better understand the factors that make hospitalist use more or less likely in local areas.

Our study had several limitations. First, we considered a relatively small number of communities, with necessarily limited generalizability. However, while many qualitative studies focus on single markets, these communities were prospectively sampled to be representative across several important characteristics, and they have been followed since 1996, providing particularly rich data on changes in health care delivery and their causes. Second, we did not sample hospitalist respondents to determine their perspectives (although some executives interviewed were hospitalists). But hospitalist medical groups did not exist in most markets (because most are employed by hospitals, vendors, or other organizations that we spoke with), and individual hospitalist physicians are less likely to be knowledgeable about how broader market dynamics affect health care organizations' behavior than respondents we selected. Third, we did not identify changes in hospital medicine as a study topic prospectively. However, it was a consistent theme in interviews across multiple markets, and our findings on hospitalists grew naturally out of our more general, prospectively defined research focus on related market trends. One value of qualitative research is its potential for uncovering new developments and previously unrecognized relationships. Last, we could not obtain corroborating quantitative data to verify respondents' assertions about the percentage of admissions or health plan members covered by hospitalists. However, we report only numbers that were not contradicted by different respondent reports.

The hospital medicine movement has moved beyond curiosity and insurgency to an established patient care model, but one that has proven extremely malleable by changes in local market dynamics and that varies across the country. Physicians, health care organizations, and policymakers need to

stay attuned to the resulting patchwork of hospitalists' employment arrangements and clinical roles, and anticipate how they might affect training needs, hospitalists' relationships with other physicians and health care organizations, and, most importantly, patient care.

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Special Symposium: External Threats to Professionalism in a Chaotic Health Care Environment

Organizers: Roy M. Poses MD, Wally R. Smith MD

Friday: 10:30 am - 12:00 pm

BIDIL[®] and Its Consequences: A Special Symposium on the Implications of the First Ethnically Branded Drug in the U.S.

Co-Sponsor: SGIM Diversity Task Force

Organizers: Alicia Fernandez, MD, PhD, Arleen Brown, MD, PhD, Olveen Carrasquillo, MD, MPH, Carol Horowitz, MD, Judith Long, MD, Eliseo Perez Stable, MD, Valerie Stone, MD, MPH, Donna Washington, MD, MPH

Friday, 3:30-5:00 pm

An Appreciation of the Lifeworld of General Internal Medicine

Faculty: Thomas Inui, ScM, MD, Richard Frankel, PhD, Paul Haidet, MD, Debra Litzelman, MD, David Mossbarger, MBA, Anthony Suchman, MD, MA, Penny Williamson, ScD.

Saturday, 10:30 am-12:00 noon

The Research Agenda for General Internal Medicine: A Preliminary Report from the SGIM Task Force on the Research Agenda for General Internal Medicine

Faculty: Gerald Smetana, MD; Andrew Bindman, MD; Helen Burstin, MD, MPH; Bruce Landon, MD, MBA; Eugene Rich, MD