LEE COUNTY MEDICAL SOCIETY INC.
Physicians Caring for our Community

Bulletin

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2009 Meetings and Events

LCMS Annual Meeting & Installation of Officers

Thursday, November 19th
6:30 p.m. Social Time
7:00 p.m. Dinner

Medical Expeditions to the Russian Tundra and Siberia

Speaker: *William Becknell, MD*

FineMark Bank
12681 Creekside Lane
Fort Myers, FL 33919

RSVP Medical Society Office
LCMS, PO Box 60041, Ft Myers 33906
Tel: 936-1645 Fax: 936-0533

Inserts

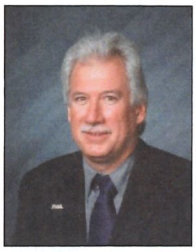
- **November Meeting Notice**
- **Holiday Sharing Card**
- **Hill, Barth & King Advertisement**

Inside this issue:

President's Message

The Hospitalist Dilemma

Larry Hobbs, M.D.



Now why would I want to discuss this with our membership? Some of you aren't involved with the hospitals nor want to work in the hospitals. But I contend that each of us is affected by the hospitalist. Either our patients are admitted to the hospital or our family and friends are admitted to the hospital and in almost every case they are cared for by the hospitalist. It is the hospitalist that greatly affects the quality of care delivered in the Lee Memorial Healthcare System.

A hospitalist is usually defined as a physician trained in internal medicine, family practice or pediatrics whose practice is in the hospital. His/her time is spent entirely in the care of hospitalized patients. Why do we have hospitalists? CMS some years ago, in an attempt to save money, decreased reimbursement for primary care physicians that saw patients in the hospital in favor of seeing them in their offices. The idea was to hopefully incentivize physicians to not admit patients to the hospital. The unintended consequence that developed was that physicians could make more during their day by seeing more patients in their offices as opposed to going to the various hospitals to see their patients. Many larger primary care groups hired younger physicians to care for the group's admitted patients allowing the principle physicians to see more patients in the office. This, too, changed as the younger physicians grew their practices and found it more efficient to just see outpatients. There was a void that needed to be filled and the advent of hospitalists began. Some hospitals were desperate to get patients cared for and employed or subsidized individuals to stay in the hospitals. More frequently entrepreneurial physicians began groups of primary care physicians to serve as hospitalists. More patient encounters meant more profitability and ability to grow their numbers. As this trend continued more advocacy organizations for hospitalists developed defining hospitalists as well as providing basic guideline for patient care. There are now fellowships developing for a subspecialty of hospitalist medicine. All this is important to fill the void left by the exodus of primary care physicians. But, like any new adventure the entrepreneurial attraction can tend to affect the intended goal.

Locally, we have seen the development of a few groups of hospitalists competing for admitted patients in our hospitals. Competition is good, as it tends to increase quality of service and availability. But there is a problem. The competition for number of patients has increased the reliance on specialist consultations and hospital resources such as radiology in order to process an ever-increasing number of patients through the system. Length of stays in hospitalized patients has increased, as has the number of complaints from patients and their primary care physicians. A growing disconnect has developed with the patient's primary care doctor and the hospital. Some have blamed the hospitals for this problem and have demanded administrative action to remedy this issue.

Here lies the dilemma. Can these competing hospitalist groups come together and define quality metrics and behaviors that would improve patient care? These metrics would include decreases in length of stay, decreased in reliance of specialty consultations or hospital resources, limiting the daily number of patients per hospitalist in order to provide more personalized care, improve direct communication with the patient's primary care physician early on during the admission and at discharge, and provide timely examination and evaluation upon admission to facilitate more directed care to name a few. If this collegial dialog is not possible, is it the purview of the hospital medical staff to develop these metrics and police their enforcement? Is this something medical staff leaders want to do or want to spend their time and efforts to accomplish? In an attempt to do just that, the physician leadership council at LMHS developed a simple definition of a hospitalist. The idea was to form a department of hospitalist medicine. After that they would meet to develop their own quality metrics. The physician hospital

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