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Perspective

Hospitalists as Surgical Comanagers

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Traditional Medical Consultation plays an important role in many hospitals; however, it has multiple limitations that led to the growth of a modern comanagement model. As such, the hospitalist role evolved from evaluating and advising to collaborating and sharing responsibilities in patient care.

Several factors influenced the move towards comanagement. Surgical patients today are older, sicker, and at greater risk for medical complications. Surgical volumes on the other hand continue to increase and demand surgeons to spend more time in the operating room. As for residents, restrictions on duty hours are tighter which limits their availability on the wards. Additionally, we are recognizing that optimal care requires a team approach that coordinates the expertise of the medical specialist and the surgeon.

Comanagement has multiple benefits, many of which are supported by evidence. Huddleston., *et al.* [1] conducted a randomized controlled trial of 526 patients undergoing elective total hip or knee arthroplasty at the Mayo Clinic. They found that nurses and surgeons strongly preferred the comanagement model, compared to standard orthopedic surgery care and internal medicine consultation as needed. Also, patients comanaged by hospitalists were more likely to be discharged without postoperative complications and were discharged half a day sooner when adjusting for skilled facility bed availability. One year later, Phy., *et al.* [2] analyzed outcomes of 466 patients over 65 years of age admitted for surgical repair of hip fracture at the same institution. Patients in the comanagement group went to surgery faster, were discharged sooner after surgery, and had an overall lower length of stay by 2.2 days. These and other benefits were replicated and documented in studies at different institutions worldwide and with different surgical specialties. Examples include lower readmission rates and increased prescribing of evidence-based treatments in Australia [3], reduced cost of care and ICU transfers in colorectal surgery patients [4] and improvement in patient safety with decreased mortality rates in vascular surgery patients [5].

National societies have responded to this emerging comanagement trend. For example, it was supported by the European Federation of Internal Medicine Working Group on Professional Issues and Quality of Care [6]. In the United States, the Society of Hospital Medicine has developed a comprehensive toolkit to help guide building a co-management program.

Finally, successful implementation of the comanagement model of care requires a team approach with clear interdisciplinary agreement and collaboration. Excellent and open communication between hospitalists and surgeons is the key to avoiding inconsistent interpretation of the roles and responsibilities, maintaining professional relationships, and making comanagement work for everyone involved.

Conflict of Interest

None.

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