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Editorial

# Perspectives from an Ophthalmic Hospitalist—Changing How We View Hospital-Based Consults

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**Abstract**

Inpatient and emergency room ophthalmology consults are becoming an increasingly important issue as fewer providers are willing to provide hospital-based coverage. In this Editorial, I explore aspects of this challenge and highlight a potential solution via the role of an ophthalmic hospitalist.

**Keywords**

- inpatient consults
- emergency room consults
- ophthalmic hospitalist

Inpatient and emergency room consults are often doomed to be the job that every ophthalmologist hates to do.

I recall the background grumble at faculty meetings where attendings would complain about the burden of staffing hospital consults while managing their busy outpatient clinics. Residents in turn would lament their late hours waiting to staff consults which were often delegated to the end of the day. Patients were unhappy about being redilated due to sporadic attending availability.

I listened to complaints from all fronts and an idea came to mind. Was there a way to craft a position such that hospital consults were a priority rather than a competing clinical obligation? What if an ophthalmologist could specifically focus their time on inpatient and emergency room consults? This could offer an ideal solution for everyone by providing hospital-based care in a way that was innovative, reliable, and professionally rewarding. I spoke with my departmental chair who seemed both surprised and delighted about the idea and my role as an ophthalmic hospitalist was born—and has successfully continued for the past 12 years.

Hospital-based consultation is a growing niche within ophthalmology that covers a wide array of clinical conditions including ocular trauma.[1] Ophthalmology is also an essential consultant for level I trauma centers which rely on subspecialty coverage in order to meet this referral designation. Despite the need for ophthalmology coverage, there have been a waning number of ophthalmologists who are willing to provide this care and the burden of coverage is largely falling on academic centers.[2]

There are a variety of reasons why hospital consults are unattractive for many ophthalmologists. Ophthalmology has largely become an outpatient field and few providers frequent the inpatient or emergency room setting after residency. Wandering an intensive care unit, donning and doffing full body personal protective equipment with a binocular indirect can feel unfamiliar and inefficient for someone who has become accustomed to a high-volume outpatient practice. Increased subspecialization may make providers less comfortable managing conditions outside their usual scope of practice. Ophthalmic equipment in an emergency room such as a proper working slit lamp can often be run down or out of date. Navigating an inpatient electronic health record (EHR) can also feel unfamiliar and pose an additional hurdle for submitting reliable hospital billing. In fact, many inpatient or emergency room-based consults often go unreimbursed.[3,4] And while some providers may be willing to provide ophthalmology coverage, there is a valid concern about sustainability in absence of other additional willing providers.

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So should we throw in the towel when it comes to hospital-based care for ophthalmology? I would hope that we would not.

Recently, there have been a handful of publications introducing an emerging role known as the ophthalmic hospitalist.[5] This is essentially an ophthalmologist who is either comprehensive or fellowship trained and focuses on inpatient and emergency room-based care. This trend for hospital-based specialization is also occurring in other outpatient fields such as dermatology with reasonable levels of career satisfaction.[6,7]

As an ophthalmic hospitalist myself, I have found that there are many reasons why this job has been a perfect fit for me. I genuinely like being in the hospital and evaluating ocular conditions that are often a result of underlying systemic disease. I enjoy conversing with other hospital services about complex cases which require multidisciplinary care for the most severe or rare of conditions. While I am not a pediatric ophthalmologist, I have come to value seeing both adult and pediatric consults and feel that we provide an important service in particular for our nonaccidental trauma consults.

Many of our hospital consults involve patients who are homeless or uninsured. Despite this socioeconomic challenge I feel that I have the luxury of practicing "ideal medicine" which is arguably easier to do in the inpatient setting. For the most part, our hospital patients receive the medications and procedures they need without the frustration of endlessly awaiting insurance authorizations. I also strive for efficient, cost-effective treatment paradigms that utilize our hospital formulary of which I am very familiar.

Another reason for my career satisfaction as an ophthalmic hospitalist is the efficiency I have developed for evaluating inpatients. By nature of spending all my clinical time in the hospital I have become very comfortable navigating its hallways and secret passageways. I am also keenly aware of what equipment I need and what I don't. Using the hospital EHR has become second nature and I can reliably submit consult billing for our department for services that would often otherwise go uncompensated.

There is also unique flexibility in work schedules for an ophthalmic hospitalist. Unlike the constraints of a 8:00 a.m. to 5:00 p.m. clinic, I am able to structure my day with unanticipated moments of teaching, linger with patients and their families when additional support is needed, and pursue other areas of interest such as a medical ethics fellowship which has wonderfully complimented my work. When I am off service, consults are covered by rotating faculty and fellows who staff for a minority portion of the year and are otherwise left to focus on their usual outpatient arena. That being said, it takes a village to create a thriving consult service and subspeciality availability for complex cases is important.

The financial structure for ophthalmic hospitalist positions can vary but many academic positions are salary-based. Due to the inherent unpredictable nature of hospital consults, patient volume fluctuates and does not lend well to a traditional fee-for-service model. Another consideration is the demographic of patients evaluated in the emergency room and inpatient setting, many of whom are uninsured with advanced untreated clinical disease. Funding sources for hospitalist positions can come from an ophthalmology department, hospital institution, or a hybrid of both. As ophthalmology is an essential consultant for level I trauma centers, it is not unreasonable to advocate that hospitals financially support this position in some way. An ophthalmic hospitalist position can also "pay for itself" via reliable hospital consult billing, capturing funding for a department that may be ordinarily lost.

Ophthalmic hospitalists are an emerging niche of ophthalmology that has gained recent growing global interest. The Ophthalmic Hospitalist Interest Group (OHIG, www.ohig.org) is an organization founded in 2020 that is designed to promote awareness and collaboration among providers who share an interest in hospital-based care. It has grown to over 100 ophthalmologists with both national and international representation. The group discusses topics relevant for hospital-based care via monthly newsletters, webinars, and an online community platform supported by the American Academy of Ophthalmology (https://aao.mobilize.io/main/groups/47315/lounge). Through this group, I have come to know several members who would consider themselves dedicated ophthalmic hospitalists. They represent providers of varied clinical backgrounds including comprehensive, neuro-ophthalmology, oculoplastics, glaucoma, and retina. They practice in academic and private practice settings. Their setups are each unique and address the important need and obligation we have as a profession to provide reliable hospital-based ophthalmology coverage.

Lastly and perhaps one of the best reasons for being an ophthalmic hospitalist is teaching residents. I often ask myself why not make hospital consults the BEST rather than worst rotation of residency? A rotation that residents actually look forward to doing. Staffing consults offer an ideal opportunity to work with residents one-on-one for extended periods of time. Many ophthalmic hospitalists represent core teaching faculty at academic institutions and help address Accreditation Council for Graduate Medical Education (ACGME) requirements for reliable direct and indirect resident supervision[8] for inpatient and emergency room care. This can be challenging to provide if a hospital is geographically located apart from clinics. The hospital setting also provides a rich learning environment to foster clinical skills and ensure other ACGME core competencies such as professionalism, observing how trainees interact with patients and colleagues of all different backgrounds, neurosurgery included.

But as we all know, the best way to teach is modeling our best self when it comes to medicine. The residents are aware of my genuine excitement and curiosity about inpatients. Dare I say, they might even seem somewhat surprised to see an ophthalmology attending happy in this role.

I believe there should be a paradigm shift in terms of how we view consults from a larger perspective. Attendings should play an invested role in the consult service which should be primarily an attending run service with resident support—and not the other way around. It is important for residents to see attendings in the consult "trenches" right alongside them, at times taking the initiative to see patients on their own to maximize efficiency and targeted teaching.

This sends the right message that inpatient care is not only important but requires a reasonable level of skill that is simply not achievable with a resident-only run service.

Overall, I genuinely feel that I have the best job in my department. I even like the exercise I get while walking around the hospital routinely working in my daily 7,000 steps compared to sitting in a chair at clinic. I have an enriching professional career and a great quality of life responding to zero patient portal messages. But no one wants to do a job that is not set up for success. Adequate salary, departmental support, and sustainable staffing schedules are essential.

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Conflict of Interest
None declared.

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