

## **“Hospitalists”- IMSANZ Position Statement and Background Issues**

### **Introduction**

The term “Hospitalist” has sparked significant debate in the literature since its introduction in the mid 1990’s. The initial debate in the American medical community centered on the threat to primary care that the introduction of Hospitalists constituted, particularly in the context of the US Board of Internal Medicine based qualifications which, in the majority of postgraduate doctors, allowed practice across primary care and referral based hospital medicine. The new specialty of “Hospitalists” was seen as a potential threat to hospital access on the part of primary care trained physicians. Once the Hospitalist started to cross national borders the debate changed its focus and when the term reached Australian shores the debate centered around who should be the hospitalist- General Physicians, Intensivists or Emergency Physicians. Clearly the General Physician was and remains the obvious choice and the debate then moved onto how this could be advanced as a subspecialty interest of general physicians with an appropriate curriculum and training program.

Now we enter a new Hospitalist debate, born out of a workforce crisis in the provision of healthcare, particularly in NSW, and failure of the state and federal departments of health to recognize the looming disaster despite advice provided by IMSANZ and the RACP. Even though the blueprint for a solution exists in the *Restoring the Balance* document, both levels of government seem to be taking an ill-informed and ill-advised path. In a medical manpower market where progress is being made towards the appropriate recognition and remuneration of the cognitive work undertaken in physician medical practice, the belief and assertion that complex medical patients in the hospital system require anything other than the standard of care provided by a physician are inappropriate. This potential “dumbing down” of the hospital medical workforce occurs at a time when ideas about how medical practitioners might be replaced in certain areas of practice by other health care professionals and technicians are gaining currency and which underpins the importance of overall supervision of patient care remaining in the hands of the physician.

The Hospitalist debate crosses the breadth of patient care, training and professional issues and below I have endeavored to address the key domains in which a trend towards Hospitalists within the medical workforce will impact.

### **IMSANZ Position Statement**

The position of IMSANZ on the recruitment and training of “hospitalists” other than FRACP holding physicians practicing in General Medicine and related subspecialty areas is that the current plan to recruit and train “hospitalists” represents a short sighted and inappropriate response to a workforce crisis already identified by IMSANZ and the RACP. The College has endorsed *Restoring the Balance* as an appropriate blueprint to navigate this crisis and hence we as a society find ourselves in conflict with the current plan as it has appeared in recently advertised positions in NSW. Solving the current work force issues by inventing a new sub-discipline of Hospitalist which is not fully explored or planned, and has the potential to compromise patient care, is not appropriate. The issue of workforce management must take into account the ongoing need for physicians to practice general medicine and recognize that these individuals are appropriately trained to undertake the role of hospitalist in an environment of aging population with multiple co-morbidities and a rising expectation of favourable healthcare outcomes. Previous poor planning and undervaluing of the general physicians does not constitute an excuse to proceed with a plan to use under trained and potentially unsuitable

medical practitioners just because it can be achieved in one electoral cycle rather than in the time frame of the current physician training program.

In addition, IMSANZ cannot support the training of physician competencies and clinical management in isolation from the College and feels that workforce solutions that are achieved without proper consultation and involvement with the College should not be supported. In the event that short term staffing crises mandate the placement of some form of career medical officer (CMO) into the public hospital system, then these doctors should remain under the supervision of physicians and that all aspects of training, maintenance of professional standards (MOPS) and continuing professional development (CPD) should be supervised by the college and that Hospitalists be offered an appropriate career path to and through physician training rather than an alternative that is substandard. The ideal Hospitalist is a general physician and the solutions to the current workforce crisis are to remove the financial and professional disincentives to not only general medical training but to all cognitive consultative practice, and to create more appropriately resourced training positions to train FRACP-accredited Hospitalists who recognize that medical practice goes beyond hospital walls and requires training and skill in community and outpatient care.

## **Background Issues**

### **What drives the push for Hospitalists?**

The medical manpower crisis particularly in NSW has resulted in recent advertisements for, and discussion around, a "Hospitalist" model of care. This response to the current medical manpower crisis has produced vigorous debate at general medicine forums. The debate has focused on the appropriateness of this model to fill the workforce need, along with the role general physicians and the RACP as a whole should be playing in the development of the Hospitalist model. The need for Hospitalists in NSW stems directly from the depletion of general medicine staff positions and training opportunities in NSW teaching hospitals and is symptomatic of a more widespread imbalance between general medicine and subspecialty medicine in hospital practice in Australia. The naïve perception that there is an untapped pool of skilled medical practitioners who, with modest additional training, can assume responsibility for the care of frail, dependant, often elderly, patients with multiple interacting comorbidities is clearly in contradistinction to the view of the IMSANZ membership and would be in conflict with the RACP's current support for more of the fellowship being able to acquire generalist skills and practice a wider scope of medicine outside of single subspecialties.

There is also the broader issue of which body should take responsibility for providing and accrediting postgraduate medical education for folk wishing to specialize in hospital medicine versus the other medical disciplines and the importance of the RACP and its special societies in guiding and consulting on this critical aspect of medical workforce education. Although there are several available models including the prevalent US based hospitalist model associated with 2 years of additional training (initially described in N Engl J Med 1996; 335: 514-517) clearly each of these have evolved in the local environment through a consultative process with existing disciplines. This consultative process must take place with all the players in hospital and community medicine as the impact of this decision will have implications across all areas, including reducing the numbers of applicants to current specialty training programs in favour of a fast track to similar levels of remuneration provided by means of the Hospitalist model.

### **How qualified are Hospitalists?**

The potential institution of a new postgraduate medical qualification to fill a workforce need when the ideal practitioner appropriately qualified for the position already exists, begs the question of why the current highly skilled and fully trained physicians practicing in general medicine are unable to attract new trainees into this challenging but rewarding discipline. Should not the government look at the disincentives to a career practicing in general medicine rather than introduce a new, lower standard of practitioner to perform tasks that are too complicated for all but the current subspecialists engaged in complex cross-disciplinary medical diagnosis and management? The duties of the new Hospitalist and those of the physician trainee at basic or advance training level are also likely to cause tension particularly in the presence of different remuneration scales and incentives to hospital administration to use lower-paid Hospitalists to lower the costs of overtime and after-hours rostering.

### **Who will supervise Hospitalists and assume ultimate clinical responsibility?**

The issue of clinical responsibility has several aspects. If the health system, patients and the public are happy to accept a potentially lower standard of health care and to have the responsibility for clinical decision making given to a new medical practitioner strata with a less inclusive qualification, then the Hospitalist option may be appropriate in its rawest form. If this overall level of inpatient care (and potentially in the future outpatient care) is the only level the community needs and can afford, then the so-called Hospitalist may not require supervision. However, should we choose to introduce this new role at a supervised CMO type level then clearly the most appropriate supervisor would be a general physician. The impact on some of our subspecialist colleagues, who practice solely within a subspecialty area which may be procedurally orientated, of taking clinical responsibility for care well outside their own specialty by a hospitalist is likely to trigger quality issues and higher consultation rates between subspecialists than currently exist with resultant greater inefficiencies in care.

### **How good will the training models for Hospitalists be?**

The model for training and assessing a new stream of Hospitalists who are to be regarded as having a postgraduate degree will require careful consideration, particularly if they are to assume responsibility for clinical decisions. In addition some state by state equivalence in training and qualification will be needed. Clearly the RACP should play a critical role in the development and accreditation of Hospitalist training programs as the curriculum content and development and training expertise already exists within the college. The introduction of new university programs which, at present, even struggle to assist with postgraduate year (PGY) 1&2 clinical training directed at simply consolidating undergraduate competencies, would further dilute teaching expertise and reduplicate training already provided within physician training programs. The fast proliferating but separate postgraduate teaching institutes will be simply unable to produce a quality teaching product without the good will of the physicians already overcommitted to basic physician training and raises again issues of inefficient duplication and need for standardization.

The other difficult issue for current physicians is what assistance they would personally offer to training Hospitalists, particularly if an inappropriate training model is adopted and if university appointed physicians who practice general medicine are compelled to participate in such training programs. It would seem appropriate for IMSANZ to support in principle any individual physician who, depending on his/her circumstances, made a stand on this issue and, as a whole, to oppose universities requiring our members to train hospitalists outside a model that we support.

### **What might be MOPS and CPD requirements for Hospitalists?**

Participation in MOPS and CPD is integral to any medical professional and a requirement for medical registration, and these processes exist within the college and are under constant review and refinement. Hence a Hospitalist model which has been declared as being appropriate to the college would require Hospitalists to participate in a college auspiced program. In contrast, current CPD programs for CMOs comprises a mixture of hospital based meetings which, in their content and aims, are unique to individual hospitals, industry sponsored meetings and web based associations such as the Australasian Society of Career Medical Officers.

### **What forms of remuneration might Hospitalists receive?**

The issue of remuneration, although not the sole area of concern, will be critical to recruitment both in a positive and negative sense. Should full specialist awards be applied to this group then the flow-on effect to the current levels of recruitment into specialties would be significant. It is unlikely that being an Hospitalist would be seen as an attractive career without a wage structure close to the level of a specialist.

### **How will standards of care be defined for Hospitalists?**

Under the Hospitalist model there is, by definition, going to be a lower level of training and a more limited list of competencies compared to the clinical competencies of general physicians. But lower quality care can lead to large increases in cost due to avoidable complications and adverse outcomes. IMSANZ clearly cannot support a decline in clinical care and so would only support a model where overseeing general physicians work in a supervisory role with the hospitalists.

The employment of Hospitalist starts the health system down the path of replacing existing medical practitioners with Hospitalists in clinical care and then with technicians in procedural areas, as is occurring in many overseas healthcare systems. These changes will impact on all aspects of our current hospitals and represent two halves of the same process of doctor substitution. Hence the headlong rush, for short term manpower reasons, into adopting a US-style Hospitalist system needs to be tempered by a careful and considerate discussion with all the stake holders.

### **Who might be the likely applicants for Hospitalist positions?**

In the current medical workforce environment the likely applicants for such positions fall into 2 groups: those who have failed to meet the required standard in physician training; and those who have made a conscious decision not to take on the rigors of complex patient care and decision making in clinical care. Neither of these groups of doctors seems the ideal choice to take on poorly supervised or unsupervised care of the complex medical patients who currently occupy our public hospital wards.

### **What might be the role of the General Physician?**

All the possible scenarios will not obviate the need for General Physicians and their colleagues such as Geriatricians to continue to provide care to patients who need those trained in multi-system consultative practice. At a time when the college and hospital governance bodies are aware of the need for a greater mass of skilled generalists and are seeking to implement

solutions such as those contained within *Restoring the Balance*, why should the college and IMSANZ stand by and watch yet another threat to the survival in Australia and New Zealand of general physicians, when even the USA has made the survival of the Generalist critical to their system.

### **The potential threat of an unsustainable increase in cross-referral burden**

Finally one of the likely outcomes of taking patient care out of the hands of the true all rounder (general physicians) will be an increase in the number of cross referrals for opinions from other subspecialist physicians. This will no doubt increase length of stay, increase the burden of work for other subspecialists, and possibly increase the risk of adverse outcomes as certain aspects of a patient's care may slip through the cracks of multi-specialist coverage.

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