

## *The Rise of Outpatient Services*

### *Introduction*

Increasing numbers of American family physicians are trading their hospital practice for increased efficiency in outpatient settings. It is argued that hospital affiliation interrupts the normal outpatient practice of physicians who are happier to leave hospital service to hospitalist physicians specialized in the care of the admitted patient, and in communication with referring physicians or specialists who also may or may not be attached to a hospital according to the traditional pattern. (Henry 1997 1) A growing number of Managed Care Organizations (MGOs), hospitals and physician-owned groups are hiring 'hospitalists' whose preliminary function is to care for patients in hospital, freeing up primary physicians to concentrate on outpatient service.

In 1996, The National Association of Inpatient Physicians (NAIP) appeared with a membership of more than 500 and this affiliation has grown quickly towards the 1500 mark. Most hospitalists are internists, general surgeons, or sub-specialists including pulmonologists, whose practices involve significant hospital contact. According to literature made available by the NAIP, the organization aims to promote high quality and cost-effective care of the hospitalized patient, upholding the highest professionalism among hospitalists and other providers of inpatient care. The NAIP also has an educative role in helping physicians, other health care workers and patients to adjust to the new system, and a research role in

investigating all areas of inpatient medicine, with another strong emphasis placed on building relations between hospitalists and other physicians and the healthcare establishment. (1998)

#### *Advantages to MCOs and other Parties*

The cost-benefit analysis so important to contemporary medical issues indicates that hospitalists can reduce the amount of time spent in hospital by one to three days. There are fewer delays between admission, observation, treatment and follow-up care. (Wachter 1996 515) The patient is never waiting for a general practitioner to find a time to dart over to the hospital, and an MCO or group practice gains a definite insurance advantage when patients are handed over to the hospitalist: there is argued to be less room for malpractice and error when a specialized and compartmentalized system is in place. The hospital and its physicians are solely responsible for whatever occurs once the patient has passed through the doors of the hospital. Where insurers are informed of a referring party's use of hospitalist care, reductions in liability insurance are likely. (Henry 1997 4)

The use of the hospitalist is not simply an out growth of managed care. As physicians' practices grow busier, some happily hand over hospital care to specialized teams. It is possible for referring doctors to build very workable relationships between hospitalists and themselves that were not quite possible under traditional systems which linked hospitals to numerous physicians with hospital privileges. A doctor need not worry about hospital politics, the dynamics of relations between in-house specialists and persons like

themselves. Some very efficient professional relationships are built up between hospitalists and individual practices or doctors which are direct and less hampered by either hospital politics or policies and procedures. The way the model is taking form, a doctor calling to inquire after a patient is better able to connect with *the person* treating the patient as opposed to a ward-team manager or a leading hand having examined a chart, or authorized a procedure to be carried out by another.

Hospitalists report that their constant presence in the hospital allows them to build up better working relationships with nurses, technicians and laboratory workers and other doctors than was possible in the day of physicians flitting in and out of a less familiar hospital, here and there ordering tests or asking for progress reports from other professionals. Since most hospitalists are internists and others who are familiar with hospital settings than office life, they claim that their talents are best used by the system that has taken form. They must still adjust to being hospital staff who are *primary care physicians* but are said to offer a great deal of expertise in simply getting things done within the hospital as it is more familiar to them. (Henry 1997 10)

However, many doctors continue to be in conflict with MCOs as their formats have taken hold, piecemeal, in different parts of America. (Newcomer 1997 43) Doctors have to be aware of constraints set by perhaps three or four different MCOs in relation to other health bodies belonging to their profession, specialty, different kinds of health insurance, and local facilities. It has become

routine for a practice to set up spreadsheet diagrams indicating the ins-and-outs of numerous sets of regulations and guidelines, in a way much resented by many practitioners. (Tobin & Large 1997 1)

Individuals and practices that track performance according to yet other record keeping can be in a good position to approach Plans indicating savings here and there. The use of hospitalist care can benefit presentations which sometimes do earn a practice some beneficial leeway for the hospitalist model does involve significant savings of time and money.

All of these points need to be reexamined from time to time, in awareness of hundreds, perhaps thousands, of American physicians who remain opposed to the entire concept of Managed Care. A 1997 survey of New York City's primary care physicians found that a full 78% opposed today's managed care and nearly 50% stated that they were considering quitting their medical careers under the current conditions. (*Monitor* 1997 4) With the arrival of hospitalists, some family physicians fear that they will lose their hospital competence that has *always* been an important aspect of their careers. (Michota *et al* 1998 1) The new system of managed care and the substitution of often young hospitalists for continuous family doctor care is anathema to some general practitioners of certain orientations, often the graduates of medical schools which have imparted an ethos in favour of every doctor being able to deliver a child, set a broken leg, and attend to a cardiac emergency. Furthermore, there is ongoing debate as to how the split

between primary and hospital care consigned to hospitalists will shape the future of American medical education. (Miner 1998 1)

### *Criticism of the Trend Towards Hospitalists*

It has not been missed by patients' rights groups in America that outpatient physicians welcome hospitalist models of inpatient care for the ways in which these reduce the former's personal liability and mean less interruption to the general practitioner's day. The outpatient practice is where a family physician makes income; daily trips to a hospital to look in on one or more patients is an expensive diversion from the business of seeing patients in succession at office. Most patient groups have become accustomed to dealing with a medical profession that is more specialized, technical, and often less equipped with the bedside manner of old. No matter how rationally feasible the new system is, some patients will prefer to know the family physician does have a role in their treatment. As part of psychological medicine, a visit from the family doctor may do wonders where morale has been lowered by chronic or traumatic disease: the patient is less concerned that a specialist be the best in his or her field, than by knowing the practitioner. For example, before women were referred routinely to obstetricians for childbirth care, many were happy to maintain the services of a GP even where choices of obstetrical specialist expertise were available. The point made here is that patients will often continue to prefer the care of a generalist who is known to them.

This issue of 'farming out' care to hospitalists becomes an ethical one in such areas as geriatric medicine and chronic care requiring the human touch. In the last generations, doctors often made it their professional and ethical responsibility to attend the final illness of a longstanding patient or a member of a family perhaps known over two or more generations. A terminal oncological patient can benefit terrifically from a friendly visit of the family doctor and is less likely to be impressed by the perhaps superior qualifications of the hospitalist who remains a comparative stranger. The old system of physicians' rounds always implied more than simply medically treating patients and one wonders how the hospitalist model will contend with such ordinary matters of humanity.

The hospitalist model has taken time to work through professional groups in favour report glitches related to patient loads. For instance, a patient may find that three or four hospitalists dote upon her case, and another patient arriving during a time of busy activity, may have the familiar delays of old with regard to being examined and treated. According to Henry, surveyed patients have claimed not to mind foregoing their personal physician during hospitalization. (Henry 1997 6-7) However, no indication was given as to what kinds of patients these were who participated in different surveys, or even whether these patients *had* a regular family practitioner to whom they presented their medical complaints. As continues to be heard with regard to every aspect of American medicine at the present time, the use of hospitalists constitutes another alteration in the profession and delivery of medical service in which patients have no voice. Akin

to managed health care, patients have had no share in devising the hospitalist models that are now being put in place. The patient is more and more a consumer only, according to contemporary healthcare reform but a kind of consumer that is bound by the decisions of governments, insurance companies, professional organizations and other players who do not happen to be patients. As critics of managed care and the shift towards hospitalists will pronounce at every turn, the American healthcare system has yet again removed the element of *choice* from the patient and increasingly from the family practitioner, too.

#### *Conclusion*

Like the MHO model, the growing pattern of hospitalist deployment is bound to remain in place, and to alter over time as adjustment is made. (Bentsen 1998 2) Providing that hospitalists take seriously the more humanitarian aspects of medicine, it is possible that the public's resistance will fade over time. The argument that the patient treated by a hospitalist experiences more direct medical care as opposed to nursing supervision seems a valid one. Moreover, the hospitalist's taking charge of the patient involves a different role within the hospital than that of a surgeon or other party who is accustomed to being based in hospital but without the demands placed on the hospitalist for all aspects of patient care. The transition is probably eased by the efforts taken by hospitalists to clearly define their professional activities and to build linkages between themselves and other doctors. Some medical colleges predict that the hospitalist practice will become the next area of medicine to become a specialty. (Bentsen 1998 3, Wachter *et al* 1997 85-86) At present, most

hospitalists are younger doctors who may bring greater enthusiasm to their careers and patients ... it is also argued that they cannot be expected to have the *mileage* of older doctors. Moreover, they do not have the knowledge of the individual patient this is often the family doctor's preserve. At the same time, it is to be hoped that general practitioners will continue to make at least an occasional visit to the hospital, even if on purely social missions, with regard to the preservation of good spirits among patients not merely undergoing a routine operation or round of tests. The family doctor retains a special status that ought to be considered an ongoing part of the profession.

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