

## The House Physician Under Managed Care: Two Futures

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Long a part time position coveted by resident physicians in need of extra cash, the house physician's role is changing almost as fast as medicine itself. During postgraduate training, many practicing physicians have served as house physicians—licensed, institutionally-based, usually salaried employees, with duties to their acute or long-term care facility, and to attending physicians.

Here, I highlight two different futures for house physicians under managed care. I suggest that although eliminating house physicians may serve some medical groups and hospitals well, elevating the role to one of "designated attending physician" may improve the quality of care at a time when the undivided bedside attention of an attending physician seems like a fond remembrance.

### The Present

No published data are available to report how many physicians practice as house physicians, how many are fully trained and how many are in training, or how many acute and long-term institutions retain them, but in 1994, hospitals formally employed 71,548 physician full time equivalents.<sup>1</sup> This figure embraces hospital-based specialists such as radiologists, anesthesiologists and pathologists, as well as house physicians. In a conversation with Tod Nodenski, JD (August 1995), it was learned that the Illinois Hospital Association reports that coverage by employed physicians after 5 PM, on weekends, and in emergencies is common in smaller communities.

Most house physicians appear to be employed by healthcare institutions, and while some are still physicians-in-training, many are fully trained, staff physicians who practice part time or full time in the hospital.

Descriptions of the house physician's role range widely from supervisor and housestaff mentor to attending physician-extender, to interpreter of hospital-based policies, rules, and protocols for attending physicians. Their current role is tersely described by Rubin, who discussed the collaboration of full time hospital-based physicians and their institutions 30 years ago. He wrote, "It is a reciprocal arrangement. The physician renders a specialized service to the hospital patients in an ethical professional manner. However, the hospital provides the facilities and the patients."<sup>2</sup> In the same year, *The House Physician Reporter* reported a call for "individuals who will serve as team leaders, coordinators, and primary physicians."<sup>3</sup>

The duties of the house physician vary from the performance of an admission history and physical examination to the accomplishment of urgently needed technical procedures and the immediate management of critically ill patients. An individual institution's description of its house physician's duties is often particular and specific, ranging from which floors are covered to which types of patient falls are to be evaluated and when.

Too often, the primary underlying motivations of the house physician and the attending physician are different. The house physician's primary motivations are to complete the assigned tasks efficiently; to sleep the whole night with as few interruptions as possible; and to arrive and depart by the clock. The effective house physician does a deft history and physical, arranging it along the lines of the discharge summary, for which he or she may also be responsible. The house physician keeps alert for notification of any urgent problems, and answers questions from the patient's nurses and from the patient and the patient's family when possible, given limited data and limited time. The house physician usually does not bill for visits, procedures, or other services.

In contrast, the attending physician's motivations are to discover and improve the patient's medical condition, when possible; to assure the patient's

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speedy transit through his or her hospital course; and to receive reimbursement for his or her work. The attending physician usually manages the case, usually co-signing the house physician's notes and orders and billing for physician services. The attending physician regards the house physician's services as a great convenience, especially in fielding calls from nurses, and as a perk from the hospital in acknowledgment of his support as an admitting physician.

### The Future

Two distinct, divergent future trends exist for house physicians. One argues for their eventual extinction; the other suggests a re-engineering of their goals and functions.

*Extinction.* Acute care institutions have become cost centers under managed care. Although some physician-hospital organizations have included positions for house physicians, an ordinary and explicit means to recover house physicians' salaries is not the rule. With a need for excellent, economical professional in-house service, hospitals and medical staffs have strong arguments for phasing out house physicians and their salaries, while creating new, demonstrably cost-effective approaches to their tasks.

In Northern California, for example, the Permanente Medical Group does not employ house physicians: the attending generalist staff rotates in-hospital call, and specialists come to the hospital to attend the patient in need. In Southern California, the Scripps Medical Group asks its internists to be inpatient managers for a week at a time, together with a physician assistant and case management nurse.

Although it means a return to spending the night in a hard hospital bed for attending physicians, these two California approaches avoid fragmentation of a medical group into outpatient and inpatient physicians, guaranteeing that all physicians know the challenges and rewards of both settings. These approaches utilize the excellent clinical skills of American internists, who have been highly trained in sophisticated inpatient facilities for more than 30 years. These approaches improve efficiency by allowing most group members to get to the office earlier, instead of conducting rounds on a few hospital patients each. These approaches explicitly value a continuous, primary physician-patient relationship with a personal attending physician, available when a patient has great medical need. These approaches may also reduce length of hospital stay, and with it, hospital charges and group costs: published data is unavailable.

Some hospitals, groups, and medical staffs employ midlevel practitioners, such as physician assistants

and advanced practice nurses, as low-cost alternative providers of in-hospital care. Anticipating residency training's gradual shift to the outpatient setting, and the restricted availability of housestaff to provide inpatient coverage, Knickman and colleagues suggest that nurse practitioners, physician assistants, or clinical nurse specialists could "take on the role of monitoring and co-ordinating care and implementing the medical decisions suggested by (attending) physicians."<sup>4</sup> Even with their limited capacity to bill for services, midlevel practitioners are affordable enough for many practices and institutions to retain them on salary, eliminating the need for a house physician.

Many practicing physicians who attend in non-teaching institutions without house physicians currently take call from home or with a mobile phone, and come in when needed. These physicians rely upon the emergency department to evaluate their urgently ill outpatients, and upon floor and unit nurses to contact them if a hospitalized patient takes a turn for the worse. This approach is strongly personal and service-oriented, requires a 24-hour commitment to a patient's needs, and relies on collegial coverage arrangements for times when the physician is unavailable. A house physician is not needed under such an arrangement.

In sum, reasonable alternatives could easily extinguish the role of house physician in the near future.

*Re-engineering.* There is another, perhaps preferable future view. House physicians could become full time, hospital-based attending physicians. In a sense, house physicians could become efficient, in-house partners with primary attending physicians and become the patient's personal hospital physician. Sharing the same incentives, guidelines, and financial arrangements with a patient's (outpatient) attending physician would foster this new role. Renamed "designated attending physicians," the new house physician could have the specific goal of improving the quality and continuity of hospital care.

Elevated to new levels of responsibility, house physicians could be an important part of increasing the efficiency of healthcare delivery. Mindful of the pressures to reduce hospital occupancy and length of stay, the competent house physician could apply a familiarity with hospital formularies, care protocols, and institutional ethics policies in individual patient cases. A physician knowledgeable about and practiced in the processes of risk management and managed care would likely improve decisionmaking and reduce institutional exposure to liability.<sup>5</sup> The physician's inpatient availability to document times, dates, and content of in-house and telephone conversations with

patient, family, and utilization management would allow time for detailed progress notes.

The model of a "designated attending physician" has precedent in some European countries: in Britain and Germany, for example, responsibility for hospital care belongs to in-hospital, full-time attending physicians.<sup>6</sup> Outpatient generalist physicians manage patients in the office and at home; inpatient physicians manage them in house. As in Western Europe, this new model recognizes that outpatient and inpatient medicine are different worlds, requiring different skills, rules, regulations, and guidelines.<sup>7</sup>

Unlike the European model, however, this model incorporates managed care's own notion of population-oriented care, which encourages patient relationships with physicians as members of medical groups and health systems. Physicians could rest assured that their technically proficient, hospital-based partner was available to care for (their) patient; patients could count on a hospital-based expert for availability and procedural proficiency, as well as the management skills of a primary attending physician. Financial advantages also accrue to both outpatient and inpatient physicians who are members of the same group or system. Each physician's medical and financial incentives then align, irrespective of whether he or she practices in the office or in the hospital.

What will it take for this model to work? Excellent communication between inpatient attending physicians and outpatient attending physicians is second in importance only to a sufficient inpatient census to make the physician's job possible. Enough information about medical problems, medications, family members' participation, and patient adherence to recommendations should be communicated to make the designated attending physician's job easy. This in itself will not be easy, but may be facilitated by the congruence of motivations, particularly if financial incentives exist for desirable patient outcomes.<sup>8</sup> Organizational problems will also need to be solved. How to structure a call schedule, compensate group members, and create ethical incentives for quality care are challenges that physicians in other fields, such as emergency medicine, currently meet.

Is this model malleable enough to accommodate generalists and specialists? Even in health maintenance organizations (HMOs), there are too many specialists,<sup>9</sup> and the role of designated attending physician might be very appealing to both HMOs and specialists. Indeed, subspecialists may want to become designated attending physicians, both in general hospitals and with hospitals with centers of excellence in their own areas. As intensity of hospital

care rises, oncologists and nephrologists seem especially good candidates for becoming "hospitalists," although the same case could be made for nearly every subspecialty. Internal medicine subspecialists have procedural and management training useful to the role of designated attending physician, and may continue to provide some primary care.<sup>10</sup> A recent classified ad in the *Annals of Internal Medicine* sought a "hospitalist-outcomes researcher";<sup>11</sup> although listed under "Internal Medicine and Primary Care," a subspecialist would have qualified as readily as a generalist.

Psychological and social obstacles can also be anticipated, especially for primary care physicians. Some who "give up" hospital medicine may feel as if they are neglecting professional skills and roles by which they have previously defined themselves. Others, such as some physicians who treat their own families,<sup>12</sup> may feel that only they can provide the best care for their own patients. Still other physicians may miss the intriguing and too occasional "fascinoma," for example, once the common cover of a community-acquired pneumonia has been peeled away.

These are not minor obstacles, yet they are surmountable. The greatest professional satisfaction of internists, both subspecialists and generalists, is still the doctor-patient relationship.<sup>13</sup> HMO physicians are generally satisfied with their ability to hospitalize patients when and if needed.<sup>14</sup> Do outpatient attending physicians provide better inpatient care for their own patients than designated attending physicians? Certainly sometimes, as the relationship is nothing if not therapeutic, but this is undiscoverable most times, as tragically, the doctor-patient relationship now is often truncated by the yearly negotiation between employer and HMO.<sup>15</sup>

This new role for house physicians has several advantages for U.S. healthcare as a whole. This new role emphasizes efficiency, and with it, the promise of more time available for internists, whose greatest dissatisfactions with medicine are too little control over their practices, and too little personal time.<sup>13</sup> It makes explicit the principles of public health in managed patient care, including the value of a continuous relationship with a medical group, and acknowledges that no one physician or medical group can be all things to all patients. Finally, it recognizes that the house physician cannot replace the primary attending physician, but instead, can represent an inpatient primary attending physician, available in the hospital, when needed.

Some medical staffs, medical groups, and acute care institutions, especially those in areas of the coun-

try without significant managed care penetration, may prefer to employ house physicians differently—as urgent care procedural physicians. House physician employment by a managed care organization (MCO) or an employment partnership with other attending physicians would be unnecessary, although desirable for purposes of creating collegiality and establishing financial incentives. The house physician would provide urgently necessary technical interventions, and a working knowledge of institutional ethics and quality guidelines needed to facilitate immediate, crisis-like management. This role permits the admitting attending physician to make the day-to-day decisions of inpatient care, while freeing the house physician to perform other hospital functions, such as teaching housestaff, performing special procedures, or developing practice guidelines.

The financial incentives to limit treatment that are inherent in managed care affect the way physicians think about practice.<sup>16</sup> Remuneration by an institution, medical staff, medical group, or MCO, without bonus or salary adjustment tied to the physician's resource utilization, should minimize managed care's use of these negative incentives.<sup>17</sup> Yet some managed care groups see financial incentives for house physicians as constructive tools to reduce costs for all MCO members. CIGNA HealthCare Mid-Atlantic, for example, capitates two IPA physicians for their outpatient practice and adds a fee-for-service payment related to patients' length of stay.<sup>18</sup> Other medical groups and staff-model MCOs pay salaries to primary and specialty physicians to staff inpatient facilities.

### Unanswered Questions

As there is virtually no published empiric data about house physician practice, unanswered questions abound. Do designated attending physicians deliver measurably better inpatient care than physicians who must go to the office and to the hospital? Will medicine break up into "hospitalists" versus "office-dwellers" to provide more efficient care, and if so, what will be the consequences of this fracture for teaching and training, and for job satisfaction? Will competent physicians be willing to spend nights in the hospital, returning to a position still associated with residency training, menial labor, and false alarms? Will the role of house physician earn a career status and remuneration commensurate with its responsibilities? Or will it continue as a transitional role, between physicians and their diminished ability to find full-time work?<sup>19</sup>

### Conclusion

Many physicians will be relieved by and even covet the house physician's regular hours, defined duties, nonexistent overhead, and hands-on procedural responsibilities. Yet highly qualified physicians will not be easily recruited to full-time house physician positions. Unless their service-oriented responsibilities are acknowledged by colleagues, and recognized by appropriate remuneration, house physicians will remain underutilized and highly capable. The future of the house physician awaits vision and innovation.

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