Resident Restrictions

Andrea M. Sattinger
Posted 02/05/2009

Introduction

Effective July 1, the Accreditation Council for Graduate Medical Education (ACGME) is adopting rules changes to further restrict the number of patients internal medicine residents follow. The impact of this change may reach beyond academic institutions and teaching services. Non-teaching services and institutions may see some fallout, as hospital administration shuffles caseloads of residents and hospitalist attendings. The potential results likely will impact resident training, hospitalist training, and hospitalist practice management, namely recruitment and hospitalist job satisfaction.

Why the Change?

With the 2003 restrictions on resident work-hours duty and now the capping of patient caseloads, the ACGME is attempting to ensure residency programs are not viewed as a source of cheap labor and excessive stress. Also, "the Residency Review Committee (RRC) is cognizant too much service can be a barrier to education," says Lenny Feldman, MD, a hospitalist and associate program director at Johns Hopkins Medical Center in Baltimore. But there is a danger in the reverse: too little service may undersupply residents with the depth and breadth of cases they need under their belts to competently enter practice. "Education should be the foremost mission for residency programs, but trying to find that exact balance between service and education is tough," Dr. Feldman says.

In a Nutshell

As leader of the 70-hospitalist Health Partners Medical Group in Minneapolis-St. Paul, a University of Minnesota affiliate working with internal medicine residents, Burke T. Kealey, MD, views the ACGME rule change on a professional and personal level. In the big picture, Dr. Kealey observes three main effects:

- Hospitalists will be seeing more patients and probably more patients at night;
- The cost of hospital care will increase for hospitals and hospital medicine groups (HMGs); and
- The experience level of new graduates applying to be hospitalists will diminish.

In essence, there are few ways to handle the looming cap on residents patient caseloads. (see Practical Approaches, p. 24) Given the financial constraints imposed by this new, unfunded mandate, and taking into account the fact most residency programs depend on federal funding, it generally is believed increasing the number of residents cannot be considered an option. "Given the looming physician shortage, there is pressure on the federal government to increase the amount of GME support and the number of residency spots," Dr. Feldman says. "Medical schools have increased enrollment pretty significantly, but the bottleneck is the number of GME-supported residency positions."
HM Crossroads

Leslie Flores, MHA, principal with Nelson Flores Hospital Medicine Consultants, and the director of SHM's Practice Management Institute, believes the new rule dramatically will impact teaching hospitals and HMGs. "I think it is likely to be harder for academic hospitalists, who are working on teaching services, to generate reasonable productivity, which will place an even greater financial burden on academic practices," she says. "But the larger effect will be that nonteaching services in teaching hospitals will be expected to pick up the slack and, subsequently, grow in order to accommodate the patient numbers."

Asking staff physicians to increase their patient load, even incrementally, is a poor solution, at best, Dr. Kealey says. And it may be tough for some places to recruit more hospitalists, a function of the hospitalist labor shortage.

William Rifkin, MD, a hospitalist and associate director of clinical medicine at Albert Einstein College of Medicine, and director of the residency program at Jacobi Medical Center, Bronx, N.Y., estimates hospitalist jobs in teaching institutions will increasingly morph into nonteaching positions. "Where currently the ratio of teaching to nonteaching jobs is 50-50," Dr. Rifkin says, "by 2009, 80% of internal medicine training programs will have to build or expand a new, non-teaching service, and more than half of hospitalist duties will be non-teaching."

A recent recommendation from the Institute of Medicine (IOM) reinforces the national movement to restructure resident work hours and duties. Released Dec. 2, 2008, the "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety" report calls for a maximum shift length of 30 hours with admission of patients for up to 16 hours, plus a five-hour, uninterrupted sleep period between 10 p.m. and 8 a.m., with the remaining hours for transitional and educational activity.

The consensus is the ACGME rules changes likely will alter the hospitalist job description and produce an even greater shortage of qualified, experienced physicians. Leora Horwitz, MD, MHS, an assistant professor in internal medicine at Yale University School of Medicine in New Haven, Conn., says "hospitalists are really an amalgamation of two very distinct types: the short-term hospitalist who takes the job for a year or two right after residency and before fellowship, and the longer-term hospitalist who takes on the job as at least an intermediate-term career. It could be that recruitment and retention differ for these types."

Dr. Rifkin isn't alone when he asks, "Can a hospitalist last that long doing patient care alone? There are only so many people who will move up to be leaders in HMGs. So while this will probably be good for recruitment in the short term, in the long term, we don't know."

Immediate Consequences

Some ramifications of hospital medicine as a whole taking on more patients and more hospitalists will parallel the growing pains of individual HMGs. For instance, hospitalist group's social bonds may not be as tight, says Dr. Feldman. But where many obstacles are surmountable, "what is not surmountable is if hospitals don't choose to increase the size of their hospitalist programs. The deathblow to most hospitalist programs is if you ask the group, and each individual, to do more work that is not commensurate with the original expectations. And with the market already tight, most hospitals can't afford to have unhappy hospitalists."

Financially, the new rules will place a heavy burden on HMGs and hospital administrators. With no additional reimbursement under the GME system, most hospitals will have to get creative with existing budgets. "Part of the concern is that patients that hospitalists see on a teaching service tend to be the lower socioeconomic population of patients Medicaid and self-pay patients where there is inadequate reimbursement anyway," Flores says. The answer likely will be sending those patients to a non-teaching service, which in essence transfers the financial burden. "Hospitals will have to find money from somewhere."

Teaching hospitals not part of large academic medical centers contribute to hospitalists' compensation when they help train family medicine and internal medicine residents. "Because they are not technically academic hospitalists," Flores says, "they need to be alerted about how these rule changes may influence the way they manage and run the finances of their practice."

Some of the solutions to the problems inherent in this change depend on the practice and scheduling model. In the
aftermath of the work-hour restriction, many hospitalist programs changed their scheduling method to day float/night float, or the "drip" method of admission (taking admissions every day), versus the "bolus" method (every fourth or fifth day), Dr. Feldman says. The bolus method likely leads to scenarios where the new ACGME cap will come into play.

There is the possibility the rule change could turn out to be a boon to HMGs, Dr. Feldman says. Programs without hospitalists may hire them; small groups may expand, increasing job opportunities. Additionally, teaching opportunities for hospitalist attendings may improve with the decreased number of patients on a service residents follow. "Hopefully, this will increase opportunities for teaching residents and increase the satisfaction of those involved in teaching," he says. "Ultimately, it may result in improved resident education while creating more job opportunities for hospitalists a win-win for both groups."

**Will Training Suffer?**

Dr. Kealey has concerns about the long-term effects on the training residents who become hospitalists. "First, they won't get enough experience to be competent hospitalists on graduation. Second, the number of patients is being capped, but the number of ACGME-required outpatient clinic sessions is rising, increasing from about 108 to 130 over a 30-month period," he says. "Residency programs will have to figure out how to fit these sessions into training, and that may squeeze out inpatient time."

Third, with the work hours and caseload restrictions on residents, educators are concerned residents will not receive an adequate level of training.

Kenneth P. Patrick, MD, director of the hospitalist program at Chestnut Hill Hospital in Philadelphia, is worried, too, especially when it comes to the educational implications. As a former residency program director, one who shares concerns about residents' large workloads, Dr. Patrick believes strongly in medical education and is wary of the path it seems to be taking. "What a hospital medicine group can provide to residents is the opportunity to learn from a smaller patient load," Dr. Patrick says, "and regulatory agencies should carefully address that. Cutting back on the number of service hours and patients can have both a positive and negative effect. Most people are only adjusting the numbers of hours and patients and not viewing the whole picture."

Another likely result of the rules change is the mindset residents could be developing, an issue that rings true with most HMG directors. "I worry that our residents will be sheltered during training and will emerge into a real world where there won't be caps," Dr. Kealey says. "They will be in systems where people have to cooperate with each other in order to handle patient surges and large patient volumes. Though they may graduate, join a group, and become acculturated, it concerns me that their initial primary training, rather than encouraging them to think as part of a system, may be training them to think of 'my restrictions, my needs, my limitation.' "

**Prepare for Change**

What is the answer? Two hospitalists echoed the same, simple solutions: "Give us more money" and "We need more bodies."

Simplicity aside, residency and hospital medicine programs will need to prepare for the change. "Instead of happening gradually, suddenly every [residency] program in the country will lose 20% of its capacity," Dr. Rikfin says.

Michael Pistoria, DO, FACP, associate general division of internal medicine chief at Lehigh Valley Hospital in Allentown, Pa., believes institutions with closely aligned hospitalist and residency programs will benefit from "enlightenment on both sides. Residency programs are increasingly alert to the vital role that HMGs play in supporting residency programs," he says. "They are more aware of the impact these types of decisions have on the staffing of HMGs."

Mid-level providers are one possible solution. "Programs will increasingly look to supplement their existing group with advanced practice clinicians—physician assistants and non-physician providers a less-expensive alternative," Dr. Pistoria says.

Does hiring mid-level practitioners pose a risk for unintended adverse events and delays to diagnosis? "There may be an extended growth curve for these providers," Dr. Pistoria says, "due to less clinical exposure and experience than a
new physician hospitalist just out of residency."

However, these advanced practice clinicians often are quick to adapt to the hospitalist setting, learning the skills required to be an effective hospitalist through on-the-job training. "On-the-job training for physician hospitalists can focus on education, quality improvement, safety some of the value-added pieces," Dr. Pistoria points out.

Without a doubt, ACGME's new cap on residency caseloads will impact hospital medicine, both at the national level and the individual group level. HMG efforts to recruit, schedule, train and pay hospitalists will be affected, as will the level of experience patients receive from recent residency graduates.

"It is incumbent on us to get involved in committees and process and performance improvement projects," Dr. Pistoria says, "so that when leadership approaches administrators regarding residency caseload cutbacks, we can make a strong case for recruiting more hospitalists."

**Sidebar: Practical Approaches**

The new ACGME rules do not piggyback with federal funding to bridge the estimated 20% loss of resident productivity. Here are some ideas HMG directors should consider as they begin addressing the new patient caseload restrictions:

- Adjust scheduling model;
- Hire or expand hiring of mid-level providers;
- Add more hospitalists to nonteaching services;
- Admit patients to non-teaching services in an academic institution; hire hospitalists on the non-teaching service to take up the slack; add residents if possible; and
- Transfer patients to a non-teaching service in another hospital, including a community hospital.

**Sidebar: Under the Miocroscope**

Rules regarding capping residents' patient caseload on internal medicine inpatient rotations (rule changes in italics):

- A first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services;
- A first-year resident must not be assigned more than eight new patients in a 48-hour period;
- A first-year resident's census must be no more than 10 patients;
- When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period;
- When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients; and,
- When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients. Source: American Council on Graduate Medical Education
Source: American Council on Graduate Medical Education

**Andrea M. Sattinger** is a medical writer based in North Carolina and a frequent contributor to *The Hospitalist*. 