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Case Mix in Ambulatory Educational Settings

THREE FACTORS have propelled the growing emphasis on ambulatory care in American teaching hospitals: 1) the idealistic notion that physicians ought to acquire the competencies necessary to provide continuity care[1, 2]; 2) a realistic recognition that the "action," in terms of diagnostics and even much of therapeutics, has been displaced from the inpatient setting[3, 4]; and 3) a pragmatic judgment that ambulatory practice is an increasingly important source of revenue for the faculty.[5, 6]

While many have talked of the importance of providing trainees with an opportunity to take care of outpatients, little has been said about precisely whom these patients should be. What proportion should be hospital follow-ups, worried well, or new patients with significant medical illnesses? How many should be indigent, poor but insured, middle class or above? Should trainee practices be indistinguishable from those of the faculty, or are there undeserved populations for whom residents are the only possible source of care? The medical literature only occasionally addresses these matters explicitly.[7]

It is therefore refreshing that Flegel and his colleagues report in this issue on the characteristics of patients seeing attending physicians and residents at Montreal's Royal Victoria Hospital.[8] The authors examined a random sample of new patients over six years and found only minor differences in rates of prior hospitalizations or emergency room visits, and in ethnicity, between patients seen by housestaff and those seen by attending physicians. Strikingly, there were no significant differences in income between patients seen by the two groups of providers. The authors conclude, correctly, that "an outpatient experience can be provided for residents that closely resembles qualitatively the practice of their mentors."

This study supports the potential for a universal health insurance program to promote equity. The introduction of the Quebec program increased the likelihood that low-income people would seek medical care when they had a significant complaint, but it did not eliminate completely disparities in access to care.[9] One thing it did do was to eliminate disincentives to take care of the poor. Everyone has identical health insurance coverage. There is no possibility of billing the patient for any more or less than the system reimburses. Thus, it is not particularly surprising to learn that attending physicians, whose incomes depend to some extent at least on clinical revenues, and residents, who are salaried, take care of similar patients, because there is no economic reason for them to do otherwise.

In the United States, the incentives are quite different, and it would be of considerable interest to acquire similar information about the patient populations served. Faculty in American schools are even more dependent on "soft money."[5, 6] The time they spend seeing patients can be lucrative, if the patients have private insurance. The faculty will earn far less if they take on large numbers of Medicaid patients; if they care for the 12% of the population with no health insurance, they earn nothing.

Compounding this is the traditional and unfortunate division of American hospitals into the "charity" institutions for the poor and those for the more fortunate. In academic departments, few of the faculty see patients at the "charity" hospitals, except in a supervisory capacity. There are exceptions, of course, but in the large public hospitals, the continuity care that is available, if any, is largely provided by trainees. This trend is exacerbated in some centers by the presence of a university hospital next door to the hospital for the indigent. The faculty's differential devotions to these two patient populations are quite evident to their trainees.

In the voluntary hospitals, the faculty are not free of the Medicaid population, but may not go out of their way to cultivate them. On the other hand, in at least one hospital with which I am familiar, the housestaff actively seek Medicaid patients because they are not obliged to present them to the attending physician at every visit. The added pressures of faculty health maintenance organization practices, which cater to middle-income insurees, and of the

inevitable referrals of well-to-do patients to university faculty, make it less likely that they will care for the poor.

Yet, the faculty are providing expanded ambulatory experiences, presumably because they wish to impress on the trainees the importance of establishing enduring bonds with their patients.[10] How successful are they? Again, we do not know, but housestaff commonly complain about the kinds of patients they see in clinic—those with complex, multisystem illnesses requiring far more attention than they can devote to them, given their overcommitted schedules; those somatisizers who are not amenable to physiologic interpretations of their complaints; or patients who have rejected, or been rejected by, innumerable prior physicians. The feeling that one might not want to spend one's life relating to patients may come from a distorted view of what a more representative mix of patients can be like. From an educational point of view, it is not inevitable that unselected patients who show up in the residents' clinics will provide an adequate substrate for achieving explicit educational goals.[11]

The faculty clearly would benefit from equitable distribution of patients as well. While bifurcation of referral patterns may enhance their incomes and exempt them from unpleasant involvement with some rather difficult patients, it also denies them the opportunity to serve in a more direct way the poor, whose care traditionally has been part of their mission. Such patient assignment also can overwhelm their practices with large numbers of worried well, who challenge some, but by no means all, of their clinical skills.

Research on the relative characteristics of faculty and housestaff patients in U.S. medical schools would clearly be valuable if it addressed the following concerns: How do patients with different characteristics get assigned within the system? What are the relative likelihoods of faculty and housestaff receiving patients via hospital discharge or emergency department referral, patients from out of town, and patients "dumped" by other practitioners within the institution or elsewhere? What are their respective roles in the care of patients who are indigent, on Medicaid, or in health maintenance organizations? Who gets the patients with chronic pain, alcoholism, human immunodeficiency virus infection, and primary psychiatric diagnoses, those with histories of noncompliance, and those with multisystem diseases?

The ways in which triage occurs for the poor and other populations that some judge less desirable are of critical importance. Educational institutions should decide prospectively what mix of these and other patients they would like their trainees to care for, and they should encourage their faculty to model the same kinds of practices. They can do no less if they harbor any hope of encouraging trainees to regard the ongoing care of such patients as something worth doing over time. — *Martin F. Shapiro, MD, PhD, Division of General Internal Medicine and Health Services Research, University of California, Los Angeles, CA 90024*

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