

# One solution to providing clinical coverage for pediatric inpatients

Richard B. Goldbloom

‡ See related article page 298

In this issue Jeremy Friedman and Ronald Laxer, of Toronto's Hospital for Sick Children, describe an innovative solution to the problem of providing 24-hour coverage for pediatric inpatients in an academic health care centre.<sup>1</sup> They recapitulate the well-known origins of the current difficulties: increased acuity of illness, reduced resident numbers, mandated infrequency of nights on call. They note that many hospitals have tried to solve this problem, with varying success, through the appointment of clinical assistants, or "hospitalists" as they are coming to be known, especially in the United States.

Clearly, this program has been successful in many respects at the Hospital for Sick Children, a world-class institution that has progressed in many activities beyond tertiary care to what is starting to be termed quaternary care. (The dividing line between tertiary and quaternary is still fuzzy, and one cannot help wondering what higher numbers lie beyond the quaternary horizon — possibly a robotic era that will render both hospitalists and clinical departmental fellows obsolete.) But until that dehumanized era arrives, many hospitals, academic and otherwise, are faced with the real-time problem of putting in place enough competent health care providers, of which doctors are only one group, to offer high-quality round-the-clock care.

On its own merits, the success of the Hospital for Sick Children's program is laudable. A key question, however, is the extent to which their solution may be generalizable to other Canadian academic centres. There is certainly a strong case to be made for a contractual agreement whereby fellows in clinical specialties, and possibly some with research responsibilities, would be required to assume some measure of responsibility for delivery of clinical care as part of their terms of fellowship and as a mandatory *quid pro quo* for receiving their specialized training. Program directors should not have to go cap in hand to postgraduate trainees or to certifying bodies for approval on this issue.

In the final analysis, the provision of highly competent clinical coverage in Canadian academic health care centres (or nonacademic ones, for that matter) will not be achieved by a "one-size-fits-all" solution. Solutions must be tailored to fit individual institutional needs and may include various "aliquots" of hospitalists, nurse practitioners and community clinicians.

Regarding this last suggestion, there may be real merit in developing long-term affiliations between newly minted, academically appointed community clinicians and mutually attractive hospital-based subspecialty divisions. In the course of their postgraduate training, many future generalist practitioners identify subspecialties that have a special appeal for

them and for which they have special aptitude. For hospitals to capitalize on such mutual attractions, formal affiliations between generalist clinicians and hospital-based subspecialty divisions would need to be established while the generalist was still in postgraduate training, and the affiliation would need to be carefully nurtured thereafter. This approach could serve several valuable purposes simultaneously. For each generalist, it would establish a distinct area of continuing interest and increasing expertise. For the hospital's subspecialty service, it would improve patient care coverage and thereby offer a form of clinical "hamburger extender" for subspecialties. Patients and subspecialists could benefit as well from the presence of physicians who would offer a more comprehensive approach to patient problems.

For each and all of these potential remedies, there are 2 underlying concerns: the availability of funds to remunerate whoever provides the additional coverage, and the potential negative effect on the continuity of care. Remember the parlour game in which one person whispers a joke to a second person, who in turn whispers it to a third, then to a fourth, who is finally asked to repeat the story aloud? Typically, the original is barely recognizable in the fourth-hand retold version. There is a real possibility that important patient-care-related information may be similarly distorted as the number of caregivers in the therapeutic relay increases. Also, families could become even more confused than they sometimes are now about who is actually responsible for their loved one's care. But putting such caveats aside for the moment, the program reported by Friedman and Laxer has clearly served the Hospital for Sick Children well. Other academic centres would be well advised to take heed and determine whether this approach, with appropriate local variations, may represent one small step toward alleviating the growing problem of clinical coverage for their inpatients.

*Dr. Goldbloom is with the IWK Grace Health Centre, Halifax, NS.*

Competing interests: None declared.

## Reference

1. Friedman J, Laxer RM. Providing after-hours on-call clinical coverage in academic health sciences centres: the Hospital for Sick Children experience. *CMAJ* 2000;163(3):298-9.

**Correspondence to:** Dr. Richard B. Goldbloom, IWK Grace Health Centre, 5850 University Ave., PO Box 3070, Halifax NS B3J 3G9; fax 902 428-3216; [rgoldbloom@iwkgrace.ns.ca](mailto:rgoldbloom@iwkgrace.ns.ca)