

All Hands on Deck: Learning to “Un-specialize” in the COVID-19 Pandemic

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Specialization, as detailed in Adam Smith’s 1776 landmark treatise, *Wealth of Nations*,¹ has been an enduring trend in labor and economics for centuries. Mirroring evolution in other sectors of the economy, the healthcare workforce has become ever more specialized.² General practitioners and family doctors have ceded ground to a bevy of specialists and subspecialists ranging from pediatric endocrinologists to otolaryngology-neurotologists. Given the growth in medical knowledge over the past century, this specialization seems both necessary and good. This same specialization that serves us in good times, though, leaves us woefully underprepared for an epidemic that will require large numbers of hospitalists/generalists and intensivists, such as the current coronavirus disease 2019 (COVID-19) pandemic.

A bit on terminology before we proceed. For purposes of this paper we define generalists as physicians trained in Internal Medicine, Family Medicine, Pediatrics, or Med/Peds who provide primary hospital care to adults and children. While some may argue that hospitalists are specialists in inpatient care, we would like to focus on hospitalists as generalists who focus on inpatient care and what we have in common with the broader community of generalists. We include as generalists anyone, irrespective of clinical training, who chooses broad primary patient responsibility over the narrower consultative role. There is always a specialist in our midst who knows more about a particular disease or condition; as generalists, most of us appreciate and welcome that expertise.

Sometimes it takes a pandemic like COVID-19 to highlight a tremendous blind spot in our healthcare system that, in retrospect, seems hard to have missed. What do we do when we need more generalists and have only a surplus of specialists, many of whom were involuntarily “furloughed” by canceled elective procedures and postponed clinics? How do we “un-specialize” our specialist workforce?

We will discuss some of the most pressing problems facing hospitals working to ensure adequate staffing for general inpatient units caused by the simultaneous reductions in physician availability (because of illness and/or quarantine) and marked-

ly increased admissions of undifferentiated COVID-19–related illnesses. We will assume that hospitals have already activated all providers practicing in areas most similar to hospital medicine, including generalists who have mixed inpatient/outpatient practices, subspecialists with significant inpatient clinical roles, fellows, and advanced practice providers (APPs) with inpatient experience. The Accreditation Council for Graduate Medical Education released guidance around the roles of physician trainees during the pandemic.³ Despite these measures, though, further workforce augmentation will be vital. To that end, several challenges to clinical staffing are enumerated below, accompanied by strategies to address them.

CLINICAL STAFFING CHALLENGES

1. Clinicians eager to help, but out of practice in the inpatient setting: As hospitals across the country work to develop physician staffing contingency plans for scenarios in which general inpatient volumes increase by 50%-300% while 33%-50% of hospitalists either become infected or require quarantine, many hospitals are looking to bolster their physician depth. We have been extremely gratified by the tremendous response from the broader physician communities in which we work. We have encountered retired physicians who have volunteered to come back to work despite being at higher risk of severe COVID-19 complications and physician-scientists offering to step back into clinical roles. We have found outstanding subspecialists asking to work under the tutelage of experienced hospitalists; these specialists recognize how, despite years of clinical experience, they would need significant supervision to function in the inpatient setting. The humility and self-awareness of these volunteers has been phenomenal.

Retraining researchers, subspecialists, and retirees as hospitalists requires purposeful onboarding to target key educational goals. This onboarding should stress COVID-19–specific medical management, training in infection prevention and control, and hospital-specific workflow processes (eg, shift length, sign-over). Onboarding must also include access and orientation to electronic health records, training around inpatient documentation requirements, and billing practices. Non-COVID-19 healthcare will continue; hospitals and clinical leaders will need to determine whether certain specialists should focus on COVID-19 care alone and leave others to continue with specialty practice still needed. Ready access to hospital medicine and medical subspecialty consultation will be pivotal in supervising providers asked to step into hospitalist roles.

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The onboarding process we describe might best be viewed through the lens of focused professional practice evaluation (FPPE). Required by the Joint Commission, FPPE is a process for the medical staff of a facility to evaluate privilege-specific competence by clinicians and is used for any new clinical privileges and when there may be question as to a current practitioner's capabilities. The usual FPPE process includes reassessment of provider practice, typically at 3 to 6 months. Doing so may be challenging given overall workforce stress and the timing of clinical demand—eg, time for medical record review will be limited. Consideration of a “preceptorship” with an experienced hospitalist providing verbal oversight for providers with emergency privileges may be very appropriate. Indeed the Joint Commission recently published guidance around FPPE during the COVID-19 epidemic with the suggestion that mentorship and direct observation are reasonable ways to ensure quality.⁴

Concerns around scope of practice and medicolegal liability must be rapidly addressed by professional practice organizations, state medical boards, and medical malpractice insurers to protect frontline providers, nurses, and pharmacists. In particular, Joint Commission FPPE process requirements may need to be relaxed to respond to a surge in clinical demand. Contingency and crisis standards of care permit doing so. We welcome the introduction of processes to expedite provider licensure in many hard-hit states.

2. Clinicians who should not help because of medical comorbidities or age: Individuals with certain significant comorbidities (eg, inflammatory conditions treated with immunosuppressants, pulmonary disease, cancer with active treatment) or meeting certain age criteria should be discouraged from clinical work because the dangers of illness for them and of transmission of illness are high. Judgment and a version of mutual informed consent will be needed to address fewer clear scenarios, such as whether a 35-year-old physician who requires a steroid inhaler for asthma or a 64-year-old physician who is otherwise healthy have higher risk. It is our opinion that all physicians should contribute to the care of patients with documented or suspected COVID-19 unless they meet institutionally defined exclusion criteria. We should recognize that physicians who are unable to provide direct care to patients with COVID-19 infection may have significant remorse and feelings that they are letting down their colleagues and the oath they have taken. As the COVID-19 pandemic continues, we are quickly learning that physicians who have contraindications to providing care to patients with active COVID-19 infection can still contribute in numerous mission-critical ways. This may include virtual (telehealth) visits, preceptorship via telehealth of providers completing FPPE in hospital medicine practice, postdischarge follow-up of patients who are no longer infectious, and other care-coordination activities, such as triaging direct admission calls.

3. Clinicians who should be able to help but are fearful: All efforts must be undertaken to protect healthcare workers from acquiring COVID-19. Nevertheless, there are models predicting that ultimately the vast majority of the world's population will be exposed, including healthcare workers.^{5,6} In our personal experience as hospitalists and leaders, the vast ma-

majority (95%-plus) of our hospitalists have not only continued to do their job but taken on additional responsibilities and clinical work despite the risk. We are hesitant to co-opt words like courage and bravery that we typically would reserve for people in far more hazardous lines of work than physicians, but in the current setting perhaps courage is the correct term. In quiet conversation, many are vaguely unnerved and some significantly so, but they set their angst aside and get to work. The same can be said for the numerous subspecialists, surgeons, nurses, and others who have volunteered to help.

Alternatively, as leaders, we must manage an extremely small minority of faculty who request to not care for patients with COVID-19 despite no clear contraindication. These situations are nuanced and fraught with difficulty for leaders. As physicians we have moral and ethical obligations to society.⁷ We also have contractual obligations to our employers. Finally, we have a professional duty to our colleagues. When such cases arise, as leaders we should try to understand the perspective of the physician making the request. It is also important to remember that as leaders we are obliged to be fair and equitable to all faculty; granting exceptions to some who ask to avoid COVID-19-related work, but not to others, is difficult to justify. Moreover, granting exceptions can undermine faith in leadership and inevitably sow discord. We suggest setting clear mutual expectations of engagement and not granting unwarranted exceptions.

CONCLUSION

In this time of a global pandemic, we face a looming shortage of hospital generalists, which calls for immediate and purposeful workforce expansion facilitated by learning to “un-specialize” certain providers. We propose utilizing the framework of FPPE to educate and support those joining hospital medicine teams. Hospitalists are innovators and health systems science leaders. Let's draw on that strength now to rise to the challenge of COVID-19.

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