Are inpatients' needs better served by hospitalists than by their family doctors?

NO

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Canadian health care is a 3-way partnership, with the needs and interests of patients, providers, and payors (and their agents, those charged with administering the system) inevitably in constant states of tension. Representatives of all 3 might strive to spin that tension in positive directions, but the competitive imperatives challenging each are undeniable. They all see themselves in desperate circumstances—patients and their loved ones, in search of adequate care; providers, crushed by time constraints and rising overheads; and the government and other sources of remuneration, blamed for deteriorating service quality, seemingly in spite of ever increasing expenditures.

Under pressure

The rapid shift to inpatient primary care by directly employed hospital-based physicians was a logical response to the growing pressures on family physicians and hospitals.[1] Attempting to make a virtue out of necessity, as is natural in human affairs, much was made of putative benefits for patients. But the increasingly beleaguered, diminishing ranks of overstretched community family doctors were closing their practices and having difficulty squeezing hospital rounds into their ever expanding workdays. Many felt they had no choice but to relinquish their hospital privileges, leaving hospitals to contend with growing numbers of unattached patients. Meanwhile, with the aging population, the levels of frailty and complexity of patients continued to rise. And specialist practice became ever more, well, specialized.

The stars aligned to favour the rapid adoption of a one-dimensional solution. Hospitals quickly hired in-house doctors because they had to. They dressed it up in the bureaucratic language of "program development," but the reality was more simple. Relieved of what they regarded as an unsustainable burden, most community family physicians quietly welcomed being excused from this aspect of the job.[2] Specialists and nurses were pleased to have in-house family physicians to tend to day-to-day general medical concerns. Tensions on the system and those working in it were momentarily reduced. An illusion of having remedied a fundamental problem took root.

Under the surface

Unintended negative consequences for patients, the most important members of the health care triad and the subject of this debate, were inevitable. In exchange for modest improvements in the quality of their inpatient experience (although, arguably, no positive change in morbidity and mortality outcomes that matter—the truth is, the literature remains limited and far from conclusive on that score[3]), patients endured further deterioration of the primary care system as a whole.

As the proponents of hospitalist programs point out, these are very attractive jobs for weary GPs, offering specified hours of work, no overhead, and flexibility.[1] And, although newly qualified family doctors are highly (and demonstrably) competent in the care of inpatients, hospitals are in a position to hire the best-of-the-best—the most competent, experienced, and efficient. As a result, a program intended to reduce reliance on inpatient care through more proactive discharge planning ends up stripping the community of its most effective and productive practitioners,[4] with upwards of 2000 newly orphaned patients per physician hired.

The loss of hospital-involved role models led to more family physician resignations and an end to new primary care recruits. With community family physicians no longer exposed to the hospital milieu, a powerful source of continuing professional development was also lost. Lack of hospital privileges has long been identified as a predictor of poor performance in practice peer-review programs.[5]

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The parties in this debate will refute each other's arguments in rebuttals to be published in an upcoming issue.

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Hospitalist advocates argue that increasing patient complexity renders the traditional model of a single daily visit and additional availability by telephone by a family physician inadequate. Complexity is a multifaceted attribute, referring, among other things, to specialized care (managed by specialists), high medical acuity (comanaged by specialists and primary care), and the growing effects of chronic conditions that bring with them a challenging blend of medical and personal care needs. Just a few decades ago, emergency rooms and wards were primarily populated with single-illness sufferers: acute upper gastrointestinal bleeds, premature coronary artery disease, poorly controlled asthma, infections, and newly diagnosed diabetes, to name a few. The dramatic prevalence shift to multiple comorbid conditions and much older patients has been well documented.[6] Fifty percent of Canadians older than 65 years of age have 5 or more chronic ailments. After the age of 85, the prevalence of cognitive impairment approaches 50%. The typical Canadian endures 1 to 3 years of dependency before dying.

Hospitalized patients and their families now routinely face difficult treatment choices. A physician's familiarity with the values and priorities of the individual and a level of rapport and trust with patients and their families alike have never been more important.[7] Anyone who has sat at the bedside of a frail family member knows the tendency to default to higher, too-often-unwelcome levels of intervention when relying on the care of strangers. The College of Family Physicians of Canada has long listed the centrality of the doctor-patient relationship as one the principles of family medicine.[8] How can we justify abandoning that relationship in such circumstances?

I have enormous sympathy for the hospital administrators who saw in-hospital primary care physicians as a tidy solution to the pressing and complex challenge of reforming and rebuilding the primary medical care sector and for the excellent doctors they hired. But the initiative is at best an interim stopgap for a much bigger project. It has, unfortunately, become one of many contributors to a dramatic increase in the fragmentation of care, a trend that is detrimental to patients.

To argue that the needs of inpatients are best served by hospitalists is to take a very narrow and shortsighted view of those needs.

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Competing interests

None declared

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CLOSING ARGUMENTS

- Recruiting hospitalists to provide inpatient care was a hastily conceived, one-dimensional response to complex systemic problems in primary care.
- The family physician–patient relationship of trust and understanding is an important resource for high-quality inpatient care that merits preserving.
- The evolution of hospitalist programs, largely in isolation, has become yet another contributor to the decline of community practice.
- Patients will be best served by hospitals and community practitioners collaborating to bring family doctors back to the inpatient team.