Editorials

Some Thoughts About Patient Ownership

C. Richard Conti, MD, MACC
Emeritus Professor of Medicine and Cardiology University of Florida College of Medicine

Address for correspondence:
C. Richard Conti,
conticr@medicine.ufl.edu

According to Oxford Dictionaries Online, the definition of ownership is "the act, state, or right of possessing something." I happen to like this word, because it relates to what I consider the appropriate strategy for teaching and for the management of hospitalized patients with any illness.

A few months ago, I was talking to a cardiovascular fellow regarding the care of patients admitted to the hospital in a setting in which medical housestaff are being trained in 2015. Our discussion made me reflect on my own housestaff training at Johns Hopkins many years ago. However, it seemed to me that we had a different attitude about patient care and continuity of care than that which is currently the standard way of training medical housestaff to manage in 2015.

During my training, it was quite clear to all of us that tradition dictated that we had primary responsibility for the patients admitted to our ward service. This came from the top (ie, chair of medicine), not from some organization that had very little to do, if anything, with patient care. In those early days, medicine housestaff were assigned to a patient, and that patient became his or her responsibility 24 hours a day, 7 days a week. Of course, we could sign out to our fellow housestaff, but we let it be known that if major problems arose with the patient assigned to us that we be called by our housestaff mate.

This concept of ownership of the patient was so ingrained in us at Hopkins that it carried over to later times when we functioned as fellows in training for cardiovascular medicine or as young cardiovascular faculty. In my case, it is carried over through all of my life, and I still feel that if a patient is assigned to me with cardiovascular disease, I am responsible for that patient's management and eventual disposition.

Consultation

If I ask for a consultation by another physician, I am not asking for that consulting physician to manage my patient; I am asking for that person to advise me about management from their perspective. Thus, a consulting physician is a consultant to me, not to my patient. I, then, have the responsibility to transmit to the patient what I have been advised by the consulting physician as to what to do with the patient. This approach does not seem to be the case with many housestaff in medical training or in some physicians who function as hospitalists.

Hospitalists often want consultants to write orders and take over the management of their patients. In my view, this presents a conflicting and confusing picture to the patients. I have always agreed with Dr. Eugene Stead who said that "what this patient needs is *a* doctor." The patient does not need several physicians taking care of them at the same time. To prevent confusing the patient and the patient's family, only 1 person needs to be in charge of decision making. I am not implying that I know everything there is to know about all aspects of medicine. I use consultants who are not in my field to advise me about how to manage patients, and I even ask for consultation by those who are in my field (eg, surgical, interventional cardiology, heart failure, electrophysiology, and imaging consultants) to help me make decisions for my patients.

Problems With Patient Ownership in 2015

I try to send this message to the housestaff with whom I work on a daily basis. I do this by making sure they review all of the data that have accumulated on a given patient, including images. Of course, I have some problems, because on many occasions the housestaff are not available to discuss the patient, because it is their day off in the middle of the week or they have to go to a clinic, which in my view is a waste of time during their inpatient training time, or they did not perform the workup on the patient initially, but instead took over the care of the patient who was worked up by other physicians in the middle of the night.

It is my hope that when physicians in training for internal medicine go home, they read about their patients or about diseases in general; but, to be honest, I do not think that is the case in every instance. The current mentality is for housestaff to leave the hospital and not really worry about anything that is going on with their patients. In fact, they are encouraged not to inquire about their patients during their time off. Although I agree that housestaff are bright people, and I enjoy working with them, I am somewhat disappointed in the current way that we are training doctors.

Conclusion

Based on my experience over the years, I am predicting that in the not-to-distant future, patients will not have one doctor, but a cadre of physicians and/or other practitioners who manage them by consensus opinion. I personally believe that this will be a rather sad day for medical education and for our patients.

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