Hospital care by family physicians

Exodus or opportunity?

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What is the role of family physicians in hospitals? How has it changed? What are the implications for the future? It is perhaps easier to answer these questions in the context of rural or smaller communities where family physicians have traditionally admitted and managed acute care patients in local hospitals and where they might be the only physicians available to provide these essential services.

What about larger urban settings where hospitals are predominantly staffed by specialists and where many family practice residents are trained? Two studies in this issue of *Canadian Family Physician* examine important aspects of urban inpatient care and teaching by family physicians.

The survey by Paterson and colleagues (page 971) demonstrates how involvement of urban community-based family physicians in tertiary care teaching hospitals has declined over the last two decades. This finding echoes downward trends reported in other Canadian studies. What is unique about this study is the documented shift in physicians' attitudes toward hospital care over the 20 years between surveys. The authors found that family doctors holding hospital privileges assumed less responsibility for their inpatients, spent fewer hours per week in hospital, and were less likely to believe in the overall relevance and effect of their work and presence in hospital. The authors also report an alarming decline in the proportion of physicians involved in hospital-based teaching activities, from 46.6% in 1977 to 6.1% in 1997. These findings provoke some questions: who will ultimately provide service and teaching? How can we prepare future family physicians to provide comprehensive care?

Pimlott and colleagues (page 983) evaluate the effect of a family practice inpatient teaching service on practice patterns after graduation by tracking and comparing graduates of family practice residency programs in urban settings. This study, to our knowledge the first of its kind published in Canada, demonstrates that trainees exposed to inpatient care and taught by community-based family physicians in a teaching hospital were more likely to be involved after graduation with inpatient care as "most responsible physician." While other factors in residency training besides hospital teaching service and style could influence subsequent inpatient practice patterns, this study shows the need to assess the effect and outcomes of training programs designed to prepare family doctors for inpatient care and to evaluate the benefits of a strong family practice presence in teaching hospitals.

If positive role modeling by family physicians builds confidence and inpatient management skills in family practice residents, and if family physicians are to continue to provide comprehensive primary care, efforts must be made to recruit excellent family doctor teachers and to organize family practice teaching services of the type described by Pimlott and colleagues in major teaching hospitals. After 7 years of experience in an urban teaching hospital where family physicians from the community admit and manage their patients on an inpatient teaching ward with first-year family practice residents, we are optimistic about the positive effect such a service has, not only for resident trainees, but on the quality and continuity of care for patients and their families, and on support for community-based urban practitioners who seek to maintain inpatient activities and skills.

Benefits of staying involved

Why should community-based family doctors stay involved in hospital activities? Berkowski[1] said, "The GP's usefulness and power lies in his or her relationship with the patient. This relationship should be medically comprehensive and ongoing." Our faith in the value of continuity of care in

both the hospital and the community by the patient's own family physician is bolstered by evidence of the benefits of continuity in other settings.[2,3] These include better patient and provider relationships and greater satisfaction, reduced resource use, and improved adherence to medical recommendations. There is also good evidence of cost benefits to hospitals when family physicians in practice and training are involved with care.

Bertakis and Robbins[4] found that, in academic tertiary care hospitals, family physicians provide lower-cost care and greater continuity than do general internists for patients randomly assigned to their care in outpatient clinics. The differences in expenses were largely attributed to consultation patterns. Tallia et al[5] demonstrated that the presence of graduate family practice training programs did not add to and, in some community hospitals, reduced the costs of inpatient care for patients with an equivalent case mix compared with other teaching and non-teaching services. Others have not found substantial differences in resource use between specialties but warn that comparisons of utilization without accounting for patient complexity are not useful.[6] We need to gather comparative data not just on costs, but on pertinent health outcomes of care[7] for patients matched for clinical and psychosocial complexity in order to assess whether involvement of the patient's own family doctor in their care in hospital improves outcomes and what components of that care afford additional health benefits over other models of inpatient care.

What influences doctors to stay involved?

Professional and personal factors influence how family physicians respond to the challenges of hospital involvement. Family physicians might be put off by disincentives, such as "family doctor of the day" duty within a hospital family practice department, especially if poorly remunerated. As more physicians relinquish their admitting privileges, the remaining departmental members might find themselves admitting and caring for more "orphan" patients who do not have family physicians or whose family physicians do not have hospital privileges.

On one hand, being asked to care for these patients reflects well on a profession used to addressing complex mixes of social and medical issues and focusing on the unique needs of patients. On the other hand, the financial and logistical burdens of providing such coverage for emergency admissions can be overwhelming and has contributed to the exodus of urban family physicians from some hospitals that require such duties. Additionally, family physicians are facing an income crunch, and in many provinces, remuneration for inpatient care has not kept pace with that of office practice. Low fees, travel time, and parking costs add to the disincentives. At the same time, demands in the office are increasing as inpatient care is harder to access, and sicker patients are being managed as outpatients.

Family physicians are also becoming more focused on lifestyle issues, often as a result of burnout and "compassion fatigue." Men and women in medicine might choose to be more involved with their families and to seek a healthier balance in their lives. Community-based family doctors who see higher numbers of patients in their offices and who have greater family or personal responsibilities have lower levels of hospital activity.[8] If we wish to encourage inpatient care by future family physicians, we must develop models that promote effective care without damaging personal and professional resilience.

Advocates for their patients

What helps some family physicians retain their admitting privileges while others are resigning? When asked this question informally at business meetings, members of the Family and Community Medicine Department at St Paul's Hospital in Vancouver, BC, said that advocating for their patients, feeling treated with respect by family practice and specialist colleagues, access to beds on a dedicated family practice inpatient ward, the opportunity to teach family practice residents about inpatient care, on-call support by residents, and relief from the burden of "doctor of the day" duty in hospitals were factors in their decision to remain active in hospital care. As Paterson et al (page 971) report, family doctors believe strongly that they should act as advocates for their patients in the hospital system and that patients want them to remain involved.

We should explore factors that influence family physicians' involvement in hospitals and develop strategies to make it more attractive for them to remain involved. Strategies might include providing inpatient care more systematically as groups and retaining a community base but participating in hospital care in rotation as do many family practice maternity services. Several of our departmental members at St Paul's Hospital have organized their office practices to provide this

type of inpatient coverage, which has been well received by patients, trainees, and hospital staff, and has improved physician satisfaction.

Other considerations are remuneration to cover the time or costs lost in the office when providing hospital care; cooperation between hospital services to admit and manage unassigned emergency patients; and flexible privileging systems[9] to allow physicians to attend patients in the hospitals most appropriate for the unique characteristics of both patients and practices.

We strongly advocate identifying and removing barriers to care for hospitalized patients by their own family physicians and encouraging these physicians to act as role models and teachers for future family doctors. At the same time, we must collect and examine evidence of the specific health and educational benefits of this model of continuous care. Embracing these opportunities might help to prevent a further exodus of Canadian family physicians from hospital care. If we move toward small groups of hospital-based family doctors exclusively practising inpatient medicine that is separated, if not divorced, from a community base, we will lose the benefits of long-standing patient-doctor relationships that cross the hospital-community interface.

We are reluctant to endorse a "hospitalist" model of care over a "community-based continuity" model without compelling evidence of improved outcomes for patients and the health care system, and yet we find surprisingly little comparative data to sway us.[10] Until these data are available, we, like McConaghy[11] will continue to provide, promote, and teach hospital care by community-based family doctors "based on a passion for the holistic traditions of family medicine."

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References

1. Berkowski G. The case of Gretel: why general practitioners must be part of the public hospital system. *Aust Fam Physician* 1996;25(11):1713-4.
2. Weyrauch KF. Does continuity of care increase HMO patients' satisfaction with physician performance? *J Am Board Fam Pract* 1996;9:31-6.
3. Deitrich AJ, Marton KI. Does continuous care from a physician make a difference? *J Fam Pract* 1982;15:929-37.
4. Bertakis KD, Robbins JA. Utilization of hospital services: a comparison of internal medicine and family practice. *J Fam Pract* 1989;26:91-6.
5. Tallia AF, Swee DE, Winter RO, Lichtig LK, Knabe FM, Knauf RA. Family practice graduate medical education and hospitals' patient care costs in New Jersey. *Acad Med* 1994;69(9):747-53.
6. MacDowell NM, Black DM. Inpatient resource use: a comparison of family medicine and internal medicine patients. *J Fam Pract* 1992;34:306-12.
7. Bertakis KD. Cost-effectiveness of care by family physicians. *J Am Board Fam Pract* 1993;6:609-12.
8. Stadler DS, Zyzanski SJ, Stange KC, Langa DM. Family physicians and current inpatient practice. *J Am Board Fam Pract* 1997;10:357-62.
9. Hennen B. Family physician hospital privileges. New approach. *Can Fam Physician* 1995;41:378-81.
10. Saver B, Doescher MP. The rising tide of hospitalism: evidence-based or anecdote-based medicine? *J Fam Pract* 1998;46:465-8.
11. McConaghy JR. The emerging role of hospitalists: will family physicians continue to practice hospital medicine? *J Am Board Fam Pract* 1998;11:324-6.