Role of family physicians in hospitals

Did it change between 1977 and 1997?

J. Michael Paterson, MSC Rossano L. Allega, MD, CCFP Philip E. Shea, MD, CCFP

abstract

OBJECTIVE To investigate whether hospital activities and attitudes toward hospitals of members of an urban family medicine department changed between 1977 and 1997. To explore whether these activities and attitudes are different among fee-for-service (FFS) and non-FFS physicians in 1997.

DESIGN Cross-sectional surveys by interview (1977) and self-administered questionnaire (1997).

SETTING Community-based family practices in Hamilton, Ont.

PARTICIPANTS In 1977, 88 of 89 (98.9%) and, in 1997, 66 of 88 (75.0%) members of the Department of Family Medicine at St Joseph's Hospital in Hamilton.

MAIN OUTCOME MEASURES Perceived reasons for involvement in hospital work; time spent and main activities in hospital; use of hospital privileges; attitudes toward family physicians' role in hospital, hospital work, and the Department of Family Medicine; perceptions of patients', consultants', and hospital administrators' attitudes toward family physicians' role in hospitals.

RESULTS In 1977 and 1997, patient care and continuing education remained key reasons for doing hospital work. In 1997, however, respondents spent a mean of 3 hours less per week in hospital; used the hospital less often for procedures, meetings, and teaching; and assumed less responsibility for their patients' in-hospital care. While perceptions of hospital work changed over the years, most physicians continued to see a need and have a desire to remain involved in hospitals. Fee-for-service and non-FFS physicians held different opinions on the needs of both hospitalized patients and family physicians.

CONCLUSION Although physicians' hospital activities and attitudes changed between 1977 and 1997, most continued to see a need and have a desire to remain involved in hospitals.

résumé

OBJECTIF Examiner si des changements se sont produits entre 1977 et 1997 dans les activités à l'hôpital des membres d'un département de médecine familiale en milieu urbain et dans les attitudes à leur égard. Explorer si ces activités et ces attitudes diffèrent selon qu'il s'agit de médecins rémunérés à l'acte ou non en 1997.

CONCEPTION Des études transversales au moyen d'entrevues (1977) et un questionnaire rempli par l'intéressé (1997).

CONTEXTE Des pratiques familiales basées dans la communauté à Hamilton, en Ontario.

PARTICPANTS En 1977, 88 sur 89 (98,9%) et en 1997, 66 sur 88 (75,0%) des membres du Département de médecine familiale au St Joseph Hospital à Hamilton.

PRINCIPALES MESURES DES RÉSULTATS Les perceptions entourant les motifs de participer au travail à l'hôpital; le temps consacré et les principales activités à l'hôpital; l'utilisation des privilèges hospitaliers; les attitudes à l'endroit du rôle des médecins de famille à l'hôpital, le travail à l'hôpital et le Département de médecine familiale; les perceptions des patients, des consultants et des administrateurs de l'hôpital à l'endroit du rôle des médecins de famille dans les hôpitaux.

RÉSULTATS En 1977 et en 1997, les soins aux patients et la formation médicale continue demeuraient des motifs importants de travailler à l'hôpital. Par ailleurs, en 1997, les répondants passaient en moyenne trois heures de moins par semaine à l'hôpital; utilisaient moins souvent l'hôpital pour des interventions, des réunions ou de l'enseignement; et assumaient moins de responsabilités dans les soins à leurs patients hospitalisés. Même si les perceptions à l'égard du travail à l'hôpital ont changé avec les années, la plupart des médecins continuaient de voir une nécessité et souhaitaient poursuivre leur travail à l'hôpital. Les médecins rémunérés à l'acte ne partageaient pas la même opinion que leurs collègues rémunérés autrement concernant les besoins à la fois des patients hospitalisés et des médecins famille.

CONCLUSION Même si les activités des médecins à l'hôpital et les attitudes ont changé entre 1977 et 1997, la majorité continuent de voir une nécessité de participer aux activités à l'hôpital et souhaitent y demeurer actifs.

This article has been peer reviewed.

Cet article a fait l'objet d'une évaluation externe.

Can Fam Physician 2001;47:971-980.

Health care and, in particular, hospital-based care has undergone tremendous change in Canada over the last two decades. Among other factors, the specialization of acute care hospitals, unprecedented bed closures, and financial disincentives have led to fewer, particularly urban, family doctors providing in-hospital care.[1-4] In a study of London, Ont, family physicians, for example, 83% reported caring for inpatients in 1974 compared with 37% in 1994; the proportion who delivered babies fell by more than 40%.[1] While similar trends have been described in other areas,[5-9] except for obstetrics, surprisingly few studies have documented these trends[1,10,11] or physicians' attitudes toward them.[12,13]

We took advantage of an earlier survey of members of our urban family medicine department[13-16] to determine whether members' hospital activities or attitudes had changed since 1977. Given renewed debate about the organization and funding of primary care in Canada, we also explored whether fee-for-service (FFS) physicians and physicians working in capitation-based health service organizations (HSOs) differed in their activities and attitudes in 1997.

METHODS

Subjects and setting

The surveys were carried out in spring 1977[13-16] and fall 1997 at St Joseph's Hospital in Hamilton, Ont, a tertiary care teaching hospital providing inpatient care to about one third of the regional municipality's 500 000 residents. Study subjects were non-academic senior, active, and associate members of the hospital's Department of Family Medicine numbering 89 in 1977 and 88 in 1997. Members with full-time academic duties were excluded.

While the region's population and number of non-specialist physicians grew marginally between 1977 and 1997, by 1997, the number of acute care beds and bassinets at St Joseph's Hospital had declined by one third. In 1977, the hospital housed a 30-bed family practice ward in which department members served as most-responsible physicians. Most staff held admitting and caring privileges hospitalwide, although in practice their use of specialty units was typically low. In 1975, for example, family doctors provided total care to fewer than 5% of their patients in the critical care unit.[14] By 1997, the family practice ward had closed, and, except for obstetric patients, family physicians' admissions were limited mainly to patients requiring complex continuing care.

During the 20 years, numerous Hamilton-area family doctors also joined Ontario's HSOs and switched from traditional FFS remuneration to a system based on rostering and capitation. By the end of 1997, Hamilton-area HSOs numbered 35, involved about 80 family and general practitioners, and represented 45% of the practices in the HSO program (personal communication from Pegoraro D, HSO Program, Ontario Ministry of Health and Long-term Care, May 2000).

Survey instrument and methods

Details of development and contents of the questionnaire were reported in 1980.[13-16] Briefly, the questionnaire had three main sections. Section 1 requested demographic and practice information.[14] Section 2 asked about hospital privileges, use of privileges, amount of and reasons for time spent at St Joseph's and other area hospitals, and perceived reasons for involvement in hospitals.[15,16] Section 3 asked doctors to "strongly" or "somewhat" agree or disagree with a series of 27 statements reflecting attitudes toward the hospital and its Department of Family Medicine and toward their hospital work.[13] In this article, we compare doctors' responses to 12 of the 27 statements covering six domains: family physicians' role in hospitals and perceptions of the importance of hospital work, of family doctors' contribution to hospital-based care, of patients' expectations of family doctors, of hospital administrators' and consultants' attitudes toward family doctors, and of the role of the hospital's Department of Family Medicine.

Two changes were made to the survey methods before readministering the questionnaire in 1997. First, given the high concentration of HSOs in the Hamilton area, we added a question about method of remuneration. Second, to reduce costs, rather than interview subjects, we conducted the second survey by mail. Three copies of the questionnaire were sent bimonthly, each accompanied by a covering letter signed by the Chief of the department and an addressed, stamped envelope in which to return the completed questionnaire. The research

Mr Paterson *is a Research Officer in the Department of Family Medicine at St Joseph's Hospital in Hamilton, Ont, and is a Research Coordinator at the Institute for Clinical Evaluative Sciences in Toronto, Ont.* **Dr Shea** *is a member and* **Dr Allega** *is Chief of the Department of Family Medicine at St Joseph's Hospital and both are Assistant Clinical Professors in McMaster University's Department of Family Medicine.*

protocol was approved by the St Joseph's Hospital Research Ethics Board.

Data analysis

Because we sought input from all department members rather than a random sample, inferential statistics were used only to compare respondents to a reference sample of Toronto- and Hamilton-area physicians who participated in the College of Family Physicians of Canada's (CFPC) 1997 National Family Physician Survey.[17] For these comparisons, statistical significance was declared at $P < .05$. Univariate descriptive statistics (proportions for categorical data and means and standard deviations [SD] for continuous data) were used to summarize results. Responses to open questions were grouped using categories established for the original survey[13-16] and were reported as frequencies and proportions. Because raw data for the 1977 survey were unavailable, comparisons drew upon a combination of published findings[13-16] and basic demographic data available from hospital records.

RESULTS

Response rate was 75.0% (66/88) in 1977 and 98.9% (88/89) in 1997. Twenty-two physicians participated in both surveys.

Demographic and practice characteristics

Table 1 summarizes respondents' characteristics by year and by method of remuneration for 1997. The table shows a substantial rise in the proportion of older, female, and certified family physicians between 1977 and 1997 and an increase in the proportion of members on staff at other Hamilton-area hospitals in addition to St Joseph's. Relative to all physicians in the surrounding area, those who responded to the 1997 survey were more frequently female, certified, and practising in non-FFS settings.[17] Compared with FFS physicians, proportionally fewer HSO physicians had practised less than 20 years or alone. These findings are consistent with the fact that the HSO program stopped recruiting physicians in 1991 and favoured group practices.

Table 1. Respondents' demographic and practice characteristics

	1977	1997			
CHARACTERISTIC	OVERALL (N=88) N (% OF RESPONDENTS)	OVERALL (N=66*) N (% OF RESPONDENTS)	FFS (N=36) N (% OF RESPONDENTS)	HSO (N=28) N (% OF RESPONDENTS)	OTHER PHYSICIANS† N (% OF RESPONDENTS)
Male sex	81 (92.0)‡	39 (59.1)§	21 (58.3)	17 (60.7)	3793 (71.3)§
Years since graduation					Not asked
• 1-10	28 (33.3)	11 (16.7)	7 (19.4)	4 (14.3)	
• 11-20	22 (26.2)	23 (34.8)	15 (41.7)	8 (28.6)	
• 21-30	22 (26.2)	21 (31.8)	6 (16.7)	14 (50.0)	
• 31-40	9 (10.7)	7 (10.6)	4 (11.1)	2 (7.1)	
• ≥41	3 (3.6)	4 (6.0)	4 (11.1)	0	
College certification	34 (38.6)	51 (77.3)¶	28 (77.8)	22 (78.6)	2546 (47.9)¶
Solo practice	44 (50.0)	28 (42.4)	21 (58.3)	7 (25.0)	2101 (39.5)
Fee-for-service remuneration	Not asked	36 (54.5)¶	–	–	4794 (90.1)¶
Active in hospital					
• St Joseph's	83 (94.3)	59 (89.4)	33 (91.7)	24 (85.7)	Not applicable
• Other	29 (33.0)	59 (89.4)	33 (91.7)	26 (92.9)	

**Two respondents described their practices as neither FFS nor HSO.*
†*Family physicians and general practitioners in Toronto, Hamilton, and surrounding areas (postal codes L and M). Information from The CFPC National Family Physician Survey, College of Family Physicians of Canada.*[17]
‡*Based on hospital staff records for 1977.*
§P < *.05.*
¶P < *.01.*

Perceived reasons for involvement in hospitals

Table 2 shows three shifts in opinion since 1977: a relative decline in the importance of hospitals as sites for continuing medical education (CME), new emphasis on the role of family physicians as patient advocates, and less emphasis on duty or habit as motivators for hospital work.

Table 2. Perceived reasons for family physicians' involvement in hospital*

CATEGORY	1977 N (% OF RESPONSES)	1997 N (% OF RESPONSES)
Patient care Quality of care Necessity of patient care	81 (33.9)	77 (50.0)
Continuing education Upkeep of skills	72 (30.1)	27 (17.5)
Public relations Meet other doctors Contact specialists	27 (11.3)	19 (12.3)
Duty, habit	21 (8.8)	2 (1.3)
Patient advocate	16 (6.7)	25 (16.2)
Remuneration Access to facilities	12 (5.0)	2 (1.3)
Challenge Personal satisfaction Influence future medicine	9 (3.8)	1 (0.6)
Other	0	1 (0.6)

**Three reasons were requested.*

Time spent in hospital

Tables 3 and **4** report distribution and mean number of hours spent in hospital weekly by year and by method of remuneration, respectively, for 1997. Compared with 1977, members reported spending a mean of 3 fewer hours weekly at St Joseph's in 1997, with an average of 1 hour separating physicians in FFS settings from those in HSOs (4.3 vs 3.3 hours weekly, respectively). This difference disappeared when we considered time spent in other area hospitals.

One explanation for the overall drop in time spent at St Joseph's since the first survey is an increase in time spent at other area hospitals; this assumption is reasonable given that a larger proportion of physicians reported being on staff at other hospitals in 1997 (**Table 1**). To explore this possibility we looked to two indirect measures of "outside" use: whether members reported spending any time at another hospital; and information for 1997 about the number of hours doctors spent weekly at all Hamilton-area hospitals combined. These data, also presented in **Table 3**, show two things: although the proportion of respondents on staff at other hospitals increased over the 20-year period (**Table 1**), the proportion reporting spending time at those hospitals actually declined; and, in 1997, subjects reported spending a mean of 5.5 hours weekly in all Hamilton-area hospitals compared with 7.1 hours at St Joseph's alone in 1977. These findings confirm that, while the magnitude of the overall decline in hospital involvement might be less than suggested by data for St Joseph's alone, the trend toward less overall involvement remains.

Table 3. Distribution of hours spent in hospital per week

	1977	1997		
NUMBER OF HOURS IN HOSPITAL PER WEEK	(N = 88) N (% OF RESPONDENTS)	OVERALL (N = 66*) N (% OF RESPONDENTS)	FFS (N = 36) N (% OF RESPONDENTS)	HSO (N = 28) N (% OF RESPONDENTS)
St Joseph's Hospital				
• 0-5	33 (37.5)	52 (78.8)	26 (74.3)	24 (85.7)
• 6-10	43 (48.9)	13 (19.7)	8 (22.9)	4 (14.3)
• >10	12 (13.6)	1 (1.5)	1 (2.9)	0
Other Hamilton-area hospitals†				
• >0	58 (60.2)	35 (53.0)	23 (63.9)	10 (32.1)

**Two respondents described their practices as neither FFS nor HSO.*
†Hamilton Health Sciences Corporation (Henderson, General, McMaster, and Chedoke Sites) in Hamilton, Ont, and Joseph Brant Hospital in Burlington, Ont.

Hospital activities

Table 5 lists the reasons for department members' attendance at hospitals and the mean proportion of time spent in hospital by activity, by year, and by method of remuneration. Findings show that the doctors' perceived and actual reasons for hospital attendance differed in several respects: relatively fewer doctors perceived hospitals to be an important site for CME in the latest survey (**Table 2**), the proportion who used hospitals for CME remained high (88%), and the relative proportion of hospital time spent on CME actually increased (from 16% to 34%, an absolute increase of about 15 minutes weekly). Second, although neither survey showed meetings with specialists or colleagues to be particularly important perceived reasons for hospital attendance, more than 75% of doctors used hospitals for these purposes in 1977. Twenty years later, that proportion had dropped to 33%, with some suggestion that FFS physicians used it more frequently than those in HSOs (perhaps due to the higher prevalence of solo FFS practices). Finally, while neither survey identified teaching as an important reason for hospital attendance, close to half of the department taught in hospitals in 1977. By 1997, that proportion had dropped to 6%.

Table 4. Mean (standard deviation) number of hours spent at St Joseph's Hospital versus all Hamilton-area hospitals combined

	1977	1997		
HOSPITAL SITE	(N = 88) MEAN HOURS (SD) PER WEEK	OVERALL (N = 66) MEAN HOURS (SD) PER WEEK	FFS (N = 36) MEAN HOURS (SD) PER WEEK	HSO (N = 28) MEAN HOURS (SD) PER WEEK
St Joseph's Hospital	7.1 (4.9)	3.9 (2.9)	4.3 (3.4)	3.3 (1.6)
All Hamilton-area hospitals combined[†]	Not available	5.5 (4.8)	5.8 (4.5)	5.2 (5.0)

[†]*Hamilton Health Sciences Corporation (Henderson, General, McMaster, and Chedoke Sites) in Hamilton, Ont, and Joseph Brant Hospital in Burlington, Ont.*

Table 5. Reasons for attendance and mean percentage of time spent in hospital by activity

	1977		1997			
	(N=88)		OVERALL (N=66)*		FFS (N=36)	HSO (N=28)
ACTIVITY	N (%)	MEAN % OF TIME IN HOSPITAL	N (%)	MEAN % OF TIME IN HOSPITAL	N (%)	N (%)
Patient care	87 (98.8)	61.1	59 (89.4)	55.7	32 (88.9)	25 (89.3)
Discussion with specialists	79 (89.8)	10.3	24 (36.4)	16.1	15 (41.7)	8 (28.6)
Continuing education	75 (85.2)	15.9	58 (87.9)	34.4	31 (86.1)	26 (92.9)
Discussion with other family doctors	68 (77.3)	8.2	16 (24.2)	14.7	12 (33.3)	4 (14.3)
Committee meetings	45 (51.1)	6.4	22 (33.3)	18.7	11 (30.6)	10 (35.7)
Teaching	41 (46.6)	7.7	4 (6.1)	13.1	2 (5.6)	1 (3.6)
Committee preparation and administration	20 (22.7)	3.6	8 (12.1)	14.7	3 (8.3)	4 (14.3)
Other activities	20 (22.7)	11.0	4 (6.1)	54.6	4 (11.1)	0

**Two respondents described their practices as neither FFS nor HSO.*

Using and not using hospital privileges

Table 6 shows the proportion of respondents holding and using hospital privileges for certain procedures by year relative to family physicians in the surrounding area. The table highlights two important changes since 1977: proportionally fewer physicians held hospital privileges; and, with the exception of intrapartum care, fewer doctors used their privileges for at least some patients. While some of these procedures are now done in the office (**Table 7**), **Table 6** confirms that, with the exception of obstetrics, department members' practices in 1997 were not unlike those of family physicians in the surrounding area.

Acute care in hospital

Table 8 shows the proportion of respondents who reported providing "total care" to at least 50% of their hospitalized patients in certain departments. Aside from areas where family doctors' role has been traditionally supportive, such as psychiatry or critical care, **Table 8** shows that, relative to 1977, fewer members remained willing or able to assume full responsibility for their patients in hospital.

Respondents' attitudes toward their role in hospital

Table 9 shows respondents' attitudes toward their role in hospital by year and by method of remuneration for

Table 6. Respondents holding and using hospital privileges for certain procedures

	1977		1997		
PROCEDURE	N (% OF RESPONSES) HOLDING PRIVILEGE	N (% HOLDING PRIVILEGE) WHO PERFORM PROCEDURES	N (% OF RESPONSES) HOLDING PRIVILEGE	N (% HOLDING PRIVILEGE) WHO PERFORM PROCEDURES	N (% OF RESPONSES) OTHER AREA FP / GPS* WHO PERFORM PROCEDURES
Minor surgery	88 (100)	79 (89.8)	49 (74.2)	21 (42.9)	2688 (50.5)
Closed fractures (hand, foot, clavicle)	80 (90.9)	71 (88.8)	41 (62.1)	10 (24.4)	1520 (28.6) (casting, splinting)
Lumbar puncture (adult)	73 (83.0)	58 (79.5)	19 (28.8)	4 (21.1)	582 (10.9)
Sigmoidoscopy	59 (67.0)	46 (78.0)	25 (37.9)	5 (20.0)	Not asked
Delivery (uncomplicated)	74 (84.1)	56 (75.7)	16 (24.2)†	16 (100)	661 (11.6)† (Intrapartum care)

**Family physicians and general practitioners in Toronto, Hamilton, and surrounding areas (postal codes L and M). Information from The CFPC National Family Physician Survey, College of Family Physicians of Canada.*[17]
†$P < .05$.

Table 7. Respondents' reasons for not using hospital privileges in 1997: *N = 24. Multiple responses permitted. Comparable data for 1977 not available.*

REASON	N (% OF RESPONSES)
Procedure done in office	10 (27.0)
Lack of time	8 (21.6)
Not enough skill	5 (13.5)
Cost	3 (8.1)
Inconvenience, scheduling challenges, inaccessibility of hospital operating room	3 (8.1)
Little communication with staff, specialists, residents	3 (8.1)
Refer to hospital emergency department	2 (5.4)
Referral required	2 (5.4)
No need	1 (2.7)

Table 8. Respondents providing "total care" to at least 50% of their hospitalized patients in certain departments: *Response categories also included "concurrent" and "supportive" care.*

DEPARTMENT OR UNIT	1977 N (% OF RESPONDENTS)	1997 N (% OF RESPONDENTS)
Outpatient		
• Emergency department	28 (31.8)	2 (3.0)
• Fracture room	22 (25.0)	4 (6.1)
Acute inpatient		
• Pediatrics (routine)	55 (62.5)	5 (7.5)
• General medicine	36 (40.9)	2 (3.0)
• Stroke, rehabilitation	15 (17.0)	1 (1.5)
• Intensive or coronary care	1 (1.1)	1 (1.5)
• Psychiatry	1 (1.1)	2 (3.0)

Table 9. Respondents' attitudes toward their role in hospital

	RESPONDENTS WHO "SOMEWHAT" OR "STRONGLY" AGREED			
	1977	1997		
CATEGORY AND STATEMENT	(N=88) N (%)	OVERALL (N=66*) N (%)	FFS (N=36) N (%)	HSO (N=28) N (%)
State of role in hospital				
• The role of the family physician in hospital has changed.	81 (92.0)	60 (93.8)	32 (91.4)	26 (96.3)
Perceived importance of hospital work				
• Hospital work is a waste of time for family physicians.	16 (18.2)	18 (28.1)	10 (28.6)	7 (25.9)
• Family physicians should withdraw from hospitals and find other ways to meet their professional needs.	7 (8.0)	10 (15.4)	4 (11.1)	5 (18.5)
Perception of contribution to patient care				
• The family physician should function as a patient advocate in the hospital system.	81 (92.0)	61 (95.3)	34 (97.1)	25 (92.6)
• If family physicians do not continue to be involved in the hospital setting, the quality of patient care in the community will decrease.	81 (92.0)	56 (87.5)	32 (91.4)	23 (85.2)
• Patient care suffers if patients are not attended by their own family physicians while in hospital.	82 (93.2)	46 (70.8)	29 (80.6)	15 (55.6)
Perception of patients' expectations				
• Patients expect me to see them in hospital.	88 (100)	59 (90.8)	34 (94.4)	23 (85.2)
Perception of hospital and consultants' attitudes				
• I feel needed by the hospital.	44 (50.6)	10 (15.2)	7 (19.4)	2 (7.4)
• I feel I can have a considerable effect on hospital policy.	32 (36.8)	13 (20.0)	6 (16.7)	6 (22.2)
• Full-time teaching consultants do not understand the role of family physicians in hospital.	73 (83.0)	46 (71.9)	26 (72.2)	19 (73.1)
Perceived role of hospital's Department of Family Medicine				
• A major role to be played by the hospital's Department of Family Medicine should be in the realm of continuing education.	81 (92.0)	55 (84.5)	30 (83.3)	23 (85.2)
• The hospital's Department of Family Medicine offers little of value to practising family physicians.	16 (18.2)	18 (27.7)	13 (36.1)	4 (14.8)

**Two respondents described their practices as neither FFS nor HSO. Variation in total N per question is due to missing data.*

1997. Most members (>70%) continued to both see a need and want to remain involved in hospitals and to believe that the hospital's Department of Family Medicine is useful for physicians, particularly in the area of CME. Patient advocacy was still perceived as a key role for doctors. The perceived relevance of hospital work and the concern that patient care would suffer if physicians did not care for hospitalized patients both declined. Proportionally fewer physicians thought they were needed by or could influence the hospital system.

Differences in the attitudes of physicians in HSO and FFS settings were most apparent in two areas: the belief that patient care suffers if hospitalized patients are not attended by their family doctors; and the belief that the Department of Family Medicine offered little of value. Both views were less prevalent among members of HSOs.

DISCUSSION

Recently, the CFPC's Health Care Policy Committee called for input into its policies on the role of family physicians in hospitals.[2] Given evidence of declining interest in hospital work, Dr Francine Lemire, then President of the CFPC, questioned whether family doctors were feeling welcome in urban hospitals.[2] Since then, similar concerns have been raised by sections of the Ontario College of Family Physicians[4] and the Ontario Medical Association.[18] While we cannot comment on the views of physicians in other hospitals or communities, our findings show that, relative to 1977, in 1997, fewer members of our urban family medicine department felt needed by their hospital or saw the relevance of hospital work, and, despite believing that hospitalized patients expect them to visit, fewer agreed that patient care would suffer if they did not.

Patient advocacy

At the same time, respondents perceived their patient advocacy role as taking on new meaning and importance. One definition of patient advocacy is "…involving patients in decision making, advising [them] of risks and benefits, interpreting results and consultants' recommendations, protecting patients' autonomy, and helping patients with difficult ethical decisions."[19] In light of our results, future work could explore whether this definition is apt for physicians and patients.

Reasons to attend or not attend the hospital

Although respondents spent about 3 hours less per week at St Joseph's Hospital in 1997 than in 1977, most (almost 90%) continued to attend the hospital to care for patients and to get CME. Other once-important reasons for using the hospital, such as surgery, teaching, or meetings with specialists, have become less important. Some hospital activities have moved to doctors' offices for convenience and cost, but other factors might also be involved. In a recent survey of Australian general practitioners, for example, bed shortages and "specialist dominance" were cited as the main reasons for family doctors' withdrawal from urban public hospitals; 75% of respondents predicted their complete exclusion from public hospitals in the foreseeable future.[12] In other surveys, desire for a change in lifestyle, demands of office practice, concerns about medicolegal liability, and inadequate compensation have been cited as reasons for excluding or reducing in-hospital services or care.[10,20]

While these and other reports imply concern about trends in office practice,[1-4] the National Health Service's introduction of payments for office-based surgery suggests otherwise. Since payment started in 1990, GPs' performance of office-based minor surgery in the United Kingdom has risen dramatically.[21] Reasons cited include convenience and changes in both patients' attitudes and physicians' thresholds for treatment.[21,22] If financial incentives can help broaden the scope of office practice, why not hospital practice?

One strategy that some believe will promote hospital work is a remuneration scheme that incorporates the principles of rostering and capitation.[4] In Ontario, HSO physicians receive monthly payments based on capitation rate and on the size and age-sex composition of their practices. Between 1979 and 1993, they also received bonus payments, through the Ambulatory Care Incentive Plan, if their patients had lower-than-average rates of hospital use.[23] While numerous studies have compared physicians' practice patterns under various remuneration systems, few have considered hospital-based care[23] or doctors' attitudes toward their role in hospitals. We took advantage of the many HSO members in our department to explore these issues and, although we found few practice differences that would be considered meaningful, given the small sample sizes, the differences of opinion on the needs of both hospitalized patients and family doctors might be worth a closer look.

While this study confirms many of the trends observed by Bass and associates[1] and others,[10,24] questions remain about the implications of these trends for family medicine in Canada. Outside obstetrics, where there are ongoing concerns about access to service,[25-28] what are the implications of urban family doctors spending less time in hospital? Edsall cites

three potential dangers.[29] Given the emergence of "midlevel" providers in the United States, Edsall warns that, in the long run, less hospital work might mean fewer incentives for payers to continue to support physician-led primary care. Philosophically, he wonders about the risks to continuity of care. And professionally, he cautions that less time in hospital might mean fewer skills, fewer opportunities to learn from consultants, and a reduced sense of "physician community." Further, once lost, he says such skills and privileges might be tough to regain.

Continuity of care

In terms of continuity of care, studies find for both sides of the issue. In a recent comparison of two Montreal hospitals (one in which family doctors were attending physicians and one that employed a more traditional model of care), for example, Sicotte and colleagues found that, for general medicine patients, more family physician involvement was associated with more physicians making bedside visits and, thus, less "continuity."[30] This contrasted findings for surgical patients, for whom there was no difference in continuity measures across the two hospitals. Some share Edsall's concerns about the potential loss of skills and "community."[1-3] Others, however, argue that, given the pace of change in medicine and technology, keeping abreast of new developments in both inpatient and outpatient medicine is difficult and that patients (and perhaps family doctors) would be better off if family physicians focused on the increasingly complex and demanding task of keeping patients out of hospital.[31-34] Articles by Rochon and Gurwitz[35] and Hutchison et al[36] highlight some of the areas of preventive care urgently in need of greater attention and support.

Patients' perspective

Finally, what of the patients' perspective? Issues of cost and quality of care aside, are patients any less satisfied with their hospital care if it is not provided by their family doctors? Answers to this question will vary depending on patients' expectations and the nature of the care.[30,37] For example, while surgical patients might claim favourable effects of family physician visits in Canada,[38] reports from the United States suggest that, not only are medical patients not dissatisfied with "hospitalist" care,[31] they might appreciate the fact that their family doctors are more accessible outside the hospital.[39,40] Of course, this model assumes that patients have family doctors, and that there are sufficient physicians to provide in-hospital care.

Editor's key points

- Between 1977 and 1997, family doctors at a Hamilton teaching hospital reported a marked decline in inpatient care.
- In 1997, most family doctors still valued their connection with hospitals for continuing medical education opportunities and supportive and concurrent care.
- The most important role for family doctors in 1997 was that of "patient advocate."
- Limited comparison between fee-for-service (FFS) and non-FFS physicians shows non-FFS physicians have marginally less interest in in-hospital care.

Points de repère du rédacteur

- Entre 1977 et 1997, les médecins de famille d'un hôpital d'enseignement à Hamilton ont signalé un important déclin dans les activités de soins aux patients hospitalisés.
- En 1997, la majorité des médecins de famille valorisaient toujours leur relation avec les hôpitaux aux fins de formation médicale continue et pour offrir des soins d'appui et simultanés.
- Le rôle le plus important pour les médecins de famille en 1997 était celui de défenseur des intérêts du patient.
- Des comparaisons limitées entre les médecins rémunérés à l'acte et les médecins rémunérés autrement font valoir un intérêt marginalement moins grand de la part des médecins non rémunérés à l'acte pour les soins en milieu hospitalier.

Limitations

Our study has both strengths and limitations. It is one of very few to document changes in urban family doctors' hospital activities over an extended period and, to our knowledge, the first to track physicians' attitudes toward them. The number of HSO members in our department also permitted a preliminary look at whether physicians who choose different methods of remuneration also differ in terms of their practices and attitudes toward their hospital and hospital work; studies will no doubt continue as physicians ponder participation in Ontario's latest round of primary care reforms.[41]

The study was confined to a single, tertiary care teaching hospital, and we showed that subjects differed from their local colleagues in several respects. These features make it difficult to generalize the findings to non-participants. Although response rates

were high, respondents might have been more interested in the topic of hospital care than nonrespondents. Studies from other urban teaching and non-teaching hospitals would be worthwhile. Finally, while both surveys relied upon self-reported data, different methods were used to administer the questionnaires, and we did not test what effect this might have on our results. If, relative to the self-administered survey, the earlier interviews led to over-reporting of hospital activity or more favourable attitudes toward the hospital or department, our methods would serve to accentuate observed declines in both.

CONCLUSION

In 1997, family doctors in our department reported spending about 3 hours less per week in hospital, delivering fewer babies, conducting fewer procedures in hospital, and assuming less responsibility for in-hospital patients than in 1977. Despite these changes, most continued to attend the hospital to provide concurrent or supportive care and to obtain CME, and remained committed to their hospital, department, and role as patient advocates. We hope these findings contribute to further research and debate about what are important trends in urban family practice in Canada.

Acknowledgment

We thank department members who participated in this survey, Anna Hoover and Carol Conroy for their help in preparing the report, and Dr John Sellors for his comments on an earlier draft.

Contributors

All the authors helped conceive the project, interpret data, and write the report. **Mr Paterson** *and* **Dr Allega** *collected the data, and* **Mr Paterson** *analyzed the data and drafted the report.*

Competing interests

None declared

Correspondence to: *Michael Paterson, Research Officer, Department of Family Medicine, St Joseph's Hospital, 50 Charlton Ave E, Hamilton, ON L8N 4A6; telephone (905) 522-1155, extension 5166; fax (905) 521-6010; e-mail* paterson@ices.on.ca

References

1. Bass MJ, McWhinney IR, Stewart M, Grindrod A. Changing face of family practice. *Can Fam Physician* 1998;44:2143-9.
2. Lemire F. Role of the family doctor in hospital [letter]. *Can Fam Physician* 1998;44:2369-70.
3. Ontario College of Family Physicians. *Examples of excellence in family medicine*. Toronto, Ont: Ontario College of Family Physicians; 1999.
4. Ontario College of Family Physicians. *Family medicine in the 21st century: a prescription for excellence in health care*. Toronto, Ont: Ontario College of Family Physicians; 1999.
5. Evans EO, McEwan ED. Future role of the general practitioner in the hospital service. *BMJ* 1969;1:172-3.
6. Jones RH. General practitioners and hospitals. *J R Coll Gen Pract* 1986;36:346-8.
7. Harris M, Fisher R, Knowlden S. Improving general practitioner involvement in urban hospitals. *Med J Aust* 1993;158:304-7.
8. Clinton C, Schmittling G, Stern TL, Black RR. Hospital privileges for family physicians: a national study of office-based members of the American Academy of Family Physicians. *J Fam Pract* 1981;3:361-71.
9. Stadler DS, Zyzanski SJ, Stange KC, Langa DM. Family physicians and current inpatient practice. *J Am Board Fam Pract* 1997;10:357-62.
10. Woodward CA, Rosser W. Effect of medicolegal liability on patterns of general and family practice in Canada. *Can Med Assoc J* 1989;141:291-9.
11. Montalto M, Gunesekera A, Sanderson F. The use of inpatient admission privileges by members of a division of general practice. *Aust Fam Physician* 1994;23:453-61.
12. Schattner P, Dunt D. General practitioner involvement in non-procedural medicine in public hospitals in Melbourne, Australia. *Fam Pract* 1989;6:141-5.
13. Premi JN, Johnston MA, Shea PE, Tweedie T. The role of the family physician in hospital. Part 4: family physicians' attitudes toward their hospital care. *Can Fam Physician* 1980;26:521-4.
14. Shea PE, Johnston MA, Premi JN, Tweedie T. The role of the family physician in hospital. Part 1: demography. *Can Fam Physician* 1980;26:53-5.
15. Johnston MA, Tweedie T, Premi JN, Shea PE. The role of the family physician in hospital. Part 2: use of hospital privileges. *Can Fam Physician* 1980;26:215-20.
16. Tweedie T, Johnston MA, Shea PE, Premi JN. The role of the family physician in hospital. Part 3: obstetrics. *Can Fam Physician* 1980;26:365-7.
17. College of Family Physicians of Canada. *The CFPC National Family Physician Survey*. [Part of the Janus project: family physicians meeting the needs of tomorrow's society. Regional Report]. Mississauga, Ont: College of Family Physicians of Canada; 1998. Available from: www.cfpc.ca/Janus/janusregto.htm. Accessed August 1999.
18. Ontario Medical Association. *Maintaining the role of the GP within the hospital. General and family practice position paper*. Toronto, Ont: Ontario Medical Association; 1999.
19. College of Family Physicians of Canada. *The role of the family physician in hospitals. A report of the College of Family Physicians of Canada in collaboration with the Ontario Chapter CFPC*. Mississauga, Ont: College of Family Physicians of Canada; 1990.
20. Reid AJ, Caroll JC. Choosing to practise obstetrics: what factors influence family practice residents? *Can Fam Physician* 1991;37:1859-67.
21. Lowy A, Brazier J, Fall M, Thomas K, Jones N, Williams BT. Minor surgery by general practitioners under the 1990 contract: effects on hospital workload. *BMJ* 1993;307:413-7.
22. O'Cathain A, Brazier JE, Milner PC, Fall M. The cost-effectiveness of minor surgery in general practice: a prospective comparison with hospital practice. *Br J Gen Pract* 1992;42:13-7.
23. Hutchison B, Birch S, Hurley J, Lomas J, Stratford-Devai F. Do physician payment mechanisms affect hospital utilization? A study of health service organizations in Ontario. *Can Med Assoc J* 1996;154:653-61.
24. Kaczorowski J, Levitt C. Intrapartum care by general practitioners and family physicians. Provincial trends from 1984-1985 to 1994-1995. *Can Fam Physician* 2000;46:587-97.
25. Rosser WW, Muggah H. Who will deliver Canada's babies in the 1990s? *Can Fam Physician* 1989;35:2419-22,2424.
26. Lofsky S. Who will deliver Ontario's children? *Ont Med Rev* 1996;63:25-7.
27. Levitt C. Addressing a crisis. *Can Fam Physician* 1999;45:553-5.
28. Reid AJ, Grava-Gubins I, Carroll JC. Family physicians in maternity care. Still in the game? Report from the CFPC's Janus Project. *Can Fam Physician* 2000;46:601-11.
29. Edsall RL. Family practice without hospital practice. *Fam Pract Manag* 1997;(July/August):11. Available from www.aafp.org/fpm/970700fm/editor.html. Accessed August 1999.
30. Sicotte C, Beaudoin C, Jacques A, Millette B. Family physicians' involvement in two hospitals. Two different models of inpatient care. *Can Fam Physician* 1996;42:1939-44.
31. Henry LA. Will hospitalists assume family physicians' inpatient care roles? *Fam Pract Manag* 1997;(July/August):42. Available from: http://www.aafp.org/fpm/970700fm/cover.html. Accessed August 1999.
32. Henry LA. Working with hospitalists. *Fam Pract Manag* 1997;(November/December):32. Available from: http://www.aafp.org/fpm/971100fm/. Accessed August 1999.
33. Gripe B. Hospitalists: friend or foe? [letter]. *Fam Pract Manag* 1997;(October):15. Available from: http://www.aafp.org/fpm/971000fm/letters.html. Accessed August 1999.
34. Mandaro SL. Hospitalists: friend or foe? [letter]. *Fam Pract Manag* 1997;(October):15. Available from: http://www.aafp.org/fpm/971000fm/letters.html. Accessed August 1999.
35. Rochon PA, Gurwitz JH. Prescribing for seniors. Neither too much nor too little. *JAMA* 1999;282:113-5.
36. Hutchison B, Woodward CA, Norman GR, Abelson J, Brown JA. Provision of preventive care to unannounced standardized patients. *Can Med Assoc J* 1998;158:185-93.
37. Hansen NH. Family physicians and teaching hospitals: a litany of woes. *Can Fam Physician* 1984;30:2319-24.
38. Lynn K. Surgical patients need their family doctors. *Can Fam Physician* 1990;36:1247-8.
39. Lurye DR. Hospitalists: friend or foe? [letter]. *Fam Pract Manag* 1997;(October):15. Available from: http://www.aafp.org/fpm/971000fm/letters.html. Accessed August 1999.
40. Weinman HM. Hospitalists: friend or foe? [letter]. *Fam Pract Manag* 1997;(October):15. Available from: http://www.aafp.org/fpm/971000fm/letters.html. Accessed August 1999.
41. Borsellino M. Ontario proud of primary care reform. *Med Post* 1999;35:45. Available from: http://www.medicalpost.com. Accessed August 1999.