Family Physicians Caring for Hospital Inpatients

A Discussion Paper Prepared by
The College of Family Physicians of Canada

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The College of Family Physicians of Canada

MISSION STATEMENT

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA (CFPC) IS A NATIONAL VOLUNTARY ORGANIZATION OF FAMILY PHYSICIANS THAT MAKES THE CONTINUING MEDICAL EDUCATION OF ITS MEMBERS MANDATORY. THE COLLEGE STRIVES TO IMPROVE THE HEALTH OF CANADIANS BY PROMOTING HIGH STANDARDS OF MEDICAL EDUCATION AND CARE IN FAMILY PRACTICE, BY CONTRIBUTING TO THE PUBLIC UNDERSTANDING OF HEALTHFUL LIVING, BY SUPPORTING READY ACCESS TO FAMILY PHYSICIAN SERVICES, AND BY ENCOURAGING RESEARCH AND DISSEMINATING KNOWLEDGE ABOUT FAMILY MEDICINE.

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AS THE VOICE OF FAMILY MEDICINE IN CANADA, THE COLLEGE OF FAMILY PHYSICIANS OF CANADA:

GOAL 1: CHAMPIONS QUALITY HEALTH CARE FOR ALL PEOPLE IN CANADA
GOAL 2: SUPPORTS ITS MEMBERS IN PROVIDING QUALITY PATIENT CARE THROUGH EDUCATION, RESEARCH AND THE PROMOTION OF BEST PRACTICES
GOAL 3: ENSURES THAT THE ROLE OF THE FAMILY PHYSICIAN IS WELL UNDERSTOOD AND WIDELY VALUED

FOUR PRINCIPLES OF FAMILY MEDICINE

- THE FAMILY PHYSICIAN MUST BE A SKILLED CLINICIAN
- THE DOCTOR-PATIENT RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN
- FAMILY MEDICINE IS A COMMUNITY BASED DISCIPLINE
- THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION

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Executive Summary

Background

This discussion paper has been written for family doctors, health professionals with whom they work, hospital administrators and managers, medical school leaders, the patients whom family doctors serve, and other public audiences interested in the value and importance of family doctors working in various health care environments. Specifically, it addresses the way our Canadian health care system has impacted inpatient hospital care provided by family physicians (FPs) and describes the experiences of family physicians who provide this care. The recommendations in this paper are written to enhance hospital care for patients and to define appropriate roles for their family doctors.

Public surveys continue to show that Canadians hold family physicians in high regard for the quality of care they provide. According to Statistics Canada, 92% of Canadians believe the quality of care they receive from their personal family doctor is good to excellent.[1] In a Decima survey commissioned by The College of Family Physicians of Canada (CFPC) in the fall of 2002 to explore the public perception of FP shortages, over 80% of Canadians rated the quality of care they received from their family doctors as good to excellent[2]. Nevertheless, with the evolution of community-based family practice and the changing roles of family physicians and hospitals in our Canadian health care system, it has become increasingly challenging for family physicians to care for their patients in hospital. Many family physicians wonder if they should and how important this is to the continuity and coordination of care that they have traditionally provided their patients.

The Canadian health care system has undergone significant change in the last few decades. This includes restructuring, regionalization, changing physician and patient population demographics and advances in technology. In preparation for this paper, the CFPC commissioned a study on the status of family physicians providing inpatient hospital care. A comprehensive search of the literature and semi-structured interviews with 27 informants from across the country were conducted. A focus group involving 40 physicians was held in an Ontario community. The purpose of the study was to find out why family physicians were withdrawing from inpatient hospital care. This discussion paper presents the results of the study as well as a series of recommendations that address the issues it raised.

The Challenge

Traditionally, family physicians have played an active role in managing hospital inpatients. Their roles have ranged from being the most responsible physician caring for patients, to caring for patients concurrently with specialists, to paying courtesy visits to help coordinate care and supports for their patients.

[1] Statistics Canada. Access to Health Care Services in Canada, 2001. Ottawa May 2002

The CFPC 2001 National Family Physician Workforce Survey (NFPWS 2001)[3] identified that 34.5% of FPs provided care for their patients on hospital units and wards. On average, respondents indicated that they spent 7.3 hours per week managing inpatients. There was considerable variation across the country. For instance, family physicians in small towns (51%) and rural areas (54%) were much more likely to provide inpatient hospital care than FPs practicing in cities (16%) and suburban areas (26%). Age was also a factor. Involvement in hospital care decreased with increasing age, both in the number of FPs offering that type of care, and the number of hours providing it. The NFPWS 2001 indicated that FPs under the age of 35 years are more likely to be involved in hospital care. They are also more likely to have selected inpatient hospital care or emergency care as their main practice setting.[4]

The involvement of FPs in hospital care remains very important to patients. In an editorial in *Canadian Family Physician (CFP)*, the Executive Director and CEO of the College of Family Physicians of Canada, Dr. Calvin Gutkin, wrote:

"*The value to hospitalized patients of having skilled and knowledgeable family physicians providing bedside care, coordinating the services of other health care workers, advocating for them, and ensuring that all hospital caregivers understand them as people with an important past and a meaningful ongoing role within their families and communities cannot be underestimated.*"[5]

Orphan patients, i.e., patients admitted to a hospital where their family doctor is unavailable to attend to their care, create an ever-increasing burden for FPs still caring for hospital inpatients. For many FPs, the main reason for providing inpatient services is the satisfaction of managing their own patients across the continuum of care and meeting patients' expectations that they will do so. Orphan patients who are not part of their ongoing practice, take away from this satisfaction. This can result in a vicious cycle. As FPs leave hospital because of the workload generated by orphan patients, the burden of care shifts to their medical colleagues who maintain their privileges. They, in turn, experience increased pressure and consider leaving as well.

There are other challenges in retaining the involvement of FPs in inpatient hospital care. Our study found that significant numbers of FPs have decreased their involvement in hospital work in the last few years. The pressure of managing other doctors' patients combined with inadequate remuneration and access to consultant services is prompting an increasing number of FPs to withdraw. Involving family physicians in hospital care promotes continuity and coordination for patient care.

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[2] Decima Express National Telephone Omnibus Survey, October 2002. Commissioned by The College of Family Physicians of Canada.
[3] The 2001 CFPC National Family Physician Workforce Survey Database (weighted data). Part of the JANUS Project, College of Family Physicians of Canada. Mississauga ON, 2001.
[4] Average time excluding 3% of FPs who identified hospital in-patient care as their main practice setting.
[5] Gutkin C. Vital Signs. *Can Fam Physician* 1999(45):2248.

Other benefits for both patients and their doctors include:

- The potential for positive patient outcomes
- Strengthening the ability of patients and families to cope with stressful situations
- Using resources more efficiently, e.g. avoiding the repeat of tests already requested
- Opportunities for family physicians to advocate for their patients
- Developing appropriate patient care strategies that include FPs as part of the care team with specialists and other health care professionals
- Opportunities to decide the appropriateness of patient consultations
- Opportunities for family physicians to apply their hospital acquired knowledge and skills to community practices
- Enhanced career satisfaction and professional stimulation that family physicians experience with the hospital environment, relationships with specialists and other colleagues

On the other hand, reasons given by FPs for their withdrawal from hospitals include:

- Limited opportunities for hospital privileges
- Limited access to hospital beds
- Impact of hospital restructuring and regionalization
- Increased office workloads/diminished time available for hospital work
- Increased acuity and complexity of patient problems in both the community and the hospital
- Increased hospital workloads with increasing numbers of orphan patients
- Frustration of attending numerous orphan patients
- Feeling unwelcome and not respected in some hospital settings
- Low remuneration for hospital work
- Enhanced skills required to care for increasingly complex hospitalized patients

Some of these concerns were echoed in the NFPWS 2001[6]. 45.5% of respondents reported satisfaction in their relationship with their hospital whereas 22.2% were neutral and 32.3% indicated some level of dissatisfaction.

In view of these and other issues, our health care system is facing challenges to family physicians caring for hospital inpatients. Appropriate solutions must be found to address the reasons family doctors are withdrawing from inpatient care. The role of family doctors caring for hospital inpatients should be supported as an important and valuable contribution to Canadian health care.

[6] The 2001 CFPC National Family Physician Workforce Survey Database (weighted data). Part of the JANUS Project, College of Family Physicians of Canada. Mississauga, Ontario, Canada, 2001.

Recommendations

1. To improve the continuity and coordination of patient care:
   A. Hospitalized patients should have their own family physician participating in their hospital care whenever possible.
   B. Appropriate communication should be maintained by hospitals with family physicians in the community, including timely notification of their patients' hospital admissions, progress and discharges.

2. To improve the continuity and coordination of patient care:
   A. All hospitals should have privileging criteria that recognize and support the role of family physicians in caring for their patients in hospital.
   B. Family physicians should be permitted and encouraged to apply to any hospital in their community for medical staff privileges, enabling them to carry out appropriate roles in the care of their hospitalized patients.
   C. Family physicians should be represented in the development of hospital policies that affect their patients.

3. Family physicians should organize themselves into networks or groups of an appropriate size to share the responsibilities and workload of managing hospital inpatients.

4. Appropriate remuneration and/or incentives for all hospital responsibilities should be available to family physicians to support their ongoing involvement in inpatient hospital care.

5. The role of family physicians in hospital should be augmented in all medical schools, ensuring family physician role models for all medical students, family practice residents and specialty residents.

6. All family practice residency programs should include training in hospitals with family physician role models, as a condition for full program accreditation.

7. The CFPC's accreditation standards should require all family medicine programs to provide family medicine residents with the opportunity to acquire the acute care skills needed for both rural and urban inpatient hospital care.

8. Medical schools and university departments of family medicine should offer enhanced skills training and accredited CME/CPD programs in areas related to in-hospital care for family medicine residents and practicing family physicians.

Recommendations

9. **Where hospitalists are required:**
   - A. **Hospitals should actively encourage and welcome family physicians to maintain their privileges and care for their own hospitalized patients.**
   - B. **Family physicians who choose to work as hospitalists should be encouraged to practice in the community and to work as hospitalists proportionate to their available practice time.**
   - C. **Both hospitalists and community family physicians should be supported and welcomed as members of multidisciplinary patient care teams.**
   - D. **Consideration should be given to the role of a hospital coordinator whose responsibility is to ensure appropriate liaison between community family physicians and hospitalists.**
   - E. **Hospitalists should be a CME/CPD resource for family physicians seeking further education in inpatient hospital care.**

10. **Upon discharge, patients should continue to be cared for by their own family physician. If they do not have a family physician, they should be supported in finding a community family physician for their ongoing care.**

11. **Inpatient hospital care should be considered an integral part of a patient's continuum of care that includes office-based care, home care, rehabilitation and long term care provided by interdisciplinary teams with family physicians in leadership and key caregiver roles.**

12. **More research, both qualitative and quantitative, should be conducted to evaluate the involvement of family physicians in inpatient hospital care in Canada.**

13. **The CFPC should promote the importance of family physician involvement in inpatient hospital care to the public, hospitals, medical schools, governments, and all other stakeholders in the Canadian health care system.**

1.0 The Context

This discussion paper closely examines the role of the family physician in hospital care, the ways in which this role is changing, and how members of the family practice community in Canada feel this role should develop.

Family physicians are the first point of access to Canada's primary health care system. They play an essential role in maintaining the continuity and coordination of patient care. The principles of family medicine focus on the patient-doctor relationship, the ability of skilled family doctors to provide ongoing care, and their ability to be a resource to patients in the community. When patients move in and out of hospital, these principles are put into practice. Family physicians (FPs) must ensure that their patients' care is addressed prior to admission, that day-to-day in-hospital medical care is provided, that consultations and requests for other services are carried out while in hospital, and that the treatment plan is followed after discharge from hospital.

Traditionally, Canadian FPs have played an active role in the management of their patients in hospital. However, there is growing concern about the decreasing number of FPs involved in hospital care. Reports of this phenomenon have appeared in the media[7,8,9,10]. The Ontario College of Family Physicians' discussion paper, *Where Have All the Doctors Gone*[11], outlines the situation in Ontario and options for reversing this trend. The Ontario Medical Association (OMA) established an advisory committee to address the issue and in 2001, the OMA and government of Ontario implemented a special alternative payment plan for hospital-based on-call services, including those provided by FPs. In addition, Ontario Family Health Networks (OFHN)[12] offer financial incentives for those who care for their own patients in hospital. Other provinces have also developed incentives to encourage FPs to maintain hospital privileges. Nova Scotia, for example, negotiated a significant increase in hospital visit fees for physicians.

These reports and new strategies coincide with a period of significant debate and change in Canadian health policy. Hospitals are closing, downsizing or merging, resulting in increased competition for scarce hospital beds and resources. Physician supply is strained and there are concerns about an aging physician population[13,14], chronic shortages in rural and selected urban settings[15], and changing expectations of workload[16].

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[7] Milne C. The hospitalist revolution. *Medical Post* 2002;38(19), p. 31, 33
[8] Blackwell T. Family doctors shun hospital duties, medical groups say. *Ottawa Citizen* Sept. 7, 1999; A3
[9] Foss K. 'Orphan patients' pose medical dilemma. *The Globe and Mail* Aug.30,1999;A1
[10] Langley A. Three MDs leave city hospital. *Niagara Falls Review* September 13,1999, A1
[11] Ontario College of Family Physicians. *Where have all the doctors gone?* Toronto ON: 1999
[12] Ontario Ministry of Health and Long-Term Care. Ontario Family Health Network.*Your family health network-Info Kit.* Toronto ON:2002
[13] Thurber AD, Busing N. Decreasing supply of family physicians and general practitioners: serious implications for the future. *Can Fam Physician* 1999;45:2084-2089
[14] Chan B et al. Patterns of practice among older physicians in Ontario. *Can Med Assoc J* 1998;159(9):1101-1106
[15] Chan B, Anderson GM. Trends in physician fee-for-service billing patters. In: *Patterns of Health Care in Ontario. The ICES Practice Atlas*. 2nd edition. Ottawa ON: Canadian Medical Association, 1996;247-264
[16] The 2001 CFPC National Family Physician Workforce Survey Database. Part of the JANUS Project, College of Family Physicians of Canada. Mississauga, Ontario, Canada, 2001.

Policy analysts are questioning whether there are enough physicians to meet current and future needs[17,18,19,20,21]. There is also concern about waning interest in family medicine as a career choice[22]. These changes could have an impact on the availability of FPs willing to provide hospital inpatient care.

In conjunction with these changes, primary care reform is slowly taking root in most provinces. With this reform has come a greater interest in developing models of care that emphasize coordination and integration of care and that remunerate physicians for such tasks more equitably. The role of FPs in inpatient hospital care will undoubtedly be an important topic of debate in the evolution of these reforms.

1.1 This Discussion Paper

The main focus of this discussion paper is the role of FPs in managing patients admitted to hospital. FPs' roles in providing specialized hospital care such as emergency, anesthesia, surgical and obstetrical care are considered in the discussion but are a secondary focus. The term family physician (FP) refers to all general practitioners (GPs) and family physicians. The term inpatient refers to any patient admitted to a hospital bed for the provision of health care.

In preparation for this discussion paper, we conducted:

A. Literature reviews
B. A survey and interviews with physicians from across the country, including FPs from all regions, consultant specialists and representatives of other organizations[23]
C. An interview with a focus group of 40 FPs, most of whom provided hospital-based care for an Ontario community of approximately 74,000 residents.

We studied the roles that family physicians presently fill in caring for their hospital inpatients, how these roles are changing and how members of the family practice community feel these roles should evolve.

Five key questions were asked of our study participants:

A. What is the current role of FPs in providing hospital care?
B. What are the current models of FP involvement in hospitals?
C. What evidence is there to support different models of involvement of FPs in providing hospital care?
D. What are the obstacles to, and incentives for, FP participation in hospital care?
E. What are the strategies that the CFPC should consider regarding FP involvement in hospital care?

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[17] Thurber AD, Busing N. Decreasing supply of family physicians and general practitioners: serious implications for the future. *Can Fam Physician* 1999;45:2084-2089

[18] Canadian Medical Forum. Task Force on physician workforce supply in Canada. Nov. 1999

[19] Canadian Medical Forum Task Force Two: A human resource strategy for physicians in Canada. Literature Review and Gap Analysis. Dec. 2002

[20] Dauphinee WD. Medical workforce policy making in Canada: Are we creating more problems for the future? *Clin Invest Med* 1996;19(4):286-91.

[21] Ryten E. Physician workforce and education planning in Canada: has the pendulum swung too far? *Can Med Assoc J* 1995;152(9);1395-8.

[22] Rosser W. The decline of family medicine as a career choice. *Can Med Assoc J*:2002;166:1419-1420

[23] Individuals who were interviewed (B) or participated in the focus group (C) are referred to as "participants" throughout this paper.

1.2 Data from the Literature

In preparation for this paper, the CFPC conducted extensive literature searches with limited results. Considering the body of literature and research on other aspects of health care, research on the role of the Canadian family physician in inpatient hospital care is restricted. Most recently, literature searches have indicated a significant amount of research focused on the roles of hospitalists in American hospitals. Many papers were concerned with cost comparisons between hospitalists and family physicians involved in hospital care. And while much of the research was quantitative, qualitative research appeared to be lacking.

To promote a better understanding of the activities of Canadian family doctors and to develop a suitable database that supports the evaluation of family physician resources, the CFPC created the Janus Project in 1996. This project includes an extensive study of all FPs/GPs throughout Canada through the National Family Physician Workforce Survey (NFPWS)[24], last conducted by the CFPC in 2001. This survey was sent to 28,340 FP/GPs in Canada with a response rate of 51.2%. The survey examined a variety of issues related to patterns of practice in family medicine and revealed that 34.5% of FPs are involved in inpatient hospital care. Of these, 3.3% indicated the inpatient unit or ward as their main practice setting. On average, respondents who provided inpatient hospital care spent 7.3 hours per week in this type of care. Physicians in small towns and remote or rural areas spent 7.36 hours per week, compared to 7.05 hours per week for physicians in urban, inner city and suburban areas. The Tables in Appendix A provide a summary of relevant NFPWS 2001 data on hospital care by family physicians.

The NFPWS 2001 demonstrated that while the overall percentage of FPs who spent time in inpatient hospital care had remained fairly constant since the previous survey of 1997[25], the age of FPs involved in hospital care and their degree of involvement may be changing. A significant number of younger physicians elected to spend a majority of their practice time in inpatient hospital care or emergency care, thus specializing in this type of care.

An Ontario study[26] examining physician billing data, also revealed a drop in the percentage of FPs involved in hospital care. The percentage of active FPs who performed at least 50 hospital visits per year declined from 63% in 1991-1992 to 52% in 1997-1998. The NFPWS 2001 was even more alarming: only 29% of Ontario respondents indicated that they provide inpatient hospital care to their patients.

Traditionally, FPs have also played strong roles in the provision of obstetrics, surgery, anesthesia and emergency hospital services across Canada. In 1995, Chiasson and Roy[27] examined the roles of FPs in the delivery of surgical and anesthesia services in 101 rural hospitals in Western Canada.

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[24] The 2001 CFPC National Family Physician Workforce Survey Database. Part of the JANUS Project, College of Family Physicians of Canada. Mississauga, Ontario, Canada, 2001.

[25] College of Family Physicians of Canada. *National Family Physician Survey: Summary report.* Mississauga ON, October 1998.

[26] Chan B. *Supply of physicians' services in Ontario. Atlas Reports: uses of health services*. Toronto ON: Institute for Clinical Evaluative Sciences, 1999.

[27] Chiasson PM, Roy PD. Role of the general practitioner in the delivery of surgical and anesthesia services in rural western Canada. *Can Med Assoc J* 1995;153:1447-52.

Of the 56 hospitals that provided surgical services, FPs provided some surgical services in 80%. 23% of the hospitals relied completely on FPs with varying levels of surgical training to provide surgical services. Almost two-thirds of the hospitals were also completely reliant on FPs with additional anesthesia training to provide anesthesia services.

In 1995, Freeman[28] examined hospital-based care provided by 51 staff FPs at a large community teaching hospital in Toronto (North York General Hospital). He asked about participation in obstetrics, emergency care, specialty care (Teen Clinic, Sports Medicine Clinic, Fracture Clinic, Hospital in the Home), supportive care, operating room assistance, family practice teaching, after-hours clinics, and hospital committees. All but nine of 35 respondents were involved in at least one of these hospital-based activities. Those who chose to participate were strongly influenced by the enjoyment they experienced and their dedication to providing this type of care for their patients. Lifestyle and practice considerations influenced those who did not participate in the activities. There was no evidence to suggest that younger family physicians were less involved in hospital-based care than their older colleagues. Young female FPs were as committed as their male colleagues. The NFPWS 2001 supported these findings.

In another study, Rourke[29] compared medical services provided in 60 rural hospitals from 1995 to 1988. The number of FPs attending births declined by 23% and the number of GP anaesthetists by 20%. The number of physicians providing emergency coverage remained stable. By comparison, the NPFWS 2001 indicated that the percentage of FPs providing obstetrics decreased from 20.3% in 1997 to 11.4% in 2001.

In Ontario, FPs have gradually reduced their involvement in high acuity hospital activities such as obstetrics, anesthesia and emergency care[30]. The percentage of FPs performing obstetrics declined from 24% to 15% between 1991-1992 and 1997-1998. During the same period, anesthesia services provided by FPs declined from 4% to 3% and emergency services declined from 16% to 15%. More and more physicians opted for an exclusive office-based practice with no involvement in inpatient care or any of the above services. The percentage of such office-based physicians rose from 9% to 14%.

Pimlott et al[31] surveyed 511 graduates of family medicine in 1996. Of these, 110 had been exposed to inpatient care in a tertiary care centre with a dedicated family practice inpatient service and 401 had been trained in hospitals that did not have dedicated family practice beds. The researchers found that residents exposed to a dedicated family practice inpatient service were more likely than their colleagues in other hospitals to offer this type of care in their established practices.

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[28] Freeman R, Rachlis V, Franssen E. Young family physicians- support hospital-based activities. *Can Fam Physician* 1995;41:211-20.

[29] Rourke, J. Trends in small hospital medical services in Ontario. *Can Fam Physician* 1998; 44:2107-2112

[30] Chan B. *Supply of physicians' services in Ontario. Atlas Reports: uses of health services*. Toronto ON: Institute for Clinical Evaluative Sciences, 1999.

[31] Pimlott N, Holzapfel S, Cummings S. Short report: Does training in a family proactive inpatient service affect practice after graduation? *Can Fam Physician* 2001;47:983-985.

They also thought that their training had prepared them more adequately for caring for inpatients.

Paterson et al[32] compared the results of cross-sectional surveys conducted by interviews in 1977 with self-administered questionnaires in 1997 to determine whether hospital activities and attitudes toward hospitals have changed among members of an urban family medicine department. Response rates were 98.9% (1977) and 75% (1997) from members of the Department of Family Medicine at St Joseph's Hospital in Hamilton. The study demonstrated that in both 1977 and 1997, patient care and continuing education remained key reasons for performing hospital work. There was, however, a decrease of three hours per week in total hospital time in 1997 and the hospital was used less often for procedures, meetings, and teaching. FPs also assumed less responsibility for inpatient hospital care in 1997. While perceptions of hospital work changed over the years, most respondents continued to have a desire and see a need for their involvement in hospital care.

[32] Paterson MJ, Allega R, Shea PE. Role of family physicians in hospitals: did it change between 1977 and 1997? *Can Fam Physician* 2001;47:971-80

2.0 Discussion of Challenges

2.1 Role of Family Physician in Inpatient Hospital Care

Survey participants described a wide range of hospital care activities. In most rural areas, FPs are the most responsible physicians overseeing all aspects of clinical care. In urban settings where FPs provide inpatient hospital care, FPs may still be the most responsible physicians and as such, may provide all inpatient care, obtain one-time consultations from available specialists or manage their patients concurrently with specialists. Alternatively, some FPs may visit their patients for support and to ensure that various services are effectively provided, even though they are not directly involved in the day-to-day management of their patients.

In some centres FPs share responsibilities with other FPs for inpatient care. For example, they may organize themselves according to their areas of interest and/or expertise. Within a call group, one physician might handle the intensive care unit while another might handle obstetrics or palliative care. In teaching centres, some FPs become clinical associates, e.g. assisting oncology specialists with day-to-day inpatient management.

In discussion with our survey participants and with other FPs who provided a wealth of feedback for this discussion paper, the importance of the family doctor's role in ensuring the continuity and coordination of inpatient hospital care was emphasized. The value of the family doctor's contribution to the ongoing care and management of the patient's health care needs, both before, during and after hospitalization, is considered significant and forms the basis for many recommendations contained in this report.

In some hospitals, particularly those in large urban settings, FPs are not routinely informed when their patients are admitted or discharged. This occurs most often when the FP has no hospital affiliation. Even when FPs have hospital privileges, they are sometimes not notified, especially if the patient is admitted directly for specialist care. In recent years, the early discharge of acute care patients into home care has compounded this communication problem. The CFPC's discussion paper: *The Role of the Family Physician in Home Care*[33] provided insight into concerns expressed by family physicians about the breakdown in communication that occurs when their patients are released into the community. In hospitals where there is a designated admission/discharge coordinator ensuring a smooth transition between the hospital and community, FPs generally reported that they were informed about hospital transfers.

Study participants were asked if they believed that advanced information technologies would lead to new models of FP involvement in hospital care. Some speculated that future electronic networks might facilitate communication e.g., notification of admissions, investigations and discharges, and might allow FPs to communicate more readily with patients, consultants and nurses. However, it was also noted that such models could never replace the bedside care that FPs provide for their patients.

[33] College of Family Physicians of Canada. *The Role of the Family Physician in Home Care,* December 2000;8.

Recommendations:

1. **To improve the continuity and coordination of patient care:**
   - **A. Hospitalized patients should have their own family physician participating in their hospital care whenever possible.**
   - **B. Appropriate communication should be maintained by hospitals with family physicians in the community, including timely notification of their patients' hospital admissions, progress and discharges.**

2.2 Hospital Privileges for Family Physicians

In many large academic hospitals, FPs do not have admitting privileges and care is provided exclusively by specialists. Exceptions include some teaching hospitals with family practice inpatient units/wards and family medicine hospitalist programs such as that introduced by the Calgary Health Authority. Nevertheless, the number of hospital beds for FPs is often limited and subject to competition from other specialties whose access to beds has been reduced in recent years.

This situation presents several drawbacks. The family physician is frequently aware of multiple issues relevant to his or her patient's health, whether physical, emotional or social. When this information is ignored, the patient is at risk of losing an important medical ally who will advocate on his or her behalf.

The situation in community hospitals varies widely. In some, opportunities for FPs to access hospital privileges are not restricted and may even be encouraged. However, in others, there may be a limit to the number of FPs permitted to have hospital privileges. Dr. Brian Hennen captured this scenario in an editorial in the *Canadian Family Physician* journal:

> **"*A large number of family doctors on a hospital medical staff has sometimes been viewed as unmanageable in terms of maintaining standards and quality. Some facilities have begun to limit the number of family doctors on staff. In communities with more than one hospital, an active staff appointment in one hospital often precludes a physician from holding an appointment with admitting privileges at another. The number of beds accessible to family physicians also controls the granting of privileges.*"**[34]

Unless their FP is also a surgeon, FP involvement is usually limited when patients are admitted for surgery. In surgical units, as in intensive or cardiac care units, the FP usually provides supportive care and may play and important role in helping the patient to interpret results and make more informed decisions on treatment options. The FP may often resume primary responsibility for convalescent care following medical or surgical interventions.

[34] Hennen B. Family physician hospital privileges. New approach. *Can Fam Physician* 1995;41:970.

Recommendations:

2. To improve the continuity and coordination of patient care:

A. All hospitals should have privileging criteria that recognize and support the role of family physicians in caring for their patients in hospital.

B. Family physicians should be permitted and encouraged to apply to any hospital in their community for medical staff privileges, enabling them to carry out appropriate roles in the care of their hospitalized patients.

C. Family physicians should be represented in the development of hospital policies that affect their patients.

2.3 Respect from Other Members of Medical Staff

There was a divergence of opinion among study participants about the issue of respect from other members of medical staff and the effect that this has on decisions to relinquish hospital privileges. Some respondents noted that FPs have good relations with specialists and that this is not a key factor in FPs leaving hospital. Others emphasized that consultants are very respectful of FPs in rural communities where there is less competition for access to hospital beds and less emphasis on full-time academic and hospital-based commitments.

In order to maintain and encourage their involvement in inpatient hospital care, study participants indicated that they need:

- To feel welcome in the hospital
- To be valued for the quality of care they provide
- To be respected for their contributions to patient care
- To be recognized as integral members of the patient's health care team
- To be kept informed of changes in hospital policies and protocols
- To participate in effective communications with other members of the medical staff and hospital team
- To know that there is appropriate consultant backup after hours and on weekends for additional patient care that may be required from time to time.

2.4 Workload and Burnout

In all practice settings across the country workload and burnout are significant factors in FPs leaving hospital work. A balance between workload and personal lifestyle is key to preventing burnout. In the NFPWS 2001, only 27.6% of respondents indicated that the balance they had achieved between the personal and professional commitments of their time was about right. Another 41.3% wanted more time with family; 41.5% wanted more time for themselves; and only 0.5% wanted more time for their career.

Several factors have contributed to physicians having heavier workloads in hospital. The current shortage of physicians, as well as the graying of Canada's medical workforce,[35] has contributed to larger patient volumes for those providing inpatient hospital care.

In addition, the movement towards shorter hospital stays and earlier discharges has resulted in the need for FPs to care for greater numbers of inpatients with high acuities. These factors have also contributed to increased workloads in family practice. As a result, some FPs have given up their hospital privileges, leaving the care of their inpatients to their associates. The remaining FPs experience larger and less predictable hospital patient volumes. In turn, increased inpatient numbers impacts the amount of administrative work FPs must undertake for their patients in hospital and subsequently reduces the available time that they have to devote to other aspects of family practice.

Many hospitals insist that as a condition of privileges, FPs must look after orphan patients. These are patients who are admitted to a hospital where their personal FP is unavailable to care for them, usually because the FP does not have hospital privileges. Orphan patients may have very complicated social and medical histories that are time-consuming to manage. Although such patients generate larger inpatient volumes for FPs, they often generate extra calls between the office and hospital, interrupting patient flow in the office. For many family physicians, the main reason to continue to provide hospital care is the satisfaction of managing their own patients across the continuum of care. With orphan patients, they do not receive such satisfaction.

The increased workload caused by orphan patients creates a vicious cycle. As FPs resign from hospital because of the workload generated by orphan patients, the burden of caring for them shifts to their colleagues who retain their hospital privileges. FPs who are still members of the hospital medical staff then experience an even greater workload and also consider relinquishing their hospital roles.

[35] Buske, Lynda. The greying of Canada's medical workforce continues. *Can Med Assoc J*: 2000;163:876-a

Demands to be in more than one place at one time also contribute to FP workload stress. With the transition in acute care from hospital to community, patients in the community have more complicated health problems and cannot be admitted to hospital for lack of beds. Walk-in clinics have also taken a large share of the minor, straightforward problems in family medicine, making office work more demanding. When FPs must care for a greater volume of more complicated patients in the community, they have less energy for hospital work, often performed before or after office hours.

One of the proposed solutions has been the formation of groups of FPs. While many have done this for years, the concept of family practice networks now introduced in some parts of the country could further support this strategy.

In a model familiar to many FPs, they are responsible for their own patients during daytime hours from Monday to Friday and then sign out to an on-call physician during evenings and weekends.

Recommendation:

3. Family physicians should organize themselves into networks or groups of an appropriate size to share the responsibilities and workload of managing hospital inpatients.

2.5 Hospital Restructuring

The impact of hospital restructuring on the roles and responsibilities of FPs is mixed. With hospital restructuring, the total number of available beds in a general hospital often decreases and different medical services must negotiate with one another for access to the remaining beds. Hospital restructuring has increased competition for hospital beds and may have led to FPs being squeezed out of some hospitals. This is particularly true in large tertiary or teaching hospitals. It is not usually an issue in hospitals where FPs are designated as the most responsible physicians and provide care alone or concurrently with consultants.

Hospital restructuring and funding cuts have also reduced the number and availability of informed nurses who can advise physicians of the progress of their hospitalized patients.

This has led to increased frustration in obtaining the type of information that ensures good patient care. In some instances where nurses or other services have been drastically reduced, FPs are less confident that their patients will be cared for as planned. In these settings, FPs find it necessary to conduct hospital visits more than once daily to ensure that patients are receiving the expected care.

Following hospital closure, medical staff privileges for members of the department of family medicine may be transferred to other facilities located further away. This may discourage FPs from continuing active hospital privileges. However, in other instances hospital restructuring simplifies care. This is the case in communities where multiple institutions within a small geographical area have merged and physicians then need to attend their inpatients at only one institution.

2.6 Remuneration for Inpatient Hospital Care

Most participants felt that remuneration was a major reason why many FPs no longer include hospital-based activities in their practice. In some regions, hospital visit fees provide inadequate remuneration for time spent by FPs in hospital and reflect poorly on the value placed by the health care system on their services. In Ontario, for example, the hospital visit fee is only $17.30 (Ontario Ministry of Health 2002).

Respondents noted other significant financial deterrents to FP involvement in hospital care. For instance, administrative duties can place a heavy burden on FPs in hospital. These duties include mandatory committee work and detailed record management for which they receive no remuneration in the loss of practice time.

Physicians associated with in-hospital care may also be required to pay additional fees such as medical staff dues and parking costs. These costs add to practice overhead and further decrease the net income derived from hospital inpatient visits.

In 1994 the CFPC recommended a blended funding model for physician remuneration. This emphasized the use of incentives that promote the quality, availability and comprehensiveness of care.[36] However, it is worth noting that precise strategies for implementing physician remuneration and enhancing care are the responsibilities of provincial medical associations and governments to negotiate. The recent Ontario Medical Association/Ontario Ministry of Health OFHN framework agreement is based on a blended funding model.

In 1999 Nova Scotia began to address the remuneration issue by increasing fees paid for hospital visits to 13.5 units ($24.84). Fortunately, several provincial fee schedules now recognize the extra time FPs spend on inpatient care by offering incentives or bonuses to compensate for such activities as admission or after-hours visits.

So far, it is not apparent that these incentives have brought FPs back to hospitals but it is expected they will decrease the likelihood that FPs resign their hospital privileges and may encourage new FPs to include hospital care in their practices.

[36] The College of Family Physicians of Canada. *CFPC Proposal for a Blended Funding Mechanism*, February 1994

Several provinces have implemented alternative funding approaches to ensure that FPs stay active in hospitals. In New Brunswick all new physicians must obtain hospital privileges from one of the regional hospital corporations before receiving a billing number. The impact of making hospital privileges a prerequisite for payment is that all new physicians provide hospital services. In Quebec all physicians must, during their first ten years of practice, dedicate a portion of their time to activities such as emergency coverage, hospital practice, and working in a community health centre. Otherwise, they face financial penalties. Interviewees from Quebec felt that such policies might provide an incentive to work in hospital but they also reported that they are not popular with physicians because they are coercive. The OFHN model, being implemented in several communities in Ontario, encourages FPs to participate in hospital care by recognizing their involvement with a premium of $5,000 per year.

Recommendation:

4. Appropriate remuneration and/or incentives for all hospital responsibilities should be available to family physicians to support their ongoing involvement in inpatient hospital care.

2.7 Training in Hospital Skills

Canadian FPs are usually well trained during their residency programs to appropriately manage inpatient hospital care, including decisions to refer for specialty care. Their reluctance to practice hospital medicine may sometimes be due to a lack of self-confidence in their professional abilities. It was noted that the highly technical environment of the hospital and the attitudes of some hospital physicians, administrators, and other staff can sometimes be intimidating.

The CFPC has training accreditation guidelines that specify the minimum length and type of training for family practice that includes inpatient hospital care.[37] Some survey participants felt that the CFPC should define core competencies, listing the medical conditions that a FP should be able to manage. Others felt that the CFPC's guidelines were already specific enough and that any further refinement of the guidelines would amount to micromanagement of teaching programs. There was some concern that residents had insufficient opportunity to develop procedural skills, particularly in large urban teaching centres where competition with specialty residents is intense. At the present time, CFPC working groups are looking at both the core curriculum and procedural skills training for family medicine residents.

[37] The College of Family Physicians of Canada. *Standards for Accreditation of Residency Training Programs*, 2000.

The CFPC is concerned about the lack of family practice role models in many hospitals. Some medical students and residents in both family medicine and specialty programs complete their training without ever seeing FPs looking after their own hospital patients. This is particularly true when, for example, a student or resident's exposure to hospital medicine occurs predominantly in tertiary care teaching centres. Such experiences reinforce the view on the part of new trainees that FPs have no place in the hospital.

To increase their exposure to FP role models in hospital, medical students and residents need to spend sufficient time working with FPs in non-teaching hospitals in smaller communities. In addition to recognizing the important roles of FPs in teaching hospitals, academic institutions must support and recognize the contribution of FPs who teach medical students and residents in non-academic settings. Some ways to achieve this include promoting extra training for FP teachers, financial assistance for continuing professional development, and suitable locum coverage for time away from their practices. These incentives would promote better understanding and respect for the roles of FPs in hospital.

Family practice-based rotations in hospital medicine may also expose residents to the downside of hospital practice. For instance, family practice residents left alone to attend large numbers of difficult orphan patients experience one of the most stressful and least attractive aspects of hospital practice. This may inadvertently discourage residents from continuing to practice inpatient hospital care after they complete their training.

Recommendations:

5. **The role of family physicians in hospital should be augmented in all medical schools, ensuring family physician role models for all medical students, family practice residents and specialty residents.**

6. **All family practice residency programs should include training in hospitals with family physician role models, as a condition for full program accreditation.**

7. **The CFPC's accreditation standards should require all family medicine programs to provide family medicine residents with the opportunity to acquire the acute care skills needed for both rural and urban inpatient hospital care.**

8. **Medical schools and university departments of family medicine should offer enhanced skills training and accredited CME/CPD programs in areas related to in-hospital care for family medicine residents and practicing family physicians.**

2.8 The Hospitalist Model

The hospitalist model is being used increasingly in numerous centres in the United States (Chapman, 1998) and several centres in Canada. The Agency for Health Care Policy Research (AHCPR, 1999) in the USA has defined hospitalists as "*a dedicated group of specialists in inpatient medicine in place of patients' outpatient or primary care doctor [having a responsibility] to manage care while the patient is hospitalized."*[38] In Canada a mix of family doctors and specialists is carrying out the hospitalist's role. Many hospitalist programs have been developed to address recent increases in orphan patients.

Study participants from a variety of settings in Canada described a general exodus of FPs from hospital care. At the Royal Alexandra Hospital in Edmonton, Alberta, the number of FPs with active hospital practices declined by more than 50% in recent years. The Calgary Regional Hospital and the Winnipeg Hospital Authority have both witnessed large declines in their roster of active FPs and have developed hospitalist models to fill the gap. At Grand River Hospital in Kitchener, Ontario, between 1996 and 1998 FPs were resigning their hospital privileges, not one at a time but together as community call groups, resulting in substantial increases in the number of "no-doctor patients" being admitted without a FP on staff. The result was that the hospital administration and Medical Advisory Committee began to explore the use of 24/7 inpatient hospital care by on-site practicing FPs from the department of family medicine. This model of care for inpatients was similar to that now used in many hospitals, drawing on FPs practicing in the community.

At a June 2001 *Insight* conference in Toronto, several hospitals presented the unique aspects of their hospitalist models: William Osler Health Care in Brampton, Ontario; Calgary Regional Health Authority, Calgary, Alberta; Timmins and District Hospital, Timmins, Ontario; Halton Health Care Services, Oakville, Ontario; St. Thomas- Elgin General Hospital, St. Thomas, Ontario; and Hotel-Dieu Grace Hospital, Windsor, Ontario.

The impact of the hospitalist model on patient care and on the role of FPs in hospital requires ongoing study. There is some evidence to suggest that in instances where hospitals had experienced a series of FP resignations over orphan patient issues, there were no further resignations after a hospitalist model was introduced. However, FPs who had resigned did not return to hospital staff.

Canadian institutions that have adopted the hospitalist model offer some insight into the level of remuneration necessary to attract physicians to hospital practice. Such hospitalists typically pay $300-500 for 24 hours of coverage or $50-100 per patient in addition to regular billings to the provincial insurance plan for daily hospital visits. These funds often come from the hospital's global and supplement fee-for-service billings by hospitalists.

[38] Agency for Health Care Policy Research Newsletter, March 1999.

The Calgary Regional Hospital Authority is using different hospitalist models in both the downtown area and community hospitals. The implementation of these models has been successful in halting the exodus of FPs from acute care. FPs are involved in the development and implementation of both models. In the community model (two sites), FPs in private practice sign on for 12-hour in-hospital shifts, follow their patients in hospital and take their skills back to their community practices where they continue to see their patients. These FPs are well regarded, work as team members, and are developing common standards for inpatient hospital care. This model is particularly promising as a way to uphold the principles of family medicine. Calgary's hospitalist program provides continuing medical education and according to program coordinators, is rejuvenating family practice in the area. This example demonstrates that a pro-active and productive way of addressing the problem of orphan patients is to involve FPs in the development of inpatient hospital solutions.

Several family physicians provided equally positive input on how local family physicians, acting as hospitalists on a rotating basis, have helped alleviate difficult situations in their community hospitals. The critical success factor in these instances is clear communication and coordination of care between hospitalists and the patient's own family physician during hospitalization and on discharge to ensure the continuity of patient care.

Some of the potential benefits of the hospitalists approach identified in the literature include:

- More rapid response to test results or changes in the patient's condition
- Better hospital utilization
- More timely decision-making
- Improved ability to address complex medical problems

Challenges to this approach include the potential to:

- Interrupt the continuity of patient care
- Lose the patient's own personal FP as his or her advocate
- Lose opportunities for practice-based FPs to improve their medical knowledge
- Separate family medicine from the hospitalist's role
- Increase the burden on credentialed FPs who are expected to be as involved in hospital activities as hospitalists who work solely in the hospital setting
- Increase the impact on hospitalist budgets

The CFPC recognizes that hospitals are required to find effective solutions to an acute shortage of FPs providing care to in-hospital patients. However, there is concern about the related impact of the hospitalist model on the availability of sufficient numbers of FPs to care for patients in the community. This is especially true as both rural and urban communities throughout Canada continue to experience serious shortages of available FPs.

In many communities, full-time and/or part-time FPs have been successfully integrated into multidisciplinary teams that support the hospitalist model, thus preserving the continuity and coordination of care for patients in and out of hospital. When a hospital decides to create a hospitalists model to alleviate a critical situation, it is imperative that these factors are at the center of its plans and that hospitalists are supported by and integrated within a multidisciplinary team that includes community family physicians. In some successful models, a designated coordinator has been employed to facilitate communication for patient care provided by hospitalists and FPs.

Recommendations:

9. Where hospitalists are required:

- **A. Hospitals should actively encourage and welcome family physicians to maintain their privileges and care for their own hospitalized patients.**
- **B. Family physicians who choose to work as hospitalists should be encouraged to practice in the community and to work as hospitalists proportionate to their available practice time.**
- **C. Both hospitalists and community family physicians should be supported and welcomed as members of multidisciplinary patient care teams.**
- **D. Consideration should be given to the role of a hospital coordinator whose responsibility is to ensure appropriate liaison between community family physicians and hospitalists.**
- **E. Hospitalists should be a CME/CPD resource for family physicians seeking further education in inpatient hospital care.**

3.0 The Goal: Family Physicians Involved In Hospital Care

3.1 Continuity of Care

Study participants noted that they and their patients derived many benefits from their involvement in inpatient hospital care.

Continuity of patient care is one of the main benefits of FP involvement in inpatient hospital care. FPs who see their patients regularly in the office are already aware of their patients' medical histories, findings and responses to treatment. Participation in hospital care is particularly important in discharge planning. The physician's prior knowledge of the patient's network of social, family and community supports helps to gauge what resources are necessary when the patient returns to the community. Furthermore, knowledge of the patient's course in hospital is an asset to patient care after discharge.

There is a considerable body of literature that supports the view that continuity of care enhances outcome. Most Canadians believe it is important to be treated by a doctor who knows them well (Decima, 1993). Patient satisfaction is higher if the patient sees the same doctor for each visit (Weyrauch, 1996). In addition, longer ties with one FP may decrease the likelihood of hospitalization (Weiss, 1996).

Calam and Thornsteinson summarized the benefits of FP involvement in inpatient hospital care in an editorial in *Canadian Family Physician* (May 2001):

"*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 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.*"[39]

3.2 Coordination of Care

Closely related to continuity of patient care is coordination of care. In an increasingly multidisciplinary environment, FPs play key roles by arranging referrals and consultations with a variety of health care providers. If the FP is not involved in hospital care, patients may be referred to other providers who duplicate services that have already been provided out of hospital. The result is an increased and sometimes unnecessary use of hospital resources, thus adding significant costs to inpatient hospital services.

[39] Calam B, Thorsteinson J. Hospital care by family physicians: exodus or opportunity. *Can Fam Physician* 2001;47:925-7.

Coordination of care by FPs goes beyond service delivery and includes the coordination of information shared between patients and their families, between families and care providers, and between patients, families and hospital administrators. FPs may also facilitate discharge planning and follow-up visits with hospital-based providers. Having FPs oversee pre-, during and post-inpatient hospital care enhances the expected outcomes and quality of the overall hospital experience for patients and their families.

3.3 Efficient Use of Resources

Since FPs are aware of the patient's history, medication profile, drug allergies, investigations, and previous consultations, they are in an ideal position to manage the patient's use of effective hospital and health care resources. They can avoid duplication of laboratory and diagnostic imaging investigations and consultations. Due to their extensive knowledge of the patient's condition, FPs can help other health care professionals to save time and effort in developing appropriate diagnostic and therapeutic plans for their patients.

Overall, the FP's ability to maintain the continuity of patient care, manage the coordination of care, and improve the efficient use of health care resources results in more cost-effective models of health care. This system approach to patient care facilitates the patient's flow through the continuum of care and patient care decision-making. Patients who do not have or cannot find a FP in the community present a challenge to the use of health care resources and should be encouraged, wherever possible, to find a FP who will oversee the continuity and coordination of their care.

Recognizing the pivotal importance of FPs in the health care system and the value FPs bring to inpatient hospital care could be one of the keys to attaining the economic goals of government legislators and health care policy advisors.

Recommendations:

10. **Upon discharge, patients should continue to be cared for by their own family physician. If they do not have a family physician, they should be supported in finding a community family physician for their ongoing care.**

11. **Inpatient hospital care should be considered an integral part of a patient's continuum of care that includes office-based care, home care, rehabilitation and long term care provided by interdisciplinary teams with family physicians in leadership and key caregiver roles.**

3.4 Patient Advocacy

As hospital restructuring continues and care becomes more complex and technologically advanced, the danger of fragmentation of patient care and the need for patient advocacy increase. An important role of FPs is to ensure respect for patients' rights and to intervene on their behalf when dealing with medical consultants, other health care providers, administrators, and government agencies. Although FPs have traditionally assumed this role in caring for patients, it has recently taken on new meaning and importance for hospital inpatients.

In its 1990 report on the *Role of the Family Physician in Hospitals,* the College of Family Physicians of Canada described the role of the family physician in patient advocacy:

"*The family physician involves the patients in decision-making, advises them of risks and benefits, interprets results and consultants' recommendations, protects his/her autonomy and helps him/her with difficult ethical decisions.*"[40]

In keeping with the principles of family medicine that emphasize the value of FPs as a resource to their patients, the role of FPs acting on behalf of their hospitalized patients has become more important than ever. FPs are in the best position to understand their patients' wishes and those of families or caregivers where in-hospital care planning and especially end-of-life care decisions are concerned.

3.5 Access to Specialists

Caring for in-hospital patients encourages FPs to develop better relations with their medical colleagues, including specialists. As well, through informal discussions with their colleagues during inpatient hospital rounds or more formal hospital CME/CPD sessions, FPs often learn about new or different aspects of care that are relevant to their patients and practices. This kind of interaction with colleagues enhances patient management and outcomes.

3.6 Maintenance of Skills

Managing higher acuity patients in hospital helps FPs to develop and maintain their medical knowledge and skills in areas of relevant interest to their practices. As patients are increasingly transferred more quickly from hospital to the community where FPs are then required to manage very sick patients without the same level of consultative support as in the hospital, it is especially important for FPs to take advantage of opportunities to maintain their acute care skills.

[40] Crookston D. The role of the family physician in hospitals. In: *The family physician as primary health care provider*. Mississauga, ON: The College of Family Physicians of Canada, 1993;33-40.

In return, family doctors have knowledge and skills to share with hospital-based specialists in understanding and appreciating the management of patients with acute and chronic illnesses in the community. Hospitals should be encouraged to pursue these interactions through opportunities related to continuing medical education, utilization management and quality improvement.

3.7 A Stimulating Environment

Solo practitioners with an exclusively office-based practice may be at risk of professional isolation whereas participation in hospital care adds to the rewards of family practice. Responding to the challenges of hospital medicine enhances the family physician's self-esteem. Working in a multidisciplinary collaborative environment where there is frequent exposure to hospitalized, acutely ill patients, is intellectually stimulating. It increases self-confidence and fosters mutual respect between health care professionals. The hospital milieu is an ideal setting for professional development and growth.

4.0 Conclusion: The Value of Family Physicians in Hospital

Public surveys continue to show that Canadians hold family physicians in high regard for the quality of care they provide. The 2001 Statistics Canada *Access to Health Care Services in Canada* reported that 80% of Canadian preferred to access care through their family physician and 92% believed the quality of care they received from their personal family doctor was good to excellent.[41] In a Decima survey commissioned by the CFPC in the fall of 2002 to explore the public perception of FP shortages, over 80% of Canadians rated the quality of care they received from their family doctors as good to excellent[42].

Patients have made their preferences known. They want their own FP involved in their care. This is especially important when they are admitted to an unfamiliar environment such as a hospital. In this setting, care options abound and most are too complex for the average patient to understand. Patients need their own FP to coordinate care, to help them make care decisions and when necessary, to advocate on their behalf.

In an editorial in *Canadian Family Physician* (October, 1999), Dr. Calvin Gutkin wrote:

"*Our health care system should be offering strong support for well-trained family physicians working collaboratively with consultant specialists to provide care to their hospitalized patients. Canadians deserve to have health care professionals who know them best – their family doctors – at their bedsides when they are admitted to Canada's hospitals.*"[43]

One of the best examples of the value and importance of FPs is their involvement in the continuity and coordination of care assured to their patients in hospital. This is applied most effectively when FPs combine their community office practices with the in-hospital care of their patients. Canadian family physicians interviewed in preparation for this discussion paper clearly identified other values such as better access for their patients to specialty care and improved opportunities to avoid unnecessary patient investigations. FPs also recognized the benefits to their own professional satisfaction, collegiality, skills and knowledge. Hospitals and regional health care systems benefit through a better use of limited resources, more appropriate access to health care providers, and happier patients.

If such benefits can be realized from the involvement of FPs in hospitals, why are the numbers dropping for inpatient care? It is apparent that FPs face numerous challenges in our Canadian hospital system, not the least of which is the achievement of a level of remuneration for inpatient hospital care comparable to that for office-based care. Although family practice training that includes inpatient hospital care seems to have met the needs of our participants' career experiences, FPs also need the professional support that comes with respect and recognition from their specialty colleagues.

[41] Statistics Canada. Access to Health Care Services in Canada, 2001. Ottawa May 2002
[42] Decima Survey, October 2002
[43] Gutkin C. Family physicians and hospitals. Vital Signs, *Can Fam Physician* 1999;45:2470.

At the end of the day, when work pressures and stress seem their greatest, it is the combination of good patient care and collegial relations that produces professional satisfaction.

Solutions to the challenges confronting family doctors, hospitals and patients include many factors. These challenges cannot be addressed overnight. For starters, our system must address the overriding problem of inadequate physician supply that is having a significant impact on the practice patterns of both specialists and FPs.

Should community practice FPs continue to be involved in hospital care or should this task be given to hospitalists? In our interviews, there was nearly unanimous agreement that family practice should include inpatient hospital care. However, it is recognized that various pressures on hospitals have precipitated the development of other models such as those that employ hospitalists and when appropriate, the most ideal would be to integrate hospitalists and FPs into multidisciplinary care teams that support patient care. As noted in this paper, there is a limited amount of research that evaluates the importance of family physicians providing inpatient hospital care in Canada. Health care leaders, policy and decision makers need more information on the qualitative and quantitative benefits of family physicians remaining involved in the care of their patients in hospital.

Some of the recommendations contained in this discussion paper suggest the strengthening of old models of inpatient hospital care by family doctors. Others suggest newer approaches. What is clear is that current changes in health care threaten to totally exclude family physicians from hospitals and may not in the best interests of patients. Family physicians should be encouraged to make inpatient care an important part of their practices. The value of this to patients is significant and patients experience this by having their family doctors at their bedsides.

Recommendations:

12. **More research, both qualitative and quantitative, should be conducted to evaluate the involvement of family physicians in inpatient hospital care in Canada.**

13. **The CFPC should promote the importance of family physician involvement in inpatient hospital care to the public, hospitals, medical schools, governments, and all other stakeholders in the Canadian health care system.**

Recommendations

1. **To improve the continuity and coordination of patient care:**
   - **A. Hospitalized patients should have their own family physician participating in their hospital care whenever possible.**
   - **B. Appropriate communication should be maintained by hospitals with family physicians in the community, including timely notification of their patients' hospital admissions, progress and discharges.**

2. **To improve the continuity and coordination of patient care:**
   - **A. All hospitals should have privileging criteria that recognize and support the role of family physicians in caring for their patients in hospital.**
   - **B. Family physicians should be permitted and encouraged to apply to any hospital in their community for medical staff privileges, enabling them to carry out appropriate roles in the care of their hospitalized patients.**
   - **C. Family physicians should be represented in the development of hospital policies that affect their patients.**

3. **Family physicians should organize themselves into networks or groups of an appropriate size to share the responsibilities and workload of managing hospital inpatients.**

4. **Appropriate remuneration and/or incentives for all hospital responsibilities should be available to family physicians to support their ongoing involvement in inpatient hospital care.**

5. **The role of family physicians in hospital should be augmented in all medical schools, ensuring family physician role models for all medical students, family practice residents and specialty residents.**

6. **All family practice residency programs should include training in hospitals with family physician role models, as a condition for full program accreditation.**

7. **The CFPC's accreditation standards should require all family medicine programs to provide family medicine residents with the opportunity to acquire the acute care skills needed for both rural and urban inpatient hospital care.**

8. **Medical schools and university departments of family medicine should offer enhanced skills training and accredited CME/CPD programs in areas related to in-hospital care for family medicine residents and practicing family physicians.**

Recommendations

9. **Where hospitalists are required:**
   - A. **Hospitals should actively encourage and welcome family physicians to maintain their privileges and care for their own hospitalized patients.**
   - B. **Family physicians who choose to work as hospitalists should be encouraged to practice in the community and to work as hospitalists proportionate to their available practice time.**
   - C. **Both hospitalists and community family physicians should be supported and welcomed as members of multidisciplinary patient care teams.**
   - D. **Consideration should be given to the role of a hospital coordinator whose responsibility is to ensure appropriate liaison between community family physicians and hospitalists.**
   - E. **Hospitalists should be a CME/CPD resource for family physicians seeking further education in inpatient hospital care.**

10. **Upon discharge, patients should continue to be cared for by their own family physician. If they do not have a family physician, they should be supported in finding a community family physician for their ongoing care.**

11. **Inpatient hospital care should be considered an integral part of a patient's continuum of care that includes office-based care, home care, rehabilitation and long term care provided by interdisciplinary teams with family physicians in leadership and key caregiver roles.**

12. **More research, both qualitative and quantitative, should be conducted to evaluate the involvement of family physicians in inpatient hospital care in Canada.**

13. **The CFPC should promote the importance of family physician involvement in inpatient hospital care to the public, hospitals, medical schools, governments, and all other stakeholders in the Canadian health care system.**

Appendix A:

2001 National Family Physician Workforce Survey Data

Table 1

FP Involvement in Emergency Room and Hospital Inpatient Unit/Ward by Province

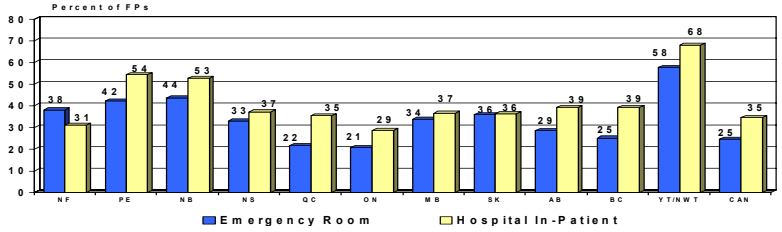


Table 2

FP Involvement in Emergency Room Hospital and Inpatient Unit/Ward As Main Practice Setting by Province

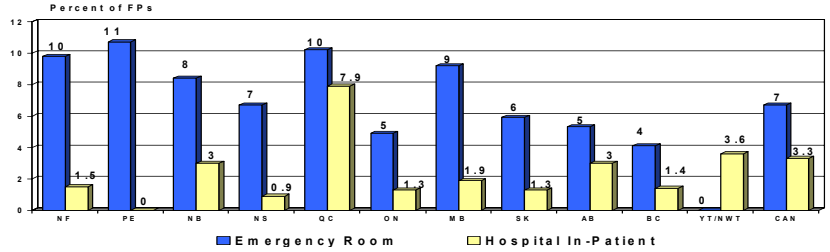


Table 3

FP Involvement in Emergency Room and Hospital Inpatient Unit/Ward by Age

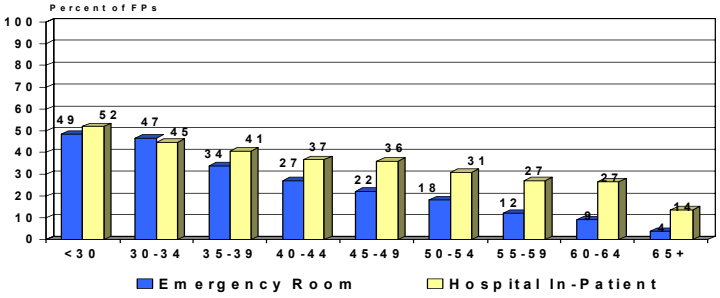


Table 4

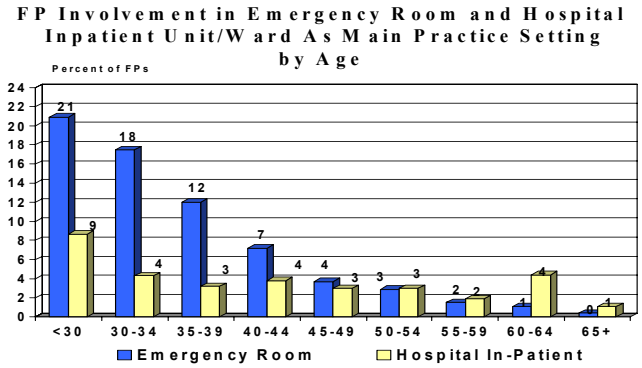


Table 5

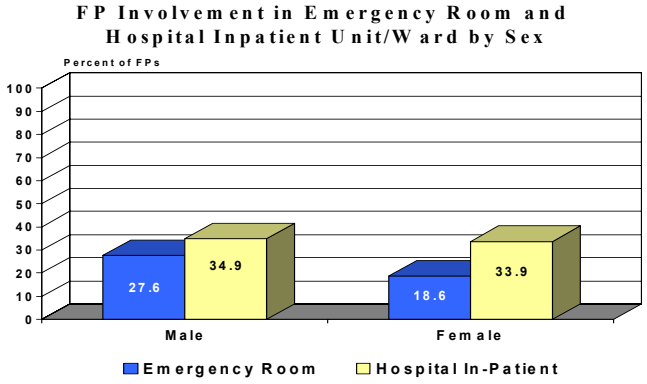


Table 6

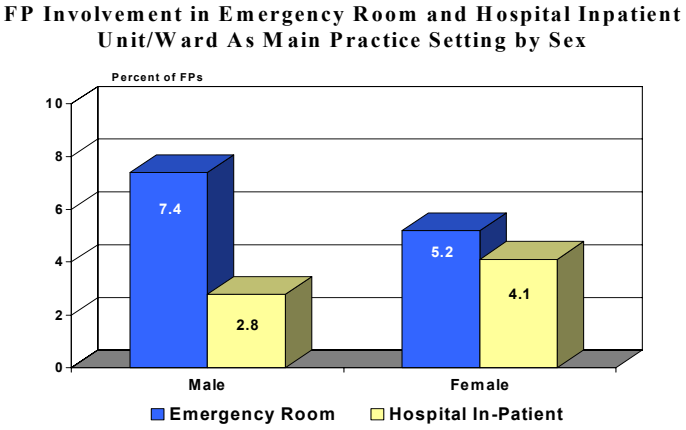


Table 7

FP Involvement in Emergency Room and Inpatient Unit/Ward by Primary Population Served

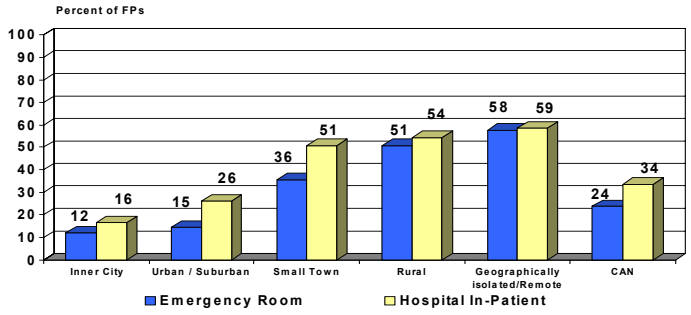


Table 8

FP Involvement in Emergency Room and Hospital Inpatient Unit/Ward As Main Practice Setting by Primary Population Served

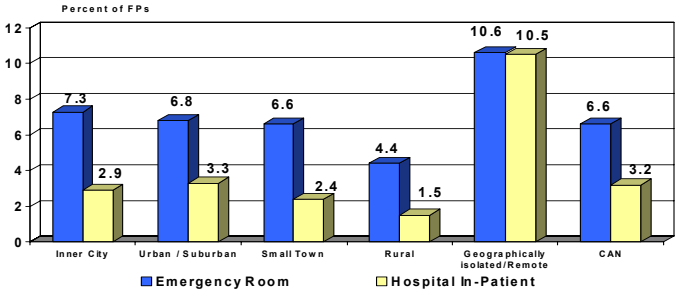
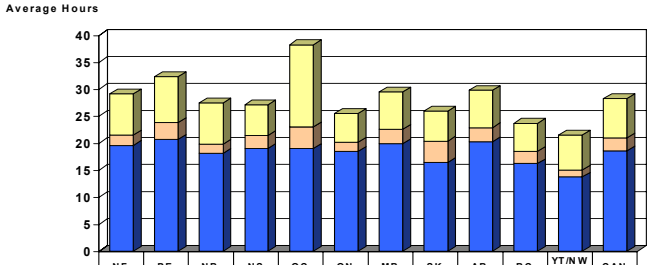


Table 9

Average Regularly Scheduled Weekly Work Hours Spent in Various Hospital Settings by Province

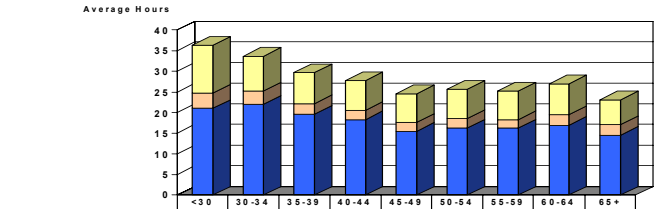


	NF	PE	NB	NS	QC	ON	MB	SK	AB	BC	YT/NWT	CAN
Hospital In-Patient	7.6	8.6	7.6	5.6	15.2	5.3	6.9	5.6	6.9	5.2	6.5	7.3
ER manage own Patient	2	3	1.7	2.4	4	1.7	2.6	3.9	2.6	2.2	1.3	2.4
ER MD on Duty	19.5	20.7	18.1	19	19	18.4	19.9	16.4	20.2	16.2	13.7	18.5

2001 National Family Physician Workforce Survey Data

Table 10

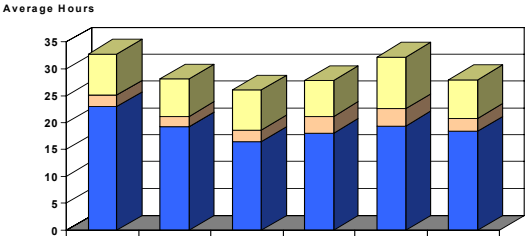
Average Regularly Scheduled Weekly Work Hours Spent in Various Hospital Settings by Age Cohorts



	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Hospital In-Patient	11.6	8.4	7.5	7.2	6.9	7.1	6.9	7.4	6
ER manage own Patient	3.7	3.2	2.6	2.2	2.1	2.3	2.1	2.6	2.6
ER MD on Duty	21	22	19.6	18.3	15.5	16.2	16.2	16.9	14.5

Table 11

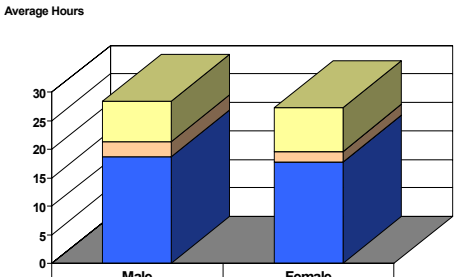
Average Regularly Scheduled Weekly Work Hours Spent in Various Hospital Settings by Primary Population Served



	Inner City	Urban / Suburban	Small Town	Rural	Geographically Isolated / Remote	CAN
Hospital In-Patient	7.7	6.9	7.5	6.7	9.6	7.2
ER manage own Patient	2.1	2	2.1	3.2	3.2	2.4
ER MD on Duty	23	19.2	16.5	18	19.4	18.4

Table 12

Average Regularly Scheduled Weekly Work Hours Spent in Various Hospital Settings by Sex



	Male	Female
Hospital In-Patient	7.2	7.6
ER manage own Patient	2.6	1.9
ER MD on Duty	18.7	17.8

Table 13

FP Satisfaction Ratings for Relationship with Hospital

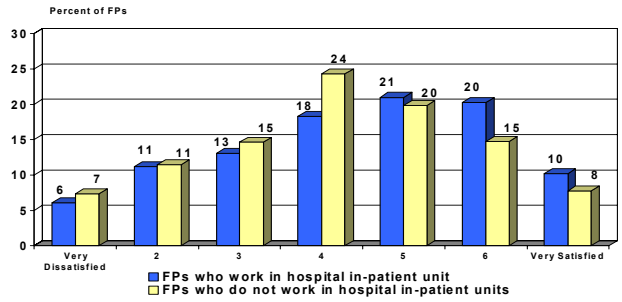


Table 14

Percent of FPs Who Coordinate the Health Care of Regular and/or Other Patients by Main Practice Setting

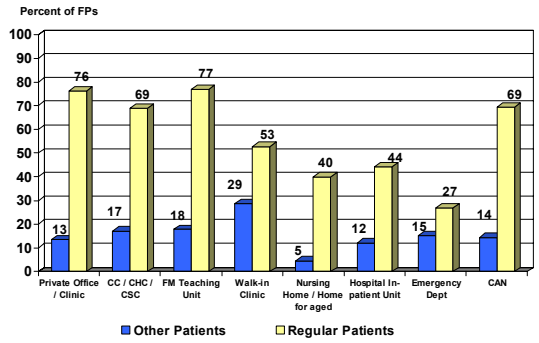
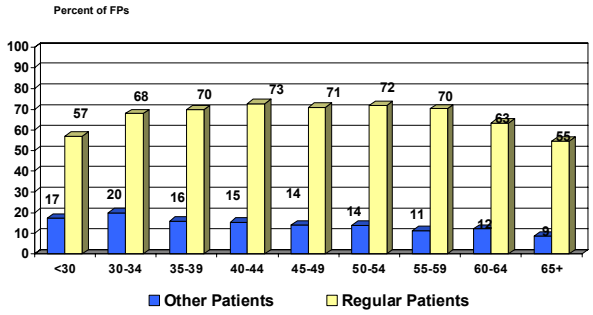


Table 15

Percent of FPs Who Coordinate the Health Care of Regular and/or Other Patients by Age Cohort



Appendix B: Survey Grid for Semi-Structured Interviews

This grid served as a guide only. Different areas of the grid could be explored in detail, depending on the experience and perspective of the interviewee. No restrictions were placed on the questions in the grid if the interviewee wanted to expand on a point.

Questions

1. What type of setting do you practice in?

2A. In your practice setting, what is the range of roles of FPs involved in inpatient care in acute care hospitals?

2B. What is the benefit of family physician involvement in hospital care?

2C. What are the downsides of family physician involvement in hospital care?

2D. What are the limits of family physician involvement in hospital care?

3.A What are the barriers to family physician involvement in hospital care?

Ask first as opened-ended questions, then prompt on the following:

- financial (ask what the fee for hospital care is locally C002)
- parking, cost of maintaining privileges
- no economies of scale (e.g., go in to see two patients)
- opportunity cost of seeing patients in hospital
- access to admitting privileges
- credentialing
- demands of active staff involvement (e.g. committee work)
- lack of training
- lifestyle
- lack of confidence in high tech environment
- burnout
- hospital restructuring
- perceived hostility of other members of medical staff

3B. Do family physicians want to play a more active role but can't, or do they not want the role at all?

4. New models of primary care physician participation?

Ask first as open-ended questions, then prompt on the following:

- hospitalist model
- quasi-specializations
- impact of information technology (e.g., smart cards with electronic health record, instantaneous information transfer between the offices of FPs and other care providers)

5. What level of participation in FP care should the CFPC be encouraging?

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