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Hospitalists

I agree with Dr Samoil that hospitalists improve hospital care.[1] In Cambridge, Ont (population 125 000), in 2000, we had 55 FPs overseeing 60 patients in the medical ward. This was inefficient. Eighty percent of those FPs resigned and we got hospitalists, who have done a wonderful job. Our FPs still take calls for the hospitalists and are encouraged to see their own patients if they want, and 20% still do.

It's important to note that, in 2000, Ontario FPs were being paid $17 per hospital visit. When you think that half goes to overhead and half of what's left goes to taxes, we were getting $5 for the sickest patients in our practice and had to pay $500 per year to park! Also, we were being forced to take on orphan patients whom we had looked after in-hospital at our practices, in spite of being way over our comfort level.

So you can see why busy FPs get out of hospital work. As one older FP said to me, "the hospital gives me 2% of my pay and 98% of my problems."

—John W. Crosby, MD CCFP(EM) FRCPC
Cambridge, Ont

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Open dialogue

I found the debate on hospitalists[1,2] interesting. Unfortunately, it is a rather irrelevant issue for those of us practising in urban areas. Family physicians have not been looking after inpatients at my community hospital for years and I do not see that changing in the future.

A more relevant issue for me and others in my community is the lack of communication between physicians with respect to our hospitalized patients. I was hoping that having hospitalists who were also family physicians would improve this situation. Unfortunately, at my hospital,

I do not receive telephone calls from hospitalists to share information about our joint patients. We family physicians, who know our patients best, are rarely, if ever, contacted to discuss issues of concern. For example, I had an elderly dysphasic patient admitted to our hospital several months ago. She underwent numerous unnecessary tests, which proved unhelpful. As the patient was unable to provide a good history, it would have made sense to call me for background information. I would have informed the attending hospitalist of the chronicity of her problems and saved the patient from undergoing those tests.

Having family physician hospitalists can be advantageous, but only if they communicate with their community brethren.

—Joel D. Weinstein MD CCFP FCFP
North York, Ont

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Palliative care *is* a specialty

I have followed the correspondence over Dr Shadd's article on palliative care as a specialty.[1,2]

I am firmly of the opinion that any physician who engages in clinical activity involving patient contact should have the knowledge and skills to treat patients with potentially life-threatening illnesses. And I have no argument that the "cradle to grave" philosophy of family medicine should include palliative care.

At the same time, for the same reasons that cardiology and nephrology are relevant as specialties (actually, as subspecialties of internal medicine), it is important to have people who have immersed themselves in the minutiae of end-of-life care. These people can then be a resource for all physicians.

However, I would disagree with the suggestion that palliative medicine be a subspecialty of family medicine. Anyone with an interest in end-of-life care should be able to acquire the skills. The father of palliative care in Canada was trained as a urologist. In fact, the accredited training program is a joint venture of the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

As a non–family physician who practises palliative care, I think it is important to focus not on the pathway to reach the specialty, but on the skills that practitioners have to offer.

—Hershl D. Berman MD FRCPC
Toronto, Ont

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