A change of place and pace

Family physicians as hospitalists in Canada

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After I relocated from the Okanagan Valley to Victoria, BC, when my spouse was transferred, I paused to take stock and think about my career. At that juncture in my life I was ready to head in a new direction. After 2 decades of enjoying a very full, broad practice (running a private office, doing hospital work with emergency shifts and obstetrics, working in a nursing home, and providing extended care, along with teaching students and family medicine residents), I chose to alter my career slightly and become a hospitalist. Change is always challenging and this was not an "easy" change or an "easier" job. Frankly, I would never have predicted being so content in my new role.

The principles of family medicine

Running an office while doing obstetrics or geriatric nursing home work, being pulled in all directions, was not easy but it came with its own joys. I came to realize that hospitalists in Canada—who are first and foremost family physicians—recognize this fully and respect their colleagues who choose office practice, palliative care, or whatever fulfils them. Hospitalists, with their constantly changing groups of patients (who all need their own generalists to attend to their medical problems and coordinate and negotiate complex arrays of specialists and treatments), embrace and practise the ideals of the 4 principles of family medicine.[1] These 4 principles have guided my generation of family physicians when practising medicine and teaching students and residents[1]:

- The family physician is a skilled clinician.
- The patient-physician relationship is central to the role of the family physician.
- The family physician is a resource to a defined practice population.
- Family medicine is a community-based discipline.

In 2001, Dr Carol Herbert suggested a fifth principle—family physicians as advocates—which is also important.[2] Hospitalists and FPs alike advocate for their patients in a complex and often overwhelming system.

Since 1975, 2 grandfathers of family medicine have written articles on general practice with lasting remarks: Dr Gayle Stephens described the ability to manage patients as "the quintessential skill and area of knowledge unique to family physicians."[3] He distinguished management from treatment in that it was specific for each patient's circumstance. In 1985, Dr Lynn Carmichael made note of the limitless possibilities for family practice and pointed out that practices are more defined by their location and types of patients.[4] Having changed my locale and the focus of my practice, I can still attest to these claims.

Family physicians in hospitals

Many FPs practise family medicine that encompasses both office and hospital work. The amount of each varies with the needs of the community. When hospitalists first appeared as part of the fabric of medicine in Canada, many full-service family physicians—myself included—wondered why another layer of physicians was necessary. I remember feeling threatened by this perceived imposition. I now realize that feeling was unfounded.

Hospitalists have replaced many FPs who have voluntarily, for various reasons, relinquished their privileges to practice in hospitals. Hospital work has been a labour of love, even for those of us passionate about providing cradle-to-grave service to our communities. Although it is ideal for each hospitalized patient to have a personal family physician, this is not the reality today. While appreciating the benefits to patients, it is often difficult to justify the time spent traveling to several institutions to see only a few individuals. As hospitalists, we try to bridge this gap for some of the most disenfranchised and vulnerable Canadians. Many patients remain in-hospital for months, so there is opportunity to develop continuous relationships. Now, on-site at the hospital, I can provide the care that I always aspired to; I am not pulled away by too many competing interests.

In Victoria today, about 20 full-time hospitalists cover 2 tertiary care teaching hospitals. We have the benefit of being on-site for many hours while providing the family medicine (generalist) approach to care. As a team of physicians, we are able to quickly assess patients who become acutely ill. On-call coverage is built into the hours that we work. With the advantage of having time to adequately deal with multiple medical problems, we can often review test results within hours of their completion and facilitate earlier treatment and discharges—impossible for office-based physicians. Without such a service, many patients would be in-hospital without any single physician willing and able to oversee their care as the "Most Responsible Physician." Hospitalists care for most of the admitted patients, consulting our specialist colleagues as needed, allowing this system of best practices to function.

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Teamwork

I believe that the presence of family physician hospitalists will not close the door to community family physicians interested in returning to hospital work. There are still many orphaned patients. There are still ways for all of us to work together as a team to ensure the best care for patients. Office-based FPs are valuable resources because they have deeper knowledge about patients in their practices who might be admitted. Hospitalists, with their training, experience, and skills developed in the hospital's high-intensity environment, are similarly easily transferred back into various rural and urban community settings. This type of practice does not drain the Canadian public of family doctors, as service to our communities remains.

Even if there were specialists enough to provide the service of "Most Responsible Physician" for all patients in-hospital, I am not certain that this would be in the best interest of our patients. The patient-centred approach, which has worked well in our office practices, shines in this acute care setting. We are trained to manage patients against the backdrop of their families and communities, as well as to care for multiple concurrent medical problems that often affect one another. A specialist's approach of concentrating on one anatomic or physiologic system results in focused care but often leaves other areas or systems inadequately addressed. The position, therefore, of embracing a group of FPs who are prepared to focus their practices, but who also feel kinship with the generalized knowledge and approach of family physicians, is a strong position of advocacy for the best care of patients. An acquaintance of mine said to me 20 years ago: "I wouldn't be caught dead in hospital without a family doctor—it doesn't have to be mine, but it should be a physician who thinks like mine does, because, if I don't have this, I'll be caught dead." She did not speak lightly; I became involved in her case when she almost died on a surgical floor while her own FP was out of town.

Evolution of family medicine

Family physicians are poised to have considerable influence in this arena of medicine—the hospital. We are generalists by definition, with a broad skill set and experience coordinating care between specialists and various health care team members. Hospitalists have gradually developed a reputation within Canadian hospitals as capable physicians providing excellent and personable care. As a hospitalist, I call upon all of my skills developed over the years, as well as some new ones, in order to provide this valued service. Hospitalists have improved the reputation of family medicine from the perspective of many groups, including patients, allied health care members, specialists, administrators, and medical students and residents. We now have an operating currency—respect—something that few FPs have felt outside of our offices throughout our careers. We have attained this respect because we have rearranged our practices, and our lives, to function as a team onsite, available 24 hours a day, 7 days a week, all year round. Our schedules reflect our commitment to the philosophy of continuity of care; this is best for the patient.

When I taught residents or medical students who had not yet decided on a career choice, I always emphasized the lifetime flexibility of family medicine. I believe that this is a unique vocation in that your imagination is your only limit. It is portable, and it is possible to broaden and challenge your style and scope of practice over time, a beautiful and unique part of family medicine. Now I hear less about *just* doing family medicine (as opposed to another specialty). Part of this change is due to students and residents finally seeing family medicine as a career that gives them control, choice, and respect.

The reality of modern-day hospital medicine is different today than it was when many of us began practising. It was different when the old country doctors of Norman Rockwell vintage did "everything." We have all evolved. Patients and nursing staff expect and deserve the most timely and best care available. Family physicians are no longer able (especially in urban areas) to provide the necessary level of care on a part-time basis, as it was before when squeezed alongside all of their other responsibilities. Hospitals' financial considerations and restricted bed numbers have pushed for quicker attention to facilitate earlier treatment and discharge. If we were the patients or their families, we would expect no less.

I believe family medicine is a sustainable, satisfying, and well-respected career choice in medicine that is able to deliver high-quality medical care to our patient population. Let us ensure that a strong and competent presence of family physicians—either in offices or in hospitals—providing continuity of care continues in communities across the nation.

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Competing interests

None declared

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