Rebuttal: Are inpatients' needs better served by hospitalists than by their family doctors?

YES

Darryl Samoil MD CCFP(EM) FCFP

It seems that Dr Wilson's arguments against hospitalists have little to do with serving inpatient needs and more to do with the reform and rebuilding of the primary care system. He readily admits that hiring the "best-of-the-best ... most competent, experienced, and efficient" in-house doctors reduces tensions on the system and improves the inpatient experience. He laments the loss of these physicians from the community and the missed opportunities for continuing professional development of those who decide to excuse themselves from inpatient care. Increasingly complex inpatients and the urbanization of society have made it more difficult for traditional FPs to provide all aspects of care to all of their patients all of the time. Society is changing and the system itself needs to change in order to adapt. Family physicians working as hospitalists do provide better care for inpatients; physicians need to start rebuilding the primary care system by first being champions of this improved patient care. Computer technology makes it possible for community physicians to follow their patients' courses in hospital. Fee structure changes have allowed community physicians without hospital privileges to visit their patients in hospital, providing the rapport and trust needed to communicate patients' values and priorities to inpatient physician team. These changes will "defragment" and improve patients' transition from hospital to home, reducing the need for future hospitalizations. By working together, community FPs and hospitalist FPs will help preserve and strengthen the doctor-patient relationship. Now is not the time to argue against change that provides better patient care—we must embrace it and improve upon it to forge a better future for our health care system and everyone it serves.

Dr Samoil *is the Medical Director of the Fraser Health Authority Hospitalist Program in Langley, BC.*

Competing interests

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Cet article se trouve aussi en français à la **page 1229.**

NO

Galt Wilson MD MSc FCFP

I have argued that hospitalist programs were developed to ease the strain on hospitals and doctors. Dr Samoil seems to concede as much. He cites traffic, paperwork, inpatient-averse locums, efficiency protocols, and committee meetings as reasons—they are important concerns, but at some remove from the bedside. He concludes by declaring that "there is a substantial advantage *to the inpatient system* [my emphasis] because of hospitalist care."

I'm pleased for the system, but what happens when those patients go home? The corollary to hospitalist recruits becoming acute care experts, unfortunately, is skill atrophy on the part of those who no longer come in. In most industrialized countries community GPs were long ago excluded from the hospital. My colleagues from the United Kingdom tell me their daily interaction with consultants in their local hospitals has made them better doctors. General practitioners from France to New Zealand poignantly describe being regarded as marginal participants. Will that be our fate? What a needless, tragic loss for our patients and our professional selves.

As Dr Samoil correctly suggests, when family doctors resigned their privileges in large numbers something had to be done. Providing inpatient primary care in isolation was one option. A healthier alternative, in my respectful submission, would be to effectively address the concerns that drove GPs away with a view to bringing them back. In several communities in British Columbia, serious discussions in this regard are already under way. My colleagues and I will do what we can to help these succeed, for the sake of a more robust vision for primary care than simply optimizing the "inpatient system."

Dr Wilson *is a Clinical Professor in the Department of Family Practice at the University of British Columbia in Vancouver and Clinical Clerkship Director at the Northern Medical Program of British Columbia.*

Competing interests

None declared

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These rebuttals are responses from the authors of the debates in the August issue (*Can Fam Physician* 2008;54:1100-3).