6. Hser YI, Saxon AJ, Huang D, Hasson A, Thomas C, Hillhouse M, et al. Treatment retention among patients randomized to buprenorphine/naloxone compared to methadone in a multi-site trial. *Addiction* 2014;109(1):79-87. Epub 2013 Oct 9.
7. Potter JS, Marino EN, Hillhouse MP, Nielsen S, Wiest K, Canamar CP, et al. Buprenorphine/naloxone and methadone maintenance treatment outcomes for opioid analgesic, heroin, and combined users: Findings from Starting Treatment with Agonist Replacement Therapies (START). *J Stud Alcohol Drugs* 2013;74(4):605-13.
8. Johnson RE, Chutuape MA, Strain EC, Walsh SL, Stitzer ML, Bigelow GE. A comparison of levomethadyl acetate, buprenorphine, and methadone for opioid dependence. *N Engl J Med* 2000;343(18):1290-7.
9. Strain EC, Stitzer ML, Liebson IA, Bigelow GE. Comparison of buprenorphine and methadone in the treatment of opioid dependence. *Am J Psychiatry* 1994;151(7):1025-30.
10. Bell J, Trinh L, Butler B, Randall D, Rubin G. Comparing retention in treatment and mortality in people after initial entry to methadone and buprenorphine treatment. *Addiction* 2009;104(7):1193-200.
11. Fischer G, Gombas W, Eder H, Jagsch R, Peternell A, Stühlinger G, et al. Buprenorphine versus methadone maintenance for the treatment of opioid dependence. *Addiction* 1999;94(9):1337-47.
12. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev* 2014;6(2):CD002207.
13. British Columbia Centre on Substance Use. *A guideline for the clinical management of opioid use disorder*. Vancouver, BC: British Columbia Ministry of Health; 2017. Available from: **www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_oud_guidelines.pdf**. Accessed 2017 Jun 2.
14. Earnshaw V, Smith L, Copenhaver M. Drug addiction stigma in the context of methadone maintenance therapy: an investigation into understudied sources of stigma. *Int J Ment Health Addict* 2014;11(1):110-22.
15. Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ* 2017;357:j1550.
16. Teruya C, Schwartz RP, Mitchell SG, Hasson AL, Thomas C, Buoncristiani SH, et al. Patient perspectives on buprenorphine/naloxone: a qualitative study of retention during the Starting Treatment with Agonist Replacement Therapies (START) study. *J Psychoactive Drugs* 2014;46(5):412-26.

Hospitalists reduce harm and improve care for hospitalized patients

Dr Ladouceur's editorial in the April 2017 issue of *Canadian Family Physician*[1] is the latest in a long series of the journal's commentaries[2-4] in which the authors nostalgically reminisce about a bygone era when family doctors did everything and "comprehensive family practice" was the norm. A common thread among these editorials is the assertion that the traditional family practice model is the criterion standard and the progressive subspecialization of family doctors and the emergence of areas of focused practice is a perversion of family medicine. Interestingly, other than personal anecdotes and nostalgic references to the past, no actual evidence is provided by the authors that the quality of care delivered by family doctors during this presumed "golden era" was actually better than what is currently being provided by more focused general practitioners.

Ladouceur's April editorial,[1] however, is particularly disturbing on a number of levels. First, it is simply not true that hospitalist care is associated with increased harm levels for patients. In fact, an increasing body of Canadian evidence suggests the opposite. In an analysis of more than 30 000 patients admitted to the hospitalist program in a large community hospital in Ontario,[5] Chong and I found that compared with traditional family physicians, hospitalist care was associated with a 12% to 75% reduction in mortality odds. Our study of course had a number of limitations, particularly that it was limited to 1 particular institution. Since that study, White has demonstrated that hospitalists in Ontario statistically significantly reduce the odds of mortality for patients admitted with 4 common conditions (delirium, pneumonia, congestive heart failure, and chronic obstructive pulmonary disease) by 7% to 31%.[6] White's study used a robust methodology to look at care outcomes for more than 55 000 patients admitted to 151 hospitals in Ontario. Both studies, as well as a number of others,[7,8] have also shown similar reductions in readmission rates when hospitalists are involved. These studies certainly raise a number of questions: Should community-based family physicians with low volumes of inpatients be allowed to continue working in hospitals? Are family physicians who continue to maintain a broad practice able to maintain the competencies required to provide inpatient care?

The second reason why Dr Ladouceur's article[1] is upsetting is that physicians with family medicine training continue to comprise most hospitalists in Canada.[9] While the growing number of internists who are now working as hospitalists[10] is helping the specialty to evolve, hospital medicine in Canada continues to maintain strong ties with the family medicine community.[11] At the Regional Department of Hospital Medicine at Fraser Health Authority in British Columbia where I practise, 95% of more than 300 individuals in the Department of Hospital Medicine have Certification in Family Medicine, and many of the Divisions of Family Practice in British Columbia are making efforts to strengthen their ties to hospitalists in their local communities. Results of the 2012 National Hospital Medicine Survey also showed that most respondents had more than 10 years of experience in clinical practice, with many having spent years practising community-based family medicine before making a career change to focus on hospitalist work. Undermining the quality of the work of hospitalists also brings into question the ability of the family medicine establishment to train qualified individuals to do the kind of inpatient care that hospitalists engage in.

Finally, using a study of residents and interns in the United States (with all the limitations that Dr Ladouceur himself outlines)[1] and somehow tying that to hospitalists in Canada and concluding that their care might result in more harm for patients is a rather large leap that is reminiscent of the acrobatics observed in a Cirque du Soleil theatre! The suggestion that being a hospitalist is no different than being a medical trainee is insulting to the many thousands of experienced, highly skilled individuals who work under extremely stressful circumstances to look after an increasingly complex and multimorbid hospitalized patient population.

The nostalgia expressed by Dr Ladouceur and many others about family medicine's past fails to recognize the reality that the era of comprehensive family medicine is long gone. Apart from a small number of family physicians who work in rural areas, most primary care doctors who practise in urban areas (where more

than 80% of Canadians live) no longer practise comprehensive "cradle-to-grave" family practice. The traditional model of the general practitioner who knew a little about a lot of things and who provided a range of services worked well in the 19th and 20th centuries when medicine was simple and treatment options were limited—when the entire care team in a hospital comprised only a few nurses and physicians and there were no such things as computed tomography scanners or respiratory therapists (or any of the long list of health care professionals currently working in the acute care setting). The evidence for the demise of this model has been mounting over the past 20 years, with many studies conclusively demonstrating a progressive erosion in the scope of family physicians,[12] considerable attitudinal changes among the new generation of family doctors about the role of hospital care in their careers,[13] and changing perceptions of the importance of work-life balance and career expectations.[14]

At the same time, Canadian hospitalists have been filling the gaps in inpatient care that resulted from the voluntary mass migration of family doctors out of acute care settings, with better quality results[5,6] and better or similar efficiency despite looking after a more complex patient population.[15,16] Hospitalists are taking a leading role in teaching family medicine residents,[17] as well as engaging in quality improvement activities on a mass scale.[18] Moreover, their presence is associated with high satisfaction rates among the interprofessional care teams,[19,20] as well as community-based family physicians.[21]

Across Canada, hospitalists have demonstrated that they are an essential component of a modern acute care institution and that they bring value both to patients and the broader health care system. Hospitalists are here to stay, and it is high time that their primary care colleagues acknowledge their enormous contribution to the medical landscape.

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Competing interests

Dr Yousefi is a board member for the Canadian Society of Hospital Medicine and the CEO of Hospitalist Consulting Solutions. Opinions expressed in this letter are those of **Dr Yousefi** and do not represent the views of the Canadian Society of Hospital Medicine or Hospitalist Consulting Solutions.

References

1. Ladouceur R. Are attending physician rotations costing hospitalized patients their lives? *Can Fam Physician* 2017;63:264 (Eng), 265 (Fr).
2. Ladouceur R. Where is family medicine heading? *Can Fam Physician* 2015;61:1029 (Eng), 1030 (Fr).
3. Ladouceur R. What has become of family physicians? *Can Fam Physician* 2012;58:1322 (Eng), 1323 (Fr).
4. Pimlott N. The changing landscape of family medicine. *Can Fam Physician* 2017;63:184 (Eng), 185 (Fr).
5. Yousefi V, Chong CA. Does implementation of a hospitalist program in a Canadian community hospital improve measures of quality of care and utilization? An observational comparative analysis of hospitalists vs. traditional care providers. *BMC Health Serv Res* 2013;13:204-11.
6. White H. *Assessing the prevalence, penetration and performance of hospital physicians in Ontario. Implications for the quality and efficiency of inpatient care* [dissertation]. Toronto, ON: University of Toronto; 2016.
7. Advisory Board. *Hospitalists—the new care leaders.* Washington, DC: Advisory Board; 2015.
8. McGowen B, Nightingale M. The hospitalist program: a new specialty on the horizon in acute care medicine. A hospital case study. *BCMJ* 2003;45(8):391-4.
9. Yousefi V, Wilton D. Re-designing hospital care: learning from the experience of hospital medicine in Canada. *J Glob Health Care Syst* 2011;1(3):1-10.
10. White HL, Stukel TA, Wodchis WP, Glazier RH. Defining hospitalist physicians using clinical practice data: a systems-level pilot study of Ontario physicians. *Open Med* 2013;7(3):e74-84.
11. Maskey JM. A change of place and pace. Family physicians as hospitalists in Canada. *Can Fam Physician* 2008;54:669-70 (Eng), 672-3 (Fr).
12. Chan BT. The declining comprehensiveness of primary care. *CMAJ* 2002;166(4):429-34.
13. Neimanis I, Woods A, Zizzo A, Dickson R, Levy R, Goebel C, et al. Role of family physicians in an urban hospital. Tracking changes between 1977, 1997, and 2014. *Can Fam Physician* 2017;63:221-7.
14. Yousefi V, Maslowski R. Health system drivers of hospital medicine in Canada. Systematic review. *Can Fam Physician* 2013;59:762-7.
15. Seth P, Nicholson K, Habbous S, Ménard J. *Implementation of a hospitalist medicine model in a full-service community hospital: examining impact two years post-implementation on health resource use and patient satisfaction.* Abstract presented at: 2015 Canadian Society of Hospital Medicine Annual Conference; 2015 Mar 29-Apr 1; National Harbour, MD.
16. Gutierrez GA, Norris M. *Impact of a newly established hospitalist training program on patient LOS and RIW.* Abstract presented at: 9th Annual Canadian Society of Hospital Medicine Conference; 2011 Sep 24-26; Banff, AB.
17. Gibson C. Educational tool for hospital-based training in family medicine. *Can Fam Physician* 2014;60:946-8 (Eng), e499-501 (Fr).
18. Ligertwood S, Tukker R, Wilton D. *BC hospitalists VTE collaborative*. Presented at: 2012 Quality Forum; 2012 Mar 8-9; Vancouver, BC. Available from: **https://quality-forum.ca/qf2013/wp-content/uploads/2012/03/E3-Rapid-Fire-Stop-the-Clot-R-Tukker.pdf.** Accessed 2017 Jun 5.
19. Webster F, Bremner S, Jackson M, Bansal V, Sale J. The impact of a hospitalist on role boundaries in an orthopedic environment. *J Multidiscip Healthc* 2012;5:249-56.
20. Gotlib Conn L, Reeves S, Dainty K, Kenaszchuk C, Zwarenstein M. Interprofessional communication with hospitalist and consultant physicians in general internal medicine: a qualitative study. *BMC Health Serv Res* 2012;12:437.
21. Yousefi V, Linett L, Reid C. *Perceptions of community family physicians of a hospitalist program in Ontario, Canada.* Abstract presented at: 9th Annual Canadian Society of Hospital Medicine Conference; 2011 Sep 24-26; Banff, AB.

Correction

In one of the photo captions that appeared in the Cover Story of the June print issue of *Canadian Family Physician*,[1] Dr Melinda Fowler's honorific was inadvertently not included. The photo caption should have read as follows:

> Checkups with patients Stephanie Pollok and (centre) Dr Melinda Fowler at the Brokenhead Health Centre.

Canadian Family Physician apologizes for this error and any confusion it might have caused.

Reference

1. De Leeuw S. Indigenous medicine. Approaching the challenges with courage and humility [Cover Story]. *Can Fam Physician* 2017;63:468-71 (Eng), e324-7 (Fr).