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Perceptions of community family physicians of a hospitalist program in Ontario, Canada

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Background:

Hospitalist programs have been growing in all areas of Canada over the past decade. While many academic hospitals in large urban centres have had internist hospitalists supervising residents and medical students in "Clinical Teaching Units" for many years, the emergence of family medicine trained hospitalists in community hospitals is a recent phenomenon that has led to much debate in Canada [1,2].

Primary care enjoys an important role in the Canadian healthcare system, and family physicians and general practitioners have traditionally provided comprehensive care spanning inpatient, outpatient and long-term care settings. Indeed, the provision of comprehensive medical care across the continuum of care settings is identified as one of the pillars of family medicine by the College of Family Physicians of Canada [3, 4]. It is not surprising that the introduction of hospitalist programs, with its inherent "discontinuity of care" resulted in tensions within the family physician community. Moreover, the hiring by various hospitals of primary care physicians who have chosen to narrow their scope of practice has been viewed by some commentators as a threat to the sustainability of the broader family medicine community through depleting its already insufficient manpower base[2].

Similar concerns were observed when hospitalist programs first became popular in the United States. For example, in a survey of primary care practitioners in California the majority of respondents (63%) felt the hospitalist system upset patients' expectations that their own physicians would look after them during hospitalization, and 69% felt the system undermined the confidence of patients in their primary care practitioners [5]. Despite such reservations, other surveys have shown an increasingly favourable opinion of hospitalists amongst many primary care physicians after direct experience with hospitalist programs [6]. To our knowledge, there are no published studies of the perceptions of Canadian primary care physicians towards hospitalists. Anecdotal evidence suggests that the reaction of primary care physicians towards hospitalist programs has been mixed, with some communities enjoying high levels of collaboration while others have experienced a challenging relationship.

Methods

Lakeridge Health (LH) is a large community hospital network in South Eastern Ontario. The hospitalist program in the Oshawa campus began in 2001, and has since evolved to become one of the largest programs in Canada with a comprehensive scope of practice that includes acute medicine, surgical and psychiatric co-management, rehabilitation, acute stroke, oncology and newborn care. The 16 full time equivalent hospitalists are involved in the care of approximately 180 to 220 patients daily (49 to 59% of all hospital beds).

As part of ongoing evaluation of our hospitalist program, we conducted two surveys of community family physicians and general practitioners in our surrounding area aimed at studying their perceptions of the program and suggestions on how to enhance collaboration. While there were a number of methodological differences between the 2007 and 2010 surveys, 35% of questions were the same. Surveys were mailed to the community physicians identified through the hospital's electronic health record system. The 2007 survey allowed respondents to answer questions using a range of options (from "strongly disagree" to ""strongly agree"). The 2010 survey allowed respondents to choose between "true" and "false" options. In order to allow direct comparisons, we excluded answers to "neutral" and "not applicable" options from the 2007 survey. We grouped answers to "strongly disagree" and "disagree" options together as equivalent to the "false" option in the 2010 survey. Similarly, answers using the "strongly agree" and "agree" options were grouped to represent an equivalent to the " true" option.

Results:

Out of a pool of approximately 200 family physicians, 24 and 45 responses were received for the 2007 and 2010 surveys respectively. The results are summarized in the attached table.

	2007		2010	
	True * (%)	False ** (%)	True (%)	False (%)
Hospitalists communicate with me (via voice mail or phone) regarding my hospitalized clinic patients	14	86	13	87
I have confidence in the Hospitalists provision of safe hospital care	95	5	95	5
Hospitalists provide me with specialist recommendations or therapeutic rationales in hospital discharge communication	63	38	41	59
In the past 12 months, patients have made favourable comments about the care provided by the Hospitalist group.	64	36	81	19
I would feel comfortable with a friend or family member under the care of the Hospitalist Program	93	7	93	7

* This represents “strongly agree” and “agree” options.

** This represents the pooled results for “strongly disagree” and “disagree”.

Qualitative analysis of the feedback received from the2007 survey indicated that community physicians found the best features of the program to be consistent care for patients, professionalism, good standards of care, expedited care and the opportunity to free up general practitioners from inpatient care. Family physicians identified the worst features of the hospitalist program to be poor communication with general practitioners, the need for a forum for community physicians to provide helpful information about patients to hospitalists, late discharge summaries and changing of medications. Similar concerns were identified in the 2010 survey, with many respondents identifying the need for improved communication through standardized and timely discharge summaries.

Limitations:

The above surveys were designed as part of ongoing evaluation of the LH hospitalist program, and not as a scientific research project. As a result, no reminders were sent to recipients to encourage better return rates, and the surveys were designed using a practical approach to identifying community physician perceptions. Like all surveys, there is a risk of selection bias and some physicians with particularly negative views about the program may be under-represented. Additionally, there were methodological differences between the two surveys in both the design and focus of questionnaires: while the 2007 survey was primarily aimed at identifying the perceptions of community physicians of the hospitalist program, the 2010 survey focused on identifying barriers to communication.

Conclusions:

The results of our surveys indicate that the majority of community family physicians have a favourable view of the care provided by hospitalists, and this perception has remained stable over time. There also appears to be a trend towards a more favourable perception of hospitalists amongst patients. Despite this, a significant communication gap still exists between hospitalists and community physicians. Many family physicians still find discharge summaries to be late or lack important information, and they like to be notified when their patients are admitted to the hospital. Hospitalists, community-based physicians and healthcare organizations need to enhance their collaboration to overcome barriers to timely and seamless transfer of information between inpatient and outpatient settings.

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