THE EROSION OF THE PRIMARY CARE DOCTOR-PATIENT RELATIONSHIP DURING HOSPITALIZATION

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Master of Medical Humanities

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Dedicated in loving memory to my mother, Enid Ruth Casper, who truly believed in the power of the doctor-patient relationship. When her health was compromised, she longed for the wise care and counsel of the physicians who knew her best and could honor her wishes for dignity and grace at the end of life.

INTRODUCTION

The role of the primary-care physician during hospitalization has undergone a major shift in the last fifteen years. Amid economic pressures, lifestyle choices and the increasing specialization of medicine, primary-care physicians and hospitals now contract with groups of inpatient physicians known as hospitalists, to care for their patients when an inpatient stay is necessary. In so doing, primary-care physicians give up their privileges of seeing their patients while in the hospital, confining their practice to the outpatient setting, while the hospitalist manages the care of their patients exclusively in the inpatient setting. According to the website for the Society of Hospital Medicine, the advocacy group for hospitalists and the leading voice for the profession, today the average U.S. primary-care physician spends twelve percent of his or her time with hospitalized patients.[1] They have, on average, one or two hospitalized patients per week, a far different scenario than two decades ago when, on average, they had ten to twelve patients hospitalized per week, approximately ten times more than today. With this changing landscape, more often than not patients no longer see their primary care doctors while hospitalized for illness or injury. Instead, their primary-care physicians have, in many cases, contracted with a group of 'hospitalists' who practice hospitalist medicine – a new specialty of medicine that focuses on the care of the hospitalized patient.

Much of the literature surrounding hospitalists has shown the benefits of the model from the point of view of economics and quality. Numerous articles have touted its

[1] "Society of Hospital Medicine FAQs," Society of Hospital Medicine, accessed March 26, 2011, http://www.hospitalmedicine.org/AM/Template.cfm?Section=FAQs.

benefits, presenting the model as the answer to the challenges that have faced primary care medicine and soaring health care costs. No model is so perfect, however, as to be an answer to the complexities of hospital care. In this new model, what is affected is the doctor-patient relationship.

This thesis looks at the relatively new model of hospitalist care in the United States, common forces that helped it to emerge and the effects it has had on the doctor-patient relationship. I write from the point of view of a family member who has had many experiences with hospitalist medicine over nearly a decade, a voice that has not been much sought after in the literature. Based on my own experiences I have formulated my thesis, arguing that the hospitalist model of care compromises the continuity of care by breaking established doctor-patient relationships when patients are admitted to the hospital, a time at which they are most vulnerable.

In Chapter 1, I explore the very recent history of hospitalists in this country and its burgeoning presence throughout the United States since the late 1990s. This chapter explains the factors that have fueled its emergence and its prevalence, which has grown exponentially in the last fifteen years.

In Chapter 2, I provide a perspective about the importance of the doctor-patient relationship. For many patients, particularly the elderly, the primary-care physician is a medical confidante familiar with their health care history, their anxieties and ultimately their wishes for care at the end of life. The importance of these established relationships is explored.

Chapter 3 discusses how communication occurs between the primary care doctor and hospitalist. In this chapter I will look at whether the hospitalist model forces a breakdown in communication, or if it bridges the gap successfully.

In Chapter 4, I examine literature that considers the patient's perspective on hospitalist care. Most of the research on hospitalists has focused on patient outcomes and financial benefits for primary-care physicians and hospitals. However, patient satisfaction is also an important element in the success or failure of the hospitalist model that I investigate.

Chapter 5 addresses how this model can be improved. The days of the family doctor making daily rounds on his/her patients in the hospital may be over, but the hospitalist model is still young and evolving. Primary-care physicians and hospitalists should work together to improve communication and continuity of care, instilling a sense of confidence at times of vulnerability for the hospitalized patient. More research is needed on ways to optimize patient satisfaction with hospitalist care. What primary-care physicians can do to alleviate patients' anxieties and some alternative practice models will be discussed.

In conclusion, from my own personal experience and my research into the hospitalist movement, I will argue that the hospitalist model of care compromises the doctor-patient relationship at a fragile time during a patient's hospitalization. The field of medical humanities is rooted in the doctor-patient relationship, which makes understanding and improving the hospitalist model of care so important. Hospitalists have

already become prominent in many hospitals, and this model will most likely be the future of care delivery in hospitals throughout the country. As this shift takes place, it will be important to understand this changing relationship between patient and primary-care physician. Bridging the gap between the outpatient physician and the hospitalist presents a challenge, but it is one that should be addressed for the benefit of the hospitalized patient.

CHAPTER 1

The Emergence of the Hospitalist Model in the United States

The term 'hospitalist' was first coined in 1996, by Robert M. Wachter, M.D. and Lee Goldman, M.D., two physician colleagues from the University of California, San Francisco. In an article in The New England Journal of Medicine, the two physicians described "a new breed of physicians we call 'hospitalists' – specialists in inpatient medicine – who will be responsible for managing the care of hospitalized patients in the same way that primary-care physicians are responsible for managing the care of outpatients."[2] Hospitalists are the doctors of record while a patient is hospitalized; however, because of their lack of knowledge of the patient, I surmise that they cannot be considered an equivalent replacement to the primary-care physician. While they may have an equal or better understanding of the medical needs of a hospitalized patient, they are lacking in any understanding of a patient's psycho-social status and past medical history.

The following diagram shows how the transition of care has changed with the institution of hospitalist care, and how the chain of communication between doctor and patient is now interrupted when a patient is hospitalized:

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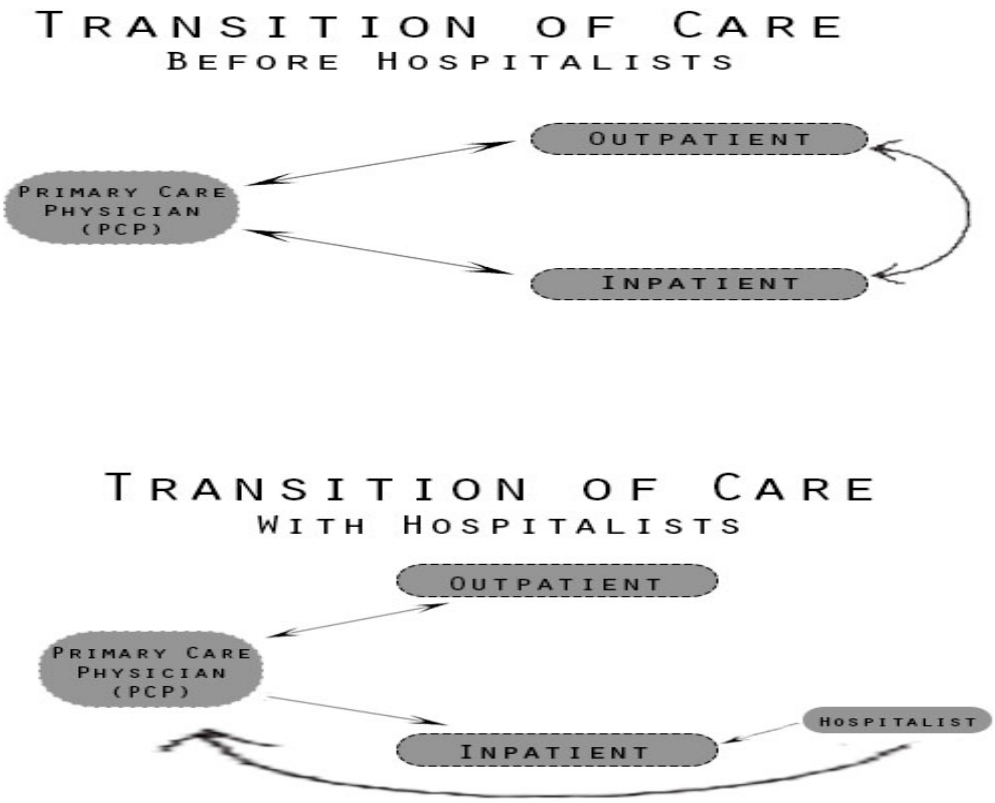
[2] Robert M. Wachter and Lee Goldman, "The Emerging Role of Hospitalists in the American Health Care System," *New England Journal of Medicine* 335, no. 7 (August 1996): 514.



Drs. Wachter and Goldman write, "Ideally, the primary-care physician would provide all aspects of care, ranging from preventive care to the care of critically ill hospitalized patients. Unfortunately, this approach collides with the realities of managed care and its emphasis on efficiency."[3] The expectation of efficiency with managed care presents challenges when the primary-care physician has to allot time in the day to visit hospitalized patients, thereby taking away precious time from patients in the office. Recognizing the explosive growth of managed care and its impact on the daily practice of the primary-care physician, Wachter and Goldman note parallel pressures in the hospital and question whether comprehensive care and continuity of care could be sustained.

[3] Wachter and Goldman, "The Emerging Role of Hospitalists…," 514.

"Since the inpatient setting involves the most intensive use of resources, it is the place where the ability to respond quickly to changes in a patient's condition and to use resources judiciously will be most highly valued."[4] In the search for a new way to address the growing pressures of managed care and efficiency in health care, the hospitalist model emerged.

In their pivotal article, Wachter and Goldman point to Canada and Great Britain as already having success with specialists in inpatient care and predicted the acceleration of the hospitalist specialty in the United States. Dr. Wachter first proposed a definition of a hospitalist in 1999:

> A hospitalist is a physician who spends at least 25% of his or her professional time serving as the physician-of-record for inpatients, during which time he or she accepts "hand-offs" of hospitalized patients from primary care providers, returning the patients to their primary care providers at the time of hospital discharge.[5]

The National Association of Inpatient Physicians (NAIP), founded in 1997 and later to become the Society of Hospital Medicine (SHM) in 2003, amended this definition slightly:

> Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to hospital care.[6]

According to statistics from SHM, Wachter's prediction of the growth of hospitalists was an underestimate. Just ten years ago, in 2002, Dr. Wachter wrote, "A recent analysis projected an ultimate US hospitalist workforce of about 19,000 (up from

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[4] Wachter and Goldman, "The Emerging Role of Hospitalists…," 514.
[5] David H. Freed, "Hospitals: Evolution, Evidence, and Eventualities," *The Health Care Manager* 23 no. 3 (Sept 2004): 239.
[6] Ibid.

5,000 presently), which would make it comparable in size to cardiology."[7] In fact, by 2003 the SHM counted over 8,000 hospitalists, and currently states on its website, "It is estimated that there are between 10,000-12,000 practicing hospitalists today, with the number expected to grow to 30,000 in the next decade."[8] In a 2012 article in the Journal of the American Medical Association, the number of hospitalists has already surpassed these predictions. "Today, more than 30,000 hospitalists staff approximately 70% of US hospitals."[9]

Data from the Centers for Medicare and Medicaid Services reported on in a study conducted at the University of Texas show a substantial increase in the care of hospitalized patients by hospitalist physicians from 1995 to 2006. "In a multilevel, multivariable analysis controlling for patient and hospital characteristics, the odds of receiving care from a hospitalist increased by 29.2% per year from 1997 through 2006. In 2006, there was marked geographic variation in the rates of care provided by hospitalists, with rates of more than 70% in some hospital-referral regions."[10] The study concludes that by 2006, almost all areas of the country were served by hospitalists and that substantial growth occurred in every geographic area and every type of hospital.

Although its growth has been steadily increasing, hospitalist medicine is not something that patients or the public are at all familiar with. Individuals may select their

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[7] Robert Wachter, "The Hospitalist Movement 5 Years Later," *The Journal of the American Medical Association* 287, no. 4 (January 2002): 487.
[8] "FAQs," Society of Hospital Medicine, accessed, June 15, 2012, http://www.hospitalmedicine.org/AM/Template.cfm?Section=FAQs&Template=/FAQ/FAQListAll.cfm.
[9] John R. Nelson, Laurence Wellikson, and Robert M. Wachter, "Specialty Hospitalists-Analyzing an Emerging Phenomenon," *Journal of the American Medical Association* 307, no. 16 (April 2012): 1699.
[10] Kuo et al, *Growth in Care of Older Patients by Hospitalists in US*, 1102.

primary-care physicians by considering a variety of factors such as insurance coverage, proximity to home, reputation or referral from a reliable source. Most are unaware, however, that if they are hospitalized today, their primary-care physician has most likely chosen to contract with a hospitalist group to cover for him or her. These are doctors the patient has never met, and the group may work on a rotating schedule so that each day may be a different hospitalist from the group caring for the patient.

The Society for Hospital Medicine explains that, "acceptance of hospital medicine was initially slow in some parts of the country but is now growing rapidly nationwide." [11] In this assertion, they are referring to acceptance from doctors and health care systems, but not from patients who have not had a choice or played a part in the decision of who will care for them in the hospital.

The country's leading metropolitan hospitals and largest managed care programs have paved the way for future growth and the expansion of new programs beyond large cities. This growth is important because it represents a shift in how health care is delivered at hospitals throughout the country. For patients, they are encountering the hospitalist for the first time during a time of illness. At a time of increased vulnerability, the role of the primary care doctor has been curtailed when a patient is hospitalized.

I first encountered the hospitalist in 2006 at a hospital in New Jersey. My elderly mother was in the emergency room waiting to be admitted and a hospitalist came to introduce himself. Even at that time, we did not realize that her primary care doctor would be entirely absent throughout her lengthy hospital stay. In addition, the hospitalist

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[11] Society of Hospital Medicine, "FAQs."

who visited in the emergency room never returned, and each day brought a new hospitalist to determine what had improved or worsened from the previous day, a difficult task considering that no observational criteria could be employed, only notes written in the chart. When it became clear that the primary-care physician was not coming to the hospital, we made repeated requests for the hospitalists to at least communicate with him, especially upon discharge. This was met with false reassurances that the primary-care physician was fully aware of her medical condition. However, visiting the primary care doctor a day after being discharged from the hospital proved otherwise, as it was clear that he had received no reports and had no idea of any of the circumstances regarding the hospital stay.

This shift to hospitalist care has not only changed the realities for patients and family members as to who will manage a patient's care, but has also changed the way primary-care physicians practice in the community. As researchers Hamel, Drazen and Epstein from the Harvard School of Public Health point out:

> Two decades ago, most doctors who chose a career as a primary-care physician did not imagine a professional life restricted to the outpatient setting. Today, many primary-care physicians work exclusively in the ambulatory setting, relying on hospitalists to care for their patients when they are admitted to the hospital.[12]

Several factors have fueled the growth of hospitalists, the most compelling being economics. With increased pressures from managed care for hospitals to find ways to provide efficient, high quality, low cost care with shortened lengths of stay, the hospitalist model took hold.

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[12] Mary Beth Hamel, Jeffrey M. Drazen, and Arnold M. Epstein, "The Growth of Hospitalists and the Changing Face of Primary Care," *New England Journal of Medicine* 360, no. 11 (March 2009): 1141.

Wachter and Goldman stated in 1996: "First, because of cost pressures, managed-care organizations will reward professionals who can provide efficient care."[13] They continued by saying, "As hospital stays become shorter and inpatient care becomes more intensive, a greater premium will be placed on the skill, experience, and availability of physicians caring for inpatients."[14] The Society of Hospital Medicine notes that, "Hundreds of hospitals, medical groups and managed care plans have adopted the hospitalist concept as 'best practice' for high-quality, well-coordinated and cost-effective management of hospitalized patients."[15] As a professional society for the advocacy of hospitalists, this is obviously a noble claim to make; its certainty, however, falls short. Here, the measurement of quality and continuity of care are measured solely in terms of economics and not taking the patient fully into account. Continuity of care, I would argue, requires a level of involvement from the primary-care physician that the hospitalist model may be unable to achieve. In an unsubstantiated claim, the group also notes, "For a number of reasons, many patients prefer hospitalists,"[16] continuing to outline the benefits they see from their point of view. Considering most people are not even familiar with the term, it is unclear where this information even comes from.

Focusing solely on the economics, however, physician, economist and researcher, David Meltzer, M.D., Ph.D., demonstrated in a study published in the Annals of Internal Medicine that the perceived benefits of reduced costs and greater efficiency with hospitalists were measurable. "…As hospitalists became more experienced, they reduced

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[13] Wachter and Goldman, "The Emerging Role of Hospitalists…," 514.
[14] Ibid.
[15] Society of Hospital Medicine, "FAQs."
[16] Ibid.

the cost of caring for the average hospitalized patient by about $780 per stay, the length of the average stay decreased, and their patients had lower thirty- and sixty- day mortality rates than patients cared for by traditional internists."[17]

Although Meltzer measured cost savings as the result of hospitalist care, Hamel is cautious when pointing to a large study by Lindenauer, et al. Hamel notes, "A recent large, multicenter observational study showed that hospitalist care was associated with a modest reduction in costs as compared with care rendered by general internists, but there was no reduction in costs as compared with care by family physicians."[18] In the article by Lindenauer and his colleagues, they conclude:

> The lack of clear cost savings, despite more than a 10% reduction in the length of stay, suggests that, as compared with their counterparts, hospitalists compress the same or even greater amounts of testing and treatment into a shorter amount of time.[19]

In addition to economic pressures, practical forces, such as time constraints on primary-care physicians, also contributed to the emergence of the hospitalist. As former primary-care physician and now health policy lecturer Frederick Barken describes in his book, *Out of Practice: Fighting for Primary Care Medicine in America*, how redistribution of delivering primary care is taking place. He recalls his own experiences

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[17] S. P. Lovinger, "David Meltzer, Physician and Economist, Discusses the New Hospitalist Movement," *The Journal of the American Medical Association* 289, no. 4 (January 2003): 411.
[18] Hamel, Drazen and Epstein, "Growth of Hospitalists…," 1142.
[19] Peter K. Lindenauer et al, "Outcomes of Care by Hospitalists, General Internists, and Family Physicians," *New England Journal of Medicine* 357, no. 25 (December 2007): 2598.

of having to run out of the office, leaving behind "a waiting room full of angry, glaring patients to be rescheduled."[20]:

> Traditionally, primary physicians attended the hospital first thing each morning, and then they headed for their offices for a long day of outpatient, or ambulatory, care. With luck, no hospitalized patient would become critically ill and thereby necessitate a doctor's speedy drive back to the hospital with the consequent cancellation of office hours.[21]

Although for years the primary-care physician balanced both worlds of inpatient and outpatient medicine, the presumption now is that primary-care physicians are best at leaving the complex navigation of the hospital stay to the hospitalist who is more in tune with the environment of the hospital. This presumably leaves the primary-care physician more time to focus on improved access to outpatient care for the majority of patients.

For pure practicality, the hospitalist movement may make sense if the loop from primary-care physician to hospitalist is closed. But studies have shown that the doctor-to-doctor communication so necessary for the model to succeed has not kept pace. In one study in The American Journal of Medicine, over 1,000 physicians were surveyed as to their preferences for receiving information about their patients from hospitalists with results showing, "Overwhelmingly, PCPs' preferred method of communication was a

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[20] Frederick Barken, *Out of Practice: Fighting for Primary Care Medicine in America* (Ithaca: ILR Press, 2011), 85.
[21] Ibid.

telephone call (77%)."[22] However, when a patient was admitted under the care of a hospitalist the study found, "one third of PCPs are 'always' notified, one third are 'usually' notified, and one third are 'sometimes' notified."[23] In another study published in JAMA in 2007, a group of researchers found that deficits in communication and information transfer between hospital-based physicians [not specifically hospitalists] and primary-care physicians at hospital discharge were common and could adversely affect patient care.[24] They selected fifty-five observational studies, published between 1979 and 2005, the more recent studies being much larger and more comprehensive. "In this literature, direct communication between hospital physicians and primary-care physicians during the discharge process occurred infrequently. Only 3% of primary-care physicians reported being involved in discussions about discharge, and 17% to 20% reported always being notified about discharges."[25]

Attempting to determine whether communication between hospital-based physicians and primary-care providers influences patient outcomes has been studied with less definitive results. In a study conducted at six U.S. academic medical centers and published in the Journal of General Internal Medicine, 1,078 hospitalized patients were studied, of which 34% had an attending physician who was a hospitalist. "Within 30 days

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[22] Steven Z. Pantilat et al, "Primary Care Physician Attitudes Regarding Communication with Hospitalists," *The American Journal of Medicine* 111, no. 9B (December 2001): 16S.
[23] Ibid., 18S.
[24] Sunil Kripalani et al, "Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians, Implications for Patient Safety and Continuity of Care," *The Journal of the American Medical Association* 297, no. 8 (February 2007): 832-833.
[25] Ibid., 831.

of discharge, 82 (7.6%) patients died, 116 (10.8%) patients were readmitted to hospital, and 69 (6.4%) patients visited an ED."[26] In this study, "few primary care providers (PCPs) had direct communication with the inpatient medical team during their patients' hospitalizations, more than half reported not receiving a discharge summary within 2 weeks, and almost one quarter did not have any knowledge that their patients had been admitted at all."[27] However, the authors of the study did not demonstrate that a lapse in communication directly affected outcomes, concluding that, "Though our results provide no direct link between physician communication and important patient outcomes, they demonstrate that communication between hospital physicians and PCPs can be substantially improved."[28]

Hospital CEO David Freed of Nyack Hospital, a member of the New York-Presbyterian Healthcare System, writes, "If cost reduction was the motive force for hospitalists, than quality improvement and physician satisfaction became its sustained impetuses."[29] From an efficiency standpoint, Hamel, et al, explains, "The lower volume of inpatients made it less practical for primary-care physicians to block off time each day for hospital rounds and reduced their experience in the inpatient setting."[30] While physician satisfaction, practicality, and physician experience is the focus here, the role of the physician as it pertains to the patient experience during hospitalization–a point at which patients are most vulnerable–is blatantly absent from the discussion.

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[26] Chaim M. Bell, "Association of Communication Between Hospital-based Physicians and Primary Care Providers with Patient Outcomes," *Journal of General Internal Medicine* 23, no. 3 (December 2008): 383.
[27] Ibid.
[28] Ibid., 384.
[29] Freed, "Hospitals," 240.
[30] Hamel, Drazen and Epstein, "The Growth of Hospitalists…," 1141.

Eight years after the groundbreaking article in The New England Journal of Medicine, Dr. Wachter published a follow-up article reflecting back on the emergence of the "new breed of physician – the 'hospitalist'"[31] In this article, he recollects, "By the late 1990s, primary-care physicians, many of whom initially objected to the concept of hospitalists because of concern about discontinuity in patient care and acceptability to patients, began to embrace the model, in part because inpatient care had become an economically inefficient use of their own time."[32] He wrote in JAMA:

> We cited numerous forces fomenting this change, including cost pressures on hospitals, physician groups, and managed care organizations; the increased acuity of hospitalized patients and the accelerated pace of their hospitalizations; the time pressures on primary-care physicians in the office; the decreasing inpatient volumes of most primary physicians; and the evidence that practice makes perfect in other medical fields.[33]

The model of primary-care physician once encompassed the office and hospital experience, serving as overall manager of a patient's treatment. But the pressures of managed care have changed this. As Bodenheimer notes, "Reimbursement based primarily on the quantity of services delivered, rather than on quality, forces primary care physicians onto a treadmill, devaluing their professional work life."[34] He thus points out that fewer U.S. medical students are choosing careers in primary care. "Between 1997 and 2005, the number of U.S. graduates entering family practice residencies dropped by

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[31] Robert M. Wachter, "Hospitalists in the United States–Mission Accomplished or Work in Progress?" *The New England Journal of Medicine* 350, no. 19 (May 2004): 1935.
[32] Ibid.
[33] Ibid., 487.
[34] Thomas Bodenheimer, "Primary Care—Will It Survive?" *The New England Journal of Medicine* 355, no. 9 (August 2006): 862, accessed March 7, 2012, www.njem.org.

50 percent. In 1998, half of internal medicine residents chose primary care; about 80 percent became subspecialists or hospitalists."[35]

Hamel, et al, lends support to this trend, explaining, "…the interest of younger physicians in careers with controllable lifestyles contributed to the emergence of a new clinical specialty focused on hospital medicine."[36] The authors assert that "there is wide acceptance that the use of hospitalists has enabled primary-care physicians to see more patients in the ambulatory setting."[37] But in a departure from other literature, they allude to the doctor-patient relationship in a way that many analyses have circumvented, raising the question of patient confidence in the primary-care physician and professional satisfaction on the part of the physician:

> Few medical students are choosing general internal medicine, and residents in internal medicine are increasingly choosing hospital medicine rather than primary care. The well-intentioned efforts of many primary-care physicians to make themselves more available to their outpatients and provide their inpatients with the benefit of doctors with expertise in hospital medicine may have reduced their own value in the eyes of their patients, and, in some instances, decreased their job satisfaction.[38]

Both economic and practical forces have been at the root of the emergence of hospitalist care, but from a historical perspective, this model of medicine is still in its infancy. Putting aside the economic rationale, which still leaves room for debate, evaluating the effectiveness of the hospitalist movement will require more than number crunching. Patients, more so than doctors and hospitals, are at the heart of the matter, and there is still a need for input from patients about their satisfaction with hospitalist care

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[35] Bodenheimer, "…Will It Survive," 862.
[36] Hamel, Drazen and Epstein, "The Growth of Hospitalists…," 1142.
[37] Ibid.
[38] Ibid.

and evidence as to whether significant reductions can be made in the rates of readmission and mortality for patients.

Though it may be challenging to evaluate hospitalist medicine, an article in the Archives of Internal Medicine explains that patient care outcomes (PCOs) are considered purely from the point of view of costs, length of stay and readmissions. The author comments, "I believe we should consider a variety of other issues that span a longer time horizon than the hospital admission. Do hospitalist systems have any negative impact on how patients view their physicians, their hospital, and the health care system?"[39]

I could not attest from my own personal experience whether the hospitalist had any effect on readmission rates or outcomes, but reliance on hospitalists strongly influenced our view of the particular hospital and the health care system in a negative way. The absence of the primary-care physician resulted in a feeling of betrayal for all members of our family at a time of heightened vulnerability and an overall erosion of confidence in a long-time medical confidante.

Hospitalist medicine has emerged, for better or for worse, in a short period of time in our history. As this chapter explored its driving forces and its exponential growth, Chapter 2 looks at the importance of the doctor-patient relationship and whether hospitalist care can overcome the lack of this inherent relationship with their patients during hospitalization.

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[39] Robert M. Centor, "A Hospitalist Inpatient System Does Not Improve Patient Care Outcomes," *Archives of Internal Medicine* 168, no. 12 (June 2008): 1257.

CHAPTER 2

The Doctor-Patient Relationship

For many patients, particularly the elderly, the doctor-patient relationship is sacrosanct. Patients convey intimate details of their lives, express their fears and hopes, and depend upon their medical confidantes at a time of illness. I have experienced this first hand witnessing my mother's deepening relationship and trust with her primary care physician as she aged (although we also witnessed its erosion as the end of her life approached). This chapter explores the power of the doctor-patient relationship by looking at the importance of confidence in the primary-care physician, the expectations of patients, and whether the art of medicine – the humanistic elements that make up the doctor-patient relationship – is important in the treatment of illness. Individuals develop confidence in their doctors when they display sharp clinical skills, a personal interest in them and a caring personality. These building blocks of a doctor-patient relationship have ramifications for the hospitalist model of care and will be explored in the second half of the chapter.

Sherwin Nuland, author, physician, and clinical professor of surgery at Yale University School of Medicine, cites the ancient Roman physician and philosopher Galen, "the great savant of second-century CE medicine,"[40] for wisdom that was deeply embedded in his many writings but has been kept alive through the ages: "He cures most successfully in whom the people have the most confidence."[41] "When we ourselves are ill, we want someone to care about us as people, not as paying customers, and to

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[40] Sherwin B. Nuland, *The Soul of Medicine: Tales from the Bedside* (New York: Kaplan, 2010) 143.
[41] Ibid., 144.

individualize our treatment according to our values,"[42] write Drs. Hartzband and Groopman in an article in the New England Journal of Medicine. Defining health care in terms of economics, "where patients are no longer patients, but rather 'customers' or 'consumers'"[43] could have "deleterious consequences,"[44] noting the challenge of attracting "creative and independent thinkers with not only expertise in science and biology but also an authentic focus on humanism and caring."[45]

An article in *The New York Times* illustrates the shift that has taken place in primary care medicine over the last decade with a profile of a Maryland physician whose thirty-two-year practice in family medicine was in jeopardy when he wanted to retire. Reporting on the transformation in medicine, the article states, "He once provided for nearly all of his patients' medical needs – stitching up the injured, directing care for the hospitalized and keeping vigil for the dying. But doctors like him are increasingly being replaced by teams of rotating doctors and nurses who do not know their patients nearly as well."[46] The journalist continues to explain that younger doctors, "want better lifestyles, shorter work days, and weekends free of the beepers, cell phones and patient emergencies that have long defined doctors' lives."[47]

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[42] Pamela Hartzband and Jerome Groopman, "The New Language of Medicine," *The New England Journal of Medicine* 365, no. 16 (April 2009): 1373, accessed March 9, 2012, www.njem.org
[43] Ibid., 1372.
[44] Ibid.
[45] Ibid., 1373.
[46] Gardiner Harris, "Family Physician Can't Give Away Solo Practice," *New York Times*, April 22. 2011, accessed June 12, 2012, http://www.nytimes.com/2011/04/23/health/23doctor.html?_r=1&sq=d.
[47] Ibid.

Allan Detsky, MD, PhD, a practicing general internist who cares for inpatients, surveyed what people really want from health care in a JAMA article in December 2011. Included in the list of top priorities were restoring health when ill, kindness, hope and certainty, and the best medicine available. Also notable among the list of "What the Public Wants Most" was the following:

> Continuity, Choice, and Coordination. Patients want continuity of care and choice. They want to build a relationship with a health care professional or team in whom they have confidence and have that same person or team care for them in each episode of a similar illness. They want the members of their health care team to communicate with each other to coordinate their care.[48]

In a distinguished paper from the North American Primary Care Research Group (NAPCRG), the correlation of continuity of care and trust in a physician was studied both in the United States and the United Kingdom. Patients in different practice settings were given a survey during office visits with questions on importance of continuity and trust in physicians. "The length of time with one's regular physician and the importance of seeing one's regular physician each time were the strongest predictors of trust. The greater the continuity, the higher the trust."[49] Which comes first, the trust or the relationship, can be different for different people. "It is unclear whether trust in one's physician leads to a continued relationship with that provider or whether seeing the same individual over time contributes to the patient-physician relationship, thereby increasing trust."[50] But in either case, the authors argued, "…continuity of care and a desire for

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[48] Allan S. Detsky, "What Patients Really Want from Health Care," *The Journal of the American Medical Association* 306, no. 22 (Dec 2011): 2500.
[49] Arch G. Mainous et al, "Continuity of Care and Trust in One's Physician: Evidence from the United States and United Kingdom," *Family Medicine* 33, no. 1 (January 2001): 22-27.)
[50] Ibid., 26

continuity were significant predictors of trust."[51]

To frame the ideas of the public's expectations from health care professionals, it is also important to recognize the evolving relationship of the physician-patient in modern times, where patients now often expect shared decision-making and have access to more resources to research their own health conditions. WebMD and other medically-minded sites are frequent hits for the internet-savvy health care consumer of today, but, as Robert Truog, MD, writes in an article in the New England Journal of Medicine, "…the reality is more complex; the wealth of information available to patients has proved to be as dangerous as it is helpful, and today patients and physicians are beginning to find a healthier balance of power through a process of shared decision-making."[52] A Pew Research study in 2009 examined the extent to which Americans use the internet for health information. They surveyed 2,253 adults and reported on the decade-long period of the 2000s: "In 2000, 46% of American adults had access to the internet… and 25% of American adults looked online for health information. Now, [2009] 75% of American adults go online… and 61% of adults look online for health information."[53] An updated report in 2013 studying 3,014 adults by the Pew Research Center's Internet & American Life Project and the California HealthCare Foundation, found that, "As of September 2012, 81% of U.S. adults use the internet and, of those, 72% say they have looked online

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[51] Mainous et al, "Continuity of Care," 26.
[48] Robert D. Truog, "Patients and Doctors–the Evolution of a Relationship," *The New England Journal of Medicine* 366, no. 7 (Feb 2012): 581, accessed March 7, 2012, www.nejm.org.
[53] Pewinternet, accessed June 21, 2013, http://www.pewinternet.org/Press-Releases/2009/The-Social-Life-of-Health-Information.aspx.

for health information in the past year."[54] Armed with this information, patients can now be more active participants in their health care, utilizing their own research in their personal health affairs. However, the values that inform each individual's health care decisions still need to be discussed with a trusted individual. As Dr. Truog states, "Although physicians may be experts on the medical facts of a patient's condition, those facts are never sufficient to specify a course of treatment; clinical decisions must always include consideration of the values and preferences of the patient."[55] The Pew study found that consulting a health care professional or trusted friend or family member still takes precedence over an internet search, finding that, "the internet comes in third (tied with books) behind asking a health professional and talking with friends or family members."[56] The value that patients gain from being understood is one of the harder aspects to measure but can be a benefit of a doctor-patient relationship.

In 1927, Harvard Medical School professor Francis Peabody, MD, authored "The Care of the Patient" in the Journal of the American Medical Association. In this landmark article, he suggested that patients are not simply the disease they present with, but deeply complex individuals with lives that impact their choices and decisions. "What is spoken of as a 'clinical picture' is not just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears."[57] Even in Dr. Peabody's time, the recognition

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[54] Pewinternet, accessed June 25, 2013, http://www.pewinternet.org/~/media//Files/Reports/PIP_HealthOnline.pdf.
[55] Truog, "Patients and Doctors," 581.
[56] Pewinternet, accessed June 21, 2013
[57] Francis W. Peabody, "The Care of the Patient," *Journal of the American Medical Association* 88, no. 12 (March 1927): 878.

of a patient's complete life and his or her sense of dignity in the face of illness, especially at a time of hospitalization, were thoughtfully considered.

My mother had a particularly warm connection to her primary care doctor. The two first connected on the basis of having grown up close to each other in Brooklyn, NY, becoming kindred souls in suburban New Jersey. Over the years they learned more about each other, sharing pictures of his daughter's wedding and her grandchildren's academic accomplishments. He spoke of his changing profession as a primary care doctor, determined to 'go it alone' before being consumed by a looming health care organization, and she gave a glimpse into her profession of child psychology earlier in her life, her love of art and her hobby of sculpting.

The word 'relationship' implies a connection between a patient and a doctor, but this connection is unique and the balance is not necessarily equal. In particular, patients choose their doctors but doctors do not have the same authority in choosing their patients. In addition, a patient's experience of illness is distinct from the physician's scientific understanding of disease. The relationship of doctor to patient was traditionally defined as one of paternalism, "framing the obligations of physicians solely in terms of promoting the welfare of the patient, while remaining silent about patients' rights."[58] Recently, however, medicine has attempted to bridge this gap, offering collaboration where patient and doctor meet as equals: "…Clinical care today is guided by norms of shared decision making rather than benevolent paternalism."[59]

[58] Truog, "Patients and Doctors," 581.
[59] Ibid., 584.

The relational aspect of the doctor and patient may also possess healing potential. While harder to pinpoint, it is certainly compelling in the understanding of the art of medicine. In the case of my mother, the chance to converse with her primary care doctor or one of several specialists who knew her on a more personal level, added a sense of mental calm to her aging body and uncertain health care picture. The familiar, reassuring face during an outpatient visit or a phone call to her home left her feeling cared for, safe and understood. A article in the Journal of General Internal Medicine presents a synopsis of theories about patient trust and notes that, "Trust is one of the central features of patient-physician relationships…Yet, despite its acknowledged importance and potential fragility, rigorous efforts to conceptualize and measure patient trust have been relatively few."[60] Noted psychiatrist George L. Engel proposed a biopsychosocial approach in 1977, and emphasized "the importance of placing the patient's narrative of his life and illness at the center of the clinical evaluation."[61] In a striking observation, Dr. Engel followed an infant born with esophageal atresia who was tube fed for the first two years of her life. At fifteen months, he discovered that her gastric acidity was regulated by her emotional state. As Harris writes, Engel observed that, "Striking differences in her gastric physiology depended on whether she was approached by a stranger or a trusted caregiver."[62]

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[60] Steven Pearson and Lisa Raeke, "Patients' Trust in Physicians: Many Theories, Few Measures, and Little Data," *Journal of General Internal Medicine* 15, no. 7 (July 2000): 509-531, accessed June 25, 2013, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495476.

[61] James C. Harris, "Toward a Restorative Medicine – the Science of Care," *The Journal of the American Medical Association,* 301, no. 16 (April 2009): 1711.

[62] Harris, "Restorative Care," 1711.

The relationship between a doctor and a patient – the humanistic art of the profession – is at the core of medical humanities and has been considered from ancient times through modern history. Howard Brody, MD, PhD, a physician, medical ethicist and advocate for the healing potential of the doctor-patient relationship writes, "The physician who listens carefully to the patient's story of the illness lays the groundwork for all the important dimensions of symbolic healing… Being willing to listen to the patient's story – which oftentimes family and friends have dismissed with impatience – sets a tone of care and compassion for the physician-patient relationship."[63] Dr. Brody argues from a moral and ethical standpoint that the patient's story is a critical component to healing:

> Physicians have known, at least since the time of Hippocrates, that the mental, emotional, and symbolic aspects of the physician-patient encounter can ameliorate (or worsen) disease every bit as much as the specific medications and other treatment the physician employs.[64]

In 1927, Dr. Peabody described medicine as "not a trade to be learned but a profession to be entered."[65] I interpret this to mean that learning the trade, or science, of medicine is only one necessary factor in becoming a good doctor. Entering the medical profession builds on that trade but is more encompassing, involving a calling to tend to the sick, to take care of patients, and become drawn into peoples' lives. He continues with the following description:

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[63] Howard Brody, "'My Story Is Broken; Can You Help Me Fix It?': Medical Ethics and the Joint Construction of Narrative," *Literature of Medicine* 13, no. 1 (Spring 1994): 80.
[64] Ibid., 79.
[65] Peabody, "Care of the Patient," 877.

> "…the application of the principles of science to the diagnosis and treatment of disease is only one limited aspect of medical practice. The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an art, based to an increasing extent on the medical sciences, but comprising much that still remains outside the realm of any science. The art of medicine and the science of medicine are not antagonistic but supplementary to each other."[66]

Dr. Peabody's words from eighty-five years ago reflected, "an era in which concerns were raised that medicine had become too scientific and hospital care was too impersonal,"[67] according to a JAMA commentary on the article by James C. Harris, MD, in 2009. But today they seem prescient in light of managed care, its focus on efficiency, costs, and the model of care provided by the hospitalist.

As hospitals adapt to the demands of managed care, the introduction of the hospitalist poses challenges to the underlying trust of an established doctor-patient relationship. Drs. Wachter and Goldman recognized this in 2002 when they looked at the hospitalist movement five years after their initial landmark paper was published. "We have postulated that patients may be willing to trade off the familiarity of their regular physician for the availability of the hospitalist,"[68] they wrote, although in surveys conducted with doctors they note that "primary-care physicians stated their belief that patients generally preferred to be cared for in the hospital by their regular physician."[69]

As the relationship with the hospitalist is temporary, it may be more difficult to establish confidence, trust, and personal connection with a hospitalized patient. In addition to being temporary, the relationship to the hospitalist is fleeting. Each

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[66] Peabody, "Care of the Patient," 877.
[67] Harris, "Restorative Care,"1710.
[68] Wachter and Goldman, "The Emerging Role of Hospitalists…," 490.
[69] Wachter and Goldman, "The Emerging Role of Hospitalists…," 490.

subsequent hospitalization during my mother's elderly years was met with a new team of hospitalists, depending on the unit to which she was admitted, lessening the likelihood of seeing the same hospitalist more than once. Truog notes the greatest challenge in the doctor-patient relationship is still before us: "…we will struggle in the years to come to balance the personal advocacy that all patients rightfully expect from their physicians with the equally compelling obligation of physicians to see that health care resources are used wisely in ways that are efficient and fair."[70]

In the vulnerable environment of a hospital, it is easy to see how patients lose their sense of trust, privacy, and personal identity. Hospitalists may be caring for an entire ward of patients who are critically ill. With good intentions they may intend to communicate with the referring physician to avoid discontinuity of care. They take advantage of emerging technologies, such as electronic medical records and digital imaging, to involve the primary-care physician, but it comes at the expense of something lost. In our family's experience, what was lost was the relational aspect of her doctor's care. Each hospitalization was met with fear, and later cynicism, of the unknown doctor and a longing for the continuity, comfort and intimacy of the relationship that had been established over so many years. While the hospitalist model may have brought efficiency, it was at the expense of personal trust and comfort. Particularly as the end of life neared, my mother's conversations with her doctor, where she had clearly talked about her wishes for dignity and realism in the face of her aging, had to be continually re-expressed to avoid unnecessary testing and procedures which she did not want. Although she was fragile and elderly, she was mentally astute about her failing condition and was well

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[70] Truog, "Patients and Doctors," 585.

aware that she had lost the continuity, comfort, and intimacy of the relationship she once had with her primary care doctor. For the six-week period in which she was hospitalized at the end of her life, her primary-care physician played no role in her care or hospitalization. Despite repeated requests, there was no contact with him during her final days, which proved to be one of the most challenging periods in her life.

Dr. Peabody recognized the challenges of the doctor-patient relationship in the hospital setting nearly a century ago. Noting how the practice of medicine is "intensely personal" he described the hospital setting as "impersonal."[71] He wrote, "At first sight this may not appear to be a very vital point, but it is, as a matter of fact, the crux of the whole situation. The treatment of a disease may be entirely impersonal; the care of the patient must be completely personal."[72]

There is an argument to be made that known protocols in medicine are just as effective if they are delivered by a hospitalist whom a patient has never met, or by the trusted primary-care physician who has a familiarity with the patient. In other words, any qualified physician can deliver medication to a patient that is known and accepted as the standard treatment for a particular illness. In such a case, does the doctor-patient relationship really have any bearing? Dr. Peabody addresses this in a statement that could ring as true today as it did in 1927:

> Sickness produces an abnormally sensitive emotional state in almost every one, and in many cases the emotional state repercusses, as it were, on the organic disease. The pneumonia would probably run its course in a week, regardless of treatment, but the experienced physician knows that by quieting the cough, getting the patient to sleep, and giving a bit of encouragement, he can save his patient's strength and lift him through many distressing hours. The institutional

[71] Peabody, "Care of the Patient," 877.
[72] Ibid.

> eye tends to become focused on the lung, and it forgets that the lung is only one member of the body.[73]

The doctor-patient relationship is especially important with the elderly population who make up the majority of hospital patients. "Elderly patients, especially those beyond the age of sixty-five, grew up in an age when doctors were more highly regarded than they are today… This doctor of the past who made house calls, delivered most of the babies, and was there when needed for care and advice remains vivid in the memories of many elderly people."[74] As primary-care physicians are now inpatient vs. outpatient in response to economic demands, lifestyle demands and the increasing complexity of care, the potential for a breakdown in the doctor-patient relationship at a time of vulnerability for the patient threatens continuity of care. Hamel, et al, raise this:

> Although hospitalists provide important benefits, their involvement disrupts the continuity of care provided by the patients' primary-care physicians, resulting in potential adverse effects for both patients and doctors… When primary-care physicians are not at the bedside of their acutely ill patients, valuable opportunities to deepen the patient-doctor relationship are missed."[75]

One factor that makes it more difficult to provide personalized medical care in the hospital environment is that the team of doctors providing care to a single patient has grown exponentially. In a speech to the 2011 graduating class of Harvard Medical School, physician and journalist Atul Gawande reported that in 1970, 2.5 clinical staff full-time equivalents were involved in the care of a typical hospital patient but by the end

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[73] Peabody, "Care of the Patient," 878.
[74] David Cram, *The Healing Touch: Keeping the Doctor-Patient Relationship Alive Under Managed Care* (Omaha: Addicus Books, 1997), 44.
[75] Hamel, Drazen, and Epstein, "The Growth of Hospitalists…," 1142.

of the 1990s, that number had grown to more than fifteen.[76] "Everyone has just a piece of patient care. We're all specialists now – even primary care doctors. A structure that prioritizes the independence of all those specialists will have enormous difficulty achieving great care."[77] This is important because it points to a resultant fragmentation of care that occurs during hospitalization, making a doctor-patient relationship all the more difficult to achieve.

Hospitalist medicine emerged at a time of increasing specialization in medicine, and it is now commonplace for patients to have a roster of doctors taking care of each individual organ or body part. As Dr. Gawande notes, "It's like no one's in charge – because no one is. The public's experience is that we have amazing clinicians and technologies but little consistent sense that they come together to provide an actual system of care, from start to finish, for people."[78]

In the absence of the primary-care physician, hospitalists take over as inpatient primary-care physicians but with little real opportunity to foster a doctor-patient relationship. There may be a different hospitalist each day during a hospital stay, and no guarantees for the same hospitalist upon readmission to the hospital.

Dr. Peabody emphasized the "vital importance of the personal relationship between physician and patient in the practice of medicine."[79] Hospitalists today likely share an interest in the personal relationship as well, but face economic and practical

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[76] Atul Gawande, "Cowboys and Pit Crews," *The New Yorker*, May 26, 2011, accessed October 9, 2012, http://www.newyorker.com/online/blogs/newsdesk/2011/05/atul-gawande-harvard-medical-school-commencement-address.html.
[77] Gawande, "Cowboys and Pit Crews."
[78] Ibid.
[79] Peabody, "Care of the Patient," 882.

obstacles that make delivering personalized care within the hospital environment more challenging. To embody the qualities of a 'good physician' as defined by Dr. Peabody is perhaps not impossible but a challenge for the hospitalist model of care in the twenty-first century:

> The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.[80]

One trade-off for patients with the hospitalist model of care is that of convenience versus familiarity. As this chapter examined the importance of the doctor-patient relationship in the care of the patient, Chapter 3 considers communication between primary care doctors, hospitalists and patients, and how it can be used to greatest effect for the benefit of the patient.

[80] Peabody, "Care of the Patient," 882.

CHAPTER 3

Physician Communication and Continuity of Care

With the growth of the hospitalist movement, much has been written about the economic benefits derived from this new model. However, the hospitalist model raises major concerns regarding continuity of care–or the possible breakdown of continuity that occurs when the primary care doctor cedes control of his or her patient to the hospitalist for inpatient care.

Since the beginning of the hospitalist movement and still today, communication is the issue at the heart of "continuity of care." Communication between the primary-care physician and the hospitalist presents possibly the greatest ongoing challenge for this model of care. "The hospitalist model creates a purposeful discontinuity between office and hospital, potentially leading to some loss of critical information relevant to patient care,"[81] explains Dr. Wachter in an article examining the trajectory of the hospitalist movement. While Dr. Wachter may consider the discontinuity as 'purposeful,' primary-care physicians and hospitalists should not just accept its negative consequences as an unfortunate corollary to hospitalist care. Instead, we need systems to support communication between the primary-care physician and the hospitalist.

Authors Drs. Pantilat, Alpers and Wachter, point out in an early article on hospitalists, "Discontinuity of care existed before the advent of hospitalists and is

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[81] Wachter, "Hospitalists in the United States—Mission Accomplished or Work in Progress?" *The New England Journal of Medicine* 350, no. 19 (May 2004): 1935, accessed March 7, 2012, www.nejm.org.

tolerated with a hand-off approach to specialists, surgeons, and intensivists."[82] This argument may lead one to consider that there is nothing different with the hand-off to a hospitalist, however the authors continue by making a strong point to counter this: "…the use of hospitalists dramatically changes the scope and impact of this discontinuity by imposing complete, rather than partial, disruption when patients most need the protection provided by a longstanding relationship."[83] Considering that Dr. Wachter is one of the authors and an early proponent of the hospitalist model, this viewpoint is particularly noteworthy in that it acknowledges the deliberate disruption of care from the outpatient to the inpatient setting, as well as the value of the doctor-patient relationship.

Primary-care physicians have been handing off care of their patients to specialists for years, but more commonly to specialists who are not practicing exclusively in the hospital environment in the way a hospitalist is. If a patient is under the care of a cardiologist in the hospital setting due to a heart problem, or a surgeon for that matter, there is a good chance that the patient will also be following up with the cardiologist and/or surgeon on an outpatient basis. Not so with the hospitalist, however. Once a patient is discharged from the hospital, subsequent follow up is with the outpatient primary-care physician. As a result, communication between the inpatient and outpatient settings is truncated, and information about admission, discharge and the overall hospital stay may be elusive. Nevertheless, the details of events during the hospital stay hold importance for the health of the patient.

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[82] Steven Z. Pantilat, Ann Alpers, and Robert M. Wachter, "A New Doctor in the House: Ethical Issues in Hospitalist Systems," *The Journal of the American Medical Association* 281, no. 2 (July 1999): 171.
[83] Ibid.

My mother's primary care physician had strong relationships with the physicians he referred her to for specialty care, including a cardiologist, hematologist and gastroenterologist among others. As community-based physicians they had established a network, which included dialogue between the parties with the goal of continuity of care. These specialists now work successfully with the hospitalists, but it is more difficult for the primary care physician to stay in the loop and establish connections with the hospitalists given the busy environment of the inpatient setting. Today hospitalized patients tend to be acutely ill, warranting their hospitalization, and hospitalists move from one acutely ill patient to the next, or from one crisis to another on a floor of many patients, each with their own primary-care physicians. In practice, the give and take of communication between hospitalist and primary-care physician upon admission, during hospitalization and upon discharge, was severely lacking in our experience.

Harold Sox, MD, writes that, "an internist entering practice today would hardly recognize the life of the internist of twenty years ago."[84] The traditional model of primary-care physicians caring for their patients when hospitalized has been replaced at the same time the severity of illness of hospitalized patients has increased. Hospitals differ as to whether it is voluntary or mandatory to transfer the responsibility of patient care to a hospitalist, but Dr. Sox points out that physicians are especially concerned in the case of mandatory hand offs:

> They will deeply resent any outside force coming between them and their hospitalized patients. They want to keep their implicit promise to be there when

[84] Harold Sox, "The Hospitalist Model: Perspectives of the Patient, the Internist and Internal Medicine," *Annals of Internal Medicine* 130, no. 4 (February 1999): 369.

> their patient needs them, regardless of the venue of care. They fear the loss of their autonomy, self-esteem, patient care skills and professional identity… A requirement to admit one's patient to the care of another physician strikes at the very core of the internist's identity.[85]

How primary-care physicians react to the hospitalist model of care may be dependent on the value they place on providing care to their patients directly. Physicians with busy practices may welcome the hospitalist model as it frees them from the obligation of providing inpatient care, while others may feel that it impinges on their professional identity as the primary care doctor and the need for them to maintain their acute care skills.

A report in the Journal of General Internal Medicine studied physician attitudes toward caring for inpatients and the hospitalist model of inpatient care. "The majority (68%) responded that care of inpatients was best directed by 'the physician who has a long-term relationship with the patient.'" [86] This study also addressed the doctor-patient relationship with the introduction of the hospitalist: "Ten percent of physicians agreed that a hospitalist service would improve patient satisfaction, and 54% felt it would reduce their satisfaction with their medical career and hurt their relationships with patients."[87]

If continuity of care is jeopardized then the result is fragmentation of care, one of the criticisms aimed at the hospitalist movement. As the specialty was gaining momentum in its early days, physician Farrin Manian, M.D., wrote in The New England Journal of Medicine, "This latest economically driven fragmentation of medical care may

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[85] Sox, "The Hospitalist Model," 369.
[86] Andrew D. Auerbach, Roger B. Davis, and Russell S. Phillips, "The Physician Views on Caring for Hospitalized Patients and the Hospitalist Model of Inpatient Care," *Journal of General Internal Medicine* 16, no. 2 (February 2001): 117.
[87] Ibid.

demonstrate that it is possible to shorten hospital stays without increasing short-term mortality, but it falls far short of preserving what has until now been a central tenet of primary care medicine: continuity of care."[88]

Deficits in communication and information transfer at hospital discharge were studied and reported on in the Journal of the American Medical Association. The investigators reviewed fifty-five observational studies published over a period between 1970 and 2005. "In this literature, direct communication between hospital physicians and primary-care physicians during the discharge process occurred infrequently. Only 3% of primary-care physicians reported being involved in discussions about discharge, and 17% to 20% reported always being notified about discharges."[89] Audits of hospital discharge documents demonstrated a lack of important details being transmitted to the primary-care physician: "For example, discharge summaries often did not identify the responsible hospital physician (missing from a median of 25%), the main diagnosis (17.5%), physical findings (10.5%), diagnostic test results (38%), discharge medications (21%), and specific follow-up plans (14%).[90]

In our numerous experiences with inpatient hospitalizations, the primary-care physician was kept out of the loop throughout the hospital stay, both physically as well as in regard to information transfer. The medical records department might eventually fax

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[88] Manian, "Whither continuity of care?" *The New England Journal of Medicine* 340, no. 17 (April 1999), accessed February 18, 2013, http://search.proquest.com/docview/223939506?accountid=48847.
[89] Sunil Kripalani et al, "Deficits in Communication and Information Transfer Between Hospital-based and Primary Care Physicians," *The Journal of the American Medical Association* 297, no. 8 (February 2007): 832-833.
[90] Ibid., 833.

over progress notes and discharge instructions, but usually far too late for any meaningful action to be taken on the part of the primary-care physician. Unfortunately this lack of communication comes at a time of great vulnerability for a hospitalized patient and confusion for family and loved ones. Patients and families may be led to believe that information between the hospital and the primary-care physician is immediate and seamless, but in fact most of the information, if it is transferred at all, comes after the fact. Thomas Bodenheimer, M.D., refers to this as the "voltage drop" in information after discharge.[91] "The hospitalist movement, which separated the outpatient physician from the inpatient hospitalist, created discontinuity at a critical juncture of the patient's life."[92]

In a recent study done to measure continuity of outpatient and inpatient care by primary-care physicians for a population of Medicare patients, researchers studied whether continuity of care was being preserved during the transition from outpatient to inpatient care. The authors explain, "Continuity is generally recognized to have 3 dimensions – continuity in information, continuity in management, and continuity in the patient-physician relationship,"[93] and their study specifically focused on the dimension of the patient-physician relationship. Using data from The Centers for Medicare and Medicaid Services, they studied whether hospitalized patients had seen a physician that

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[91] Bodenheimer, "Perilous Journey," 1067.
[92] Ibid.
[93] Sharma et al, "Continuity of Outpatient and Inpatient Care by PCPs," *Journal of American Medical Association* 301, no. 16 (April 2009): 1671, accessed March 9, 2012, www.jama.ama-assn.org.

he or she knew from an outpatient setting, and whether those with an identified primary-care physician had seen their doctor in the hospital.

Their research found that, "Between 1996 and 2006, 45.2% of hospitalized patients received care during hospitalization by a physician who had seen them at least once as an outpatient in the prior year, and 38.0% of hospitalized patients with an identified PCP received care from that PCP during hospitalization."[94] More specifically, the study observes the decreases over time of outpatient to inpatient continuity: "Outpatient to inpatient continuity with any outpatient physician decreased from 50.5% in 1996 to 39.8% in 2006. Similarly, outpatient to inpatient continuity with a PCP decreased from 44.3% in 1996 to 31.9% in 2006."[95] Their findings led them to conclude, "The proportion of patients experiencing continuity between outpatient and inpatient settings decreased substantially between 1996 and 2006… Decreases in continuity of care occurred in all areas of the country, in all types of hospitals, and for all diagnoses."[96] In their analysis they noted, "one-third of the decrease in continuity between 1996 and 2006 was associated with growth in hospitalist activity, and there is a rough correspondence of regions of the country with the biggest decreases in continuity and those with the greatest increases in hospitalist activity."[97]

The authors explain an economic reality in health care today that impacts this inevitable discontinuity: Medicare only allows reimbursement for one generalist

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[94] Sharma et al, "Continuity," 1674.
[95] Ibid.
[96] Ibid., 1677
[97] Ibid.

physician during hospitalization, so there is a disincentive for primary-care physicians to be involved in the care of their patients when a hospitalist is involved, unless they choose to visit their patients without billing for their time, make a social visit or initiate a phone call. In our family's situation, we made a specific request through the hospitalist for a visit from the primary-care physician but were told that the primary-care physicians no longer can come to the hospital. As an alternative, we made a direct appeal to the primary-care physician for a phone call to our mother, but unfortunately no such phone call ever occurred. At such a vulnerable time when she was interested in discussing important decisions reflecting her values, the absence of connection to the doctor she had had a relationship with felt like a betrayal from the health care system and from him personally. Between the rotating teams of hospitalists and specialists that are called in for consultation, it is no wonder that a study cited by Sharma and his colleagues found that "75% [of patients] were unable to name any physician participating in their care."[98] In his commentary in The New England Journal of Medicine, Dr. Manian sums this up well:

> Forcing patients to navigate various health care settings without the services of their primary-care physicians trivializes the role of the primary-care physician in seeing the patient through an illness. This approach also underestimates the important but less rigidly studied role of the primary-care physician in providing the comfort of a familiar face in a potentially frightening environment with many unfamiliar faces.[99]

I would argue that the hospitalist model of care has so far been unsuccessful in bridging the gap in communication that occurs when a patient is admitted to a hospital,

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[98] Sharma et al, "Continuity," 1678.
[99] Manian, "Whither Continuity of Care," 1362-3.

thus fueling the discontinuity of care and eroding the trust established in the doctor-patient relationship at a time of increased vulnerability.

Knowledge of the hospitalist system by the general public is severely lacking, but in Chapter 4, I review some of the literature related to the patient's perspective and share some of my own experiences that have shaped my viewpoint.

CHAPTER 4

The Patient's Perspective on Hospitalist Care

When it comes to hospitalist care, capturing the voice of the patient has been sparse at best. Most of the literature surrounding the hospitalist model has focused on patient outcomes, financial benefits, and continuity of care with primary-care physicians. Assessments of patient satisfaction primarily come from patient satisfaction surveys, done on a routine basis throughout many health-care systems. However, these surveys do not ask specific questions about the hospitalist. The patient's perspective on hospitalist care may not be a critical element in the success or failure of the hospitalist model at an institutional level; nonetheless, the patient's personal feelings can be an important factor in how a patient and family view their experiences, a factor that has implications for hospital care and medical humanities.

Press Ganey Associates is one of the nation's leading companies measuring and analyzing patient satisfaction and the overall patient experience for hospitals. As they claim on their website, "We do this by capturing the voice of the patient through innovative techniques and then our advanced analytics and expert advisors implement improvements to clinical, operation, financial and experiential outcomes."[100] Touted as "A New Solution for Increasing Hospitalist Patient Satisfaction," the Press Ganey website now markets a specific new tool to measure patient satisfaction regarding hospitalists. As they note:

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[100] "Our Mission," Press Ganey, accessed July 30, 2013, http://www.pressganey.com/aboutUs/ourMission.aspx.

> Approximately half of the hospitals in the U.S. utilize the hospitalist model. Within those facilities, hospitalists are pivotal to overall patient experience and directly impact the reputation of the hospital. Yet – despite the importance of the hospitalist team on overall patient satisfaction and facility reputation – no methodology existed for measuring, benchmarking and improving hospitalist-specific patient satisfaction until recently.[101]

The new tool they employ, Hospitalist Insights[SM], is described as a "provider-specific patient satisfaction solution,"[102] to increase patient satisfaction with the hospitalist model of care. This is accomplished by assessing individual hospitalists according to patient satisfaction scores, comparing hospitalists to other hospitalists rather than just to other physicians, aligning bonuses to performance, and tracking performance over time.[103] The results of such surveys are available to the hospitals purchasing the tool.

In 2011, Press Ganey Associates published a paper entitled, "Patient Satisfaction With Hospitalists: Facility-Level Analyses"[104] in which the authors first disclosed their potential conflict of interest ("ie, a financial relationship with the commercial organizations or products discussed in the article"[105]) but state, "A broad literature review

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[101] "Hospitalist Insights," Press Ganey, accessed July 30, 2013, http://www.pressganey.com/ourSolutions/hospitalSettings/satisfactionPerformanceSuite/hospitalistinsights.aspx.
[102] Ibid.
[103] Ibid.
[104] Bradley R. Fulton et al, "Patient Satisfaction with Hospitalists: Facility-Level Analyses," *American Journal of Medical Quality* 26, no. 2 (March 2011): 95, accessed, July 30, 3013, http://www.pressganey.com.
[105] Ibid.

suggests that evidence on patient satisfaction is inconclusive. Thus, there is no general consensus regarding the impact of hospitalists on patient satisfaction."[106]

Press Ganey conducted an exploratory study, but started out with an assumption about hospitalist care that I believe shows a bias. "Because hospitalists focus on the patient (a function of the hospitalist role) and because they are likely to spend more time with patients than other physicians, it is anticipated that facilities with hospitalists will have higher scores in relevant areas of patient satisfaction."[107] Perhaps when you start out with expectations such as these, your beliefs are borne out in the research. In this particular study, the method used to measure patient satisfaction with the hospitalist model of care was an inpatient satisfaction survey that rated 10 sections of the inpatient experience [admission, room, meals, nurses, tests and treatments, visitors and family, physician, discharge, personal issues, and overall assessment[108]] but never addressed specifics of being cared for by a hospitalist. The study notes that 41% of the 1777 hospitals surveyed had hospitalist programs, and summarize by saying, "hospitalist facilities had higher patient satisfaction scores in relation to nurses, personal issues, and overall assessment than non-hospitalist facilities."[109] They relate this summary conclusion to having a hospitalist readily available so that nurses can answer questions in a timely manner. I do not view this exploratory research as particularly strong or as a true endorsement of the hospitalist movement from a patient's perspective, as the patients were not asked directly about the presence of a hospitalist or the absence of their

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[106] Fulton, "…Facilty-Level Analyses," 95.
[107] Ibid., 96.
[108] Ibid.
[109] Ibid., 99.

primary-care physician, and the results reflect more on patient satisfaction as it relates to nursing.

Drs. Hruby, Pantilat, and Lo write, "Few studies examine what inpatients think about receiving hospital care from a physician they do not know. Anecdotal evidence suggests that they may feel abandoned by their PCP and may fear their care will suffer because of lack of communication between their inpatient and outpatient physicians."[110] The authors attempted to discern how patients view the role of the primary-care physician in inpatient care in a study interviewing hospitalized patients and seeking to "determine patients' knowledge, preferences and satisfaction regarding the involvement of their primary-care physician in their inpatient care."[111] This is a somewhat circumspect way of determining the satisfaction of patients with the hospitalist, but nevertheless gives a glimpse into the role that patients see for their primary-care physicians versus a hospital physician who does not know them. The results showed, "About 50% of respondents believed that a PCP (rather than a separate hospital physician) should inform a patient of a serious diagnosis or discuss choices between medical and surgical management. Patients under the care of an inpatient physician want contact with their PCP and want good communication between the PCP and hospital doctors."[112]

Although respondents generally had positive views about inpatient physicians [hospitalists] and agreed that they were, "more available to inpatients and more skilled in

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[110] Milena Hruby, Steven Z. Pantilat, and Bernard Lo, "How Do Patients View the Role of the Primary-Care Physician in Inpatient Care?" *The American Journal of Medicine* 111, no. 9B (December 2001): 21S-25S.
[111] Ibid.
[112] Ibid.

hospital care than clinic doctors,"[113] a mix of sadness, disappointment, anger and hurt were some of the reactions the authors detected in their interviews with patients about the role of their primary-care physician, particularly when there had been no contact at all. "Respondents also agreed that doctors whom they had known for a long time are more trustworthy and can give better care than doctors they have just met."[114] In discussing their findings, the authors make a powerful observation about patients' expectations:

> Many inpatient cases are relatively straightforward. However, when the stakes are higher for the patient, such as those with more serious illness or who require more complicated decisions, patients feel that face-to-face discussions with a familiar PCP can be helpful. Such visits may ensure that patients' concerns, questions, psychosocial issues and anxieties are addressed.[115]

Had our family or my mother as the patient been among those interviewed about the role of her primary-care physician in her care, there would have been strong emotions akin to those the authors detected in their research. At a time of hospitalization and serious illness, there was a sense of abandonment from the primary-care physician, which could easily have been eased by a phone call or a visit. In her case, the stakes were very high, and a face-to-face discussion with a physician familiar to her would have brought her reassurance and perhaps peace of mind at the end of life. As Dr. Sox notes in his observations about the break in continuity of care for a patient who is ill and not free to choose their own physician while hospitalized, "Implicit in a long-term patient-physician relationship is the physician's promise to 'be there' for the patient in times of duress.

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[113] Hruby, Pantilat, Lo, 23S.
[114] Ibid.
[115] Ibid., 24S.

Hospitalist models can endanger this fiduciary relationship."[116] Dr. Sox makes a strong case for a patient's right to choose a physician:

> Patients want their personal physician to be meaningfully involved in their hospital care. They want a personal physician who takes a deep, abiding interest in their well-being. Our profession's code of conduct requires loyalty to the patient. The two-way relationship between patient and physician has been at the heart of good medical care since earliest times.[117]

As discussed, the hospitalist model imposes a purposeful disconnect with the primary-care physician, deliberately disrupting the transition of care from outpatient to inpatient and then back to outpatient. But because hospitalist systems leave little role for a patient's primary-care physician, ethical values may be compromised. Confidentiality may be broken when sensitive information discussed with a primary-care physician must be shared with a hospitalist that the patient did not choose, let alone may not like. If hospitalist and primary-care physicians should disagree, which of the doctors is considering the patient's autonomy and his or her best interests? Authors Pantilat, Alpers, and Wachter emphasize, "In the course of an ongoing relationship, patients and their PCPs negotiate the process of medical decision making and the patient's goals and values regarding medical interventions. Fundamental ethical duties such as confidentiality and principles such as respect for patient autonomy and beneficence support these agreements and protect the patient's individuality and well-being."[118]

My mother, who was born in 1919, grew up with a similar understanding of the role of the doctor that was prevalent when Dr. Peabody wrote his insightful piece, *The*

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[116] Sox, "The Hospitalist Model," 369.
[117] Ibid., 371.
[118] Pantilat, Alpers, Wachter, "A New Doctor in the House," 171.

Care of the Patient in 1927. She valued the confidential, professional and personal relationships she established with her doctors over the years, admiring those doctors with the combination of astute clinical skills and deep personal knowledge, seeing that mix as the essence of a skilled physician. She worked hard at establishing relationships built on trust so that when she was faced with difficult choices for either herself or a family member she knew she could expect decisions to be derived from her doctor's personal understanding. Hospitalization in the new era of hospitalist medicine makes it difficult to emulate the values Dr. Peabody espoused of treating patients in a completely personal way. In his words:

> Disease in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment.[119]

Before effective research can determine patient satisfaction with the new model of hospitalist care, the public needs to be educated about the evolving roles of inpatient and outpatient practitioners for primary care. Research has correctly focused on patient outcomes, reducing the cost of care and improving quality of care, but for the hospitalist model to ultimately improve patient satisfaction and strengthen primary-care medicine, research needs to also examine the effects of the hospitalist model on the doctor-patient relationship, patient dignity and trust. These aspects of hospitalization are at the root of medical humanities and are essential elements in providing a humanistic healing

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[119] Peabody, "The Care of the Patient," 882.

environment in which a patient's full life – in the context of health, illness, family and society – are considered.

CHAPTER 5

Improving inpatient care in the era of the hospitalist

Although the days of the family doctor making daily rounds on his or her hospitalized patients may be over, the hospitalist model of care that has taken hold across the nation is still young and evolving. As such, there are many aspects of hospitalist medicine that can be strengthened. In this chapter, I will discuss some areas where the hospitalist model can be improved, including ways to overcome discontinuity of care and improve communication, opportunities for primary-care physicians and hospitalists to work together, and the importance of educating the public about this new model of care. I present these ideas from the perspective of a family member who has experienced the hospitalist model first-hand, discussing what primary-care physicians can do to alleviate patients' anxieties while hospitalized, as well as offering an alternative practice model to be considered.

Much of the literature on hospitalist medicine has touted its benefits, but the overriding concern, criticism, and liability of hospitalist medicine is discontinuity of care. Dr. Robert Wachter, who first coined the term 'hospitalist' back in the late 1990s, acknowledges this in an article in the Journal of the American Medical Association where he and co-authors discuss how hospitalists impose complete discontinuity and state "…the expanding use of hospitalists means that millions of hospitalized patients in this country will experience this disruption."[120]

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[120] Wachter et al, "A New Doctor in the House," 171.

To mitigate this disruption, one must first value personal contact with the primary-care physician. If the primary care doctor is viewed as the gateway to the health care system for their patients, then their knowledge of patients should be well-integrated not only when a patient is relatively healthy, but during a time of hospitalization. Close collaboration between the hospitalist and the primary-care physician is critical to avoid the "voltage drop"[121] of information described by Dr. Bodenheimer. With electronic health records, a computerized system that allows information to flow between PCPs and hospitalists can help alleviate the disconnect that so often occurs; but computerized systems cannot be the answer alone. Although health care today relies increasingly on technology, there is still value in a hands-on approach to patient care, which forms the core of humanism in medicine. I would argue that personal contact between doctor and patient, as well as doctor-to-doctor contact, is still the basis for effective communication (even in the age of technology) and needs to occur upon admission, during hospitalization, and upon discharge. As Dr. Sox states, "The two-way relationship between patient and physician has been at the heart of good medical care since the earliest times. The medical care system should enable physicians and patients to keep their fundamental commitment to each other."[122]

Drs. Hruby, Pantilat, and Lo state that, "At a minimum, the PCP needs to be informed that the patient is in the hospital, and the PCP should telephone the patient. Because health-care plans encourage patients to develop ongoing relationships with PCPs, it seems uncaring if PCPs do not contact patients who are sick enough to be

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[121] Bodenheimer, "Perilous Journey," 1079.
[122] Sox, "The Hospitalist Model," 371.

hospitalized."[123] Ironically, while health care plans encourage the PCP as gatekeeper, they may not reimburse a visit from a PCP when the hospitalist has assumed responsibility of care as an inpatient. Drs. Wachter and Pantilat surveyed primary-care physicians who admit patients to hospitalists and found that most do not come to see their patients in the hospital. "We surveyed 556 family physicians in California who had used hospitalists and found that only 34% stated that they usually or always visited their inpatients and just 21% usually or always called them."[124] One of the reasons cited, in addition to time pressures in the office or having to travel to the hospital, was that doctors are typically unable to bill for such a visit.

To counter discontinuity, Drs. Wachter and Pantilat suggest a "Continuity Visit," first described in 2001 in the American Journal of Medicine.[125] Different than just visiting for purely social reasons, the continuity visit underscores the important role of the PCP prior to and following hospitalization, and could also be justified as a clinical encounter between doctor and patient for which insurance could reimburse. As Dr. Wachter suggests, such a visit could also lend credibility to the hospitalist by giving patients a sense of comfort from their PCP who has sanctioned this model of care.[126] More importantly, he emphasizes that real clinical information could be gained during such a visit from a physician who is familiar with a patient, or who might be more in tune with their preferences based on a long-term trusting relationship. "Importantly, we believe that the goals of the continuity visit can be met with a single, or at most two such

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[123] Hruby, Pantilat, and Lo, "How Do Patients View the Role?" 24S.
[124] Wachter & Pantilat, "The 'Continuity Visit,'" 41S.
[125] Ibid., 42S.
[126] Ibid., 41S.

visits per hospitalization, and, in some cases, can be met by a phone call between primary physician and inpatient."[127] In addition to benefitting the patient, I would suggest that a continuity visit offers advantages for the hospitalists as well, affording them the opportunity to gain valuable insights into a patient's illness, personality and family support system that they may have been previously unaware of.

Had such a continuity visit occurred during my mother's hospitalization, it might have done wonders for both my mother's spirits and the hospitalists' knowledge. As an example, when my mother was first hospitalized on a weekend, she was started on a medication that gradually made her psychotic, not an uncommon reaction to this particular medication in an elderly patient. By Monday, when the psychosis was full-blown, a new hospitalist came on duty, different from the one covering for the weekend. When I expressed my concerns to the hospitalist that the medication was having a detrimental effect on her mental state, he dismissed my reaction, implying that she was elderly, therefore it was common to be confused at her age, and stating that it had nothing to do with medication. Trying to explain that this confusion was not normal for her was frustrating, but a call or visit from her PCP would have confirmed this right away. Later that day, because the medication was not having the intended therapeutic effect, the medication was stopped and her mental status was restored. By Wednesday, the hospitalist from Monday (different from the hospitalist from Tuesday) stopped me to apologize for his quick judgment. He had gone in for rounds that morning and found her reading *The New Yorker,* whereupon she proceeded to discuss with him one of the

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[127] Wachter & Pantilat, "The 'Continuity Visit,'" 41S.

articles she was reading with complete clarity and intellect. Insights from the primary-care physician could have helped to avert this situation.

A continuity visit lets patients know they have not been abandoned, may reduce duplicate testing and confusion over medications, and can most likely facilitate an easier transition back to outpatient care. Whether the 'visit' is in person or on the phone, it has benefits for patients, PCPs and hospitalists. In the scheme of things it seems like a minor time commitment for a potentially large gain.

In addition to addressing discontinuity of care, I would argue that enhancing the value of hospitalists and primary-care physicians working together can only benefit patient care, strengthen primary care and maintain the importance of the doctor-patient relationship. Instead of an abrupt end to the role of the primary-care physician, resulting in fragmentation, care should be coordinated across all settings including outpatient, inpatient, sub-acute and long-term care in the best interests of the patient. In a two-way dialogue, the primary-care physician can convey pertinent medical and family history and insights into a patient's view on health care decision-making, while hospitalists can keep them abreast of a patient's hospital course, such as test results, findings and diagnoses. Drs Hamel, Drazen and Epstein point out, "Proactive strategies to enhance communication between hospitalists and primary-care physicians and to efficiently transmit discharge summaries and updated medication lists can promote better care."[128] In addition, efforts to ease transitions from setting to setting can be facilitated by the hospitalist and PCP. "Ideally, systems should be in place so that every patient leaves the

[128] Hamel, Drazen, and Epstein, "Growth of Hospitalist," 1142.

hospital with a scheduled appointment to see his or her primary-care physician soon after discharge."[129]

Dr. Kripalani and co-authors address a compelling reason for bridging this communication gap upon discharge in an article published in JAMA in 2007. They state, "Research is beginning to show that poor information transfer and discontinuity are associated with lower quality of care on follow-up, as well as adverse clinical outcomes."[130] The authors cite research that found that, "errors related to discontinuity of care occurred for about 50% of patients and that lapses in communication related to diagnostic evaluations were associated with a significantly higher risk of readmission."[131] The authors present the table below suggesting several steps to improve communication

[129] Hamel, Drazen, and Epstein, "Growth of Hospitalist," 1142.
[130] Kripalani, "Deficits in Communication…," 838.
[131] Ibid.

between inpatient and outpatient physicians at hospital discharge[132]:

Box. Suggestions to Improve Communication and Information Transfer Between Inpatient and Outpatient Physicians at Hospital Discharge

On the day of discharge, a summary document should be sent to the primary care physician by e-mail, fax, or mail. If a complete discharge summary cannot be sent on the day of discharge, then an interim discharge note should be sent. At minimum, it should include the diagnoses, discharge medications, results of procedures, follow-up needs, and pending test results.

Discharge summaries should include the following:

- Primary and secondary diagnoses
- Pertinent medical history and physical findings
- Dates of hospitalization, treatment provided, brief hospital course
- Results of procedures and abnormal laboratory test results
- Recommendations of any subspecialty consultants
- Information given to the patient and family
- The patient's condition or functional status at discharge
- Reconciled discharge medication regimen, with reasons for any changes and indications for newly prescribed medications
- Details of follow-up arrangements made
- Specific follow-up needs, including appointments or procedures to be scheduled, and tests pending at discharge
- Name and contact information of the responsible hospital physician

Discharge summaries should be structured with subheadings to organize and highlight the information most pertinent to follow-up care and to ensure that all essential topics are addressed.

To the extent possible, hospitals should use information technology to extract information into discharge summaries to ensure accuracy (eg, medication names and doses) and to facilitate rapid completion of summaries.

If possible, patients should be given a copy of the discharge summary or note and told to bring it to their follow-up visit.

Even if all of these mechanisms were put in place, there is still a large void in what the public understands about the hospitalist model of care. This confusion can lead to disappointment and fear at the vulnerable time of hospitalization, especially if the hospitalist is not a physician a patient would have chosen, were they to be given a choice. "Patients generally receive no information about the use of hospitalists until they are admitted and do not give informed consent regarding hospitalist care,"[133] it is noted in a JAMA article. Education directed toward patients and the public about the use of hospitalists in inpatient care is necessary. In fact there are several opportunities to inform

[132] Kripalani, "Deficits in Communication…," 838.
[133] Wachter et al, "A New Doctor in the House," 173.

patients about the role of the hospitalist, including at a visit with the PCP, during pre-admission planning or when enrolling in a health insurance plan. Hospitals can also inform patients through patient education materials about the transition to hospitalist care. Ultimately patient education before hospitalization can mitigate the surprise factor and sense of abandonment that patients may feel upon being hospitalized. As noted in the article addressing ethical issues in hospitalist systems, "In the future, patients may select both an outpatient primary physician and inpatient physician or outpatient and inpatient care provider teams. Because hospitalists offer efficiency and cost savings in inpatient care, patients may need to shoulder some of the costs if they choose non-hospitalist systems."[134] I would advocate for education about the hospitalist model of care in order for patients to make the choices that are best for them.

Although the hospitalist model of care is taking hold for the foreseeable future, it is not the only solution to achieving a complex balance between a patient's outpatient and inpatient experience. While I would not suggest that it would be viable to go back to the old model of hospital care by the primary physician, one alternative model would be for a primary care practice to operate as a group, rotating the inpatient physician responsibilities so that all members practice both inpatient and outpatient medicine. As explained by Hamel, et al, "Many practices have long used a system in which primary care physicians who are members of the group rotate as the inpatient attending physician."[135] From a patient/family point of view, this may provide a sense of security

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[134] Wachter et al, "A New Doctor in the House," 173.
[135] Hamel, Drazen, and Epstein, "Growth of Hospitalists…," 1143.

and confidence in seeing a familiar face and in the knowledge that a colleague in their practice of choice is overseeing their care.

Finally, while research has been conducted to measure the economic benefits of the hospitalist model of care and its impact on quality, with only moderately convincing results I would note, it is time to survey patients, with research designed to asses patient understanding of and satisfaction with the hospitalist system. As hospitalist care approaches a two-decade long growth and presence in the American health care system, more rigorous analysis can shed light on whether this system is headed in the right direction. More research is needed on ways to optimize patient satisfaction with hospitalist care and instill a sense of confidence at a time of vulnerability for the hospitalized patient.

CONCLUSION

The emergence of the specialty of 'hospital medicine' has been considered by some to be one of the most promising innovations in health-care delivery. As this thesis has explored, when the specialty of hospitalist medicine first became recognized in the late 1990's, the role of the primary-care physician during their patient's hospitalization began to change. Increasingly, primary-care physicians shifted their focus to outpatient care, relinquishing privileges to see their patients in the hospital setting and relying on the expertise of the 'hospitalist' or inpatient physician. With its promise of easing economic pressures and improving quality of care, the hospitalist model has been touted as the answer to some of the challenges of primary care medicine and soaring health care costs, and indeed there have been studies to show these benefits. However, as I have argued, the hospitalist model of care compromises continuity of care by breaking established doctor-patient relationships when patients are most vulnerable during a time of hospitalization.

Unlike cost savings and economic benefits, the value of having a personal relationship with the primary care doctor involved in patient care is more difficult to measure. Nevertheless, the field of medical humanities is rooted in the doctor-patient relationship, and therefore examining the impact of hospitalist medicine is essential to improving patient care. A compromised relationship at a fragile time for a patient is not necessarily good medicine.

Much of the literature has focused on the benefits of the hospitalist model including improved quality, reduced length of stay and reduced costs. The hospitalist

field aims to address financial concerns of hospitals and lifestyle issues of physicians, but its weakness is that it has not been as focused on patient concerns. Continuity of care and the doctor-patient relationship have been sacrificed, resulting in medical care that is fragmented due to economically driven goals. When medicine is reduced to pure economics, the doctor-patient bond that is the foundation of trust between the healer and the sick is neglected and the principles that attract doctors to primary care medicine in the first place are eroded. Drs. Hartzband and Groopman stated this quite starkly: "Reducing medicine to economics makes a mockery of the bond between the healer and the sick."[136] Primary-care physicians traditionally brought knowledge and understanding of their patients to both the inpatient and outpatient setting, but now the doctor who is there to see a patient through all scenarios is a vanishing breed with the introduction of the hospitalist model of care.

When the primary-care physician is no longer the decision-maker at a time of vulnerability in the life of a patient, then trust in the physician to act in their best interest is at risk, potentially contributing to the effectiveness of medical care. Indeed, trust may be at the core of what patients consider 'high quality care.' To increase the level of trust, the hospitalist model might benefit by looking at ways to promote communication with the primary-care physician and improve continuity of care, both of which could foster a greater sense of trust for patients. Efforts to involve the primary-care physician and make the most of an established relationship may improve patient satisfaction and outcomes of care.

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[136] Hartzband and Groopman, "The New Language of Medicine…," 1373.

My thesis has explored whether 'knowing' a patient actually matters in terms of treatment and the answer is not always clear-cut. This is more complicated for older patients who may have confided their medical wishes to their primary-care physician and have the expectation that they will see them through. When hospitalization becomes dependent on judgments regarding appropriateness of care, tests and end-of-life decisions, there is more value on the doctor-patient relationship. In such cases, the loyalty of a relationship may help to explain the meaning of an illness and establish realistic hopes about treatment and prognosis.

Bridging the gap between outpatient physician (primary-care physician) and inpatient physician (hospitalist) when patients are most ill could ameliorate some of the problems facing the hospitalist model of care. Better coordination of care across all settings, including improvements in communication between physicians, enhanced communication between hospitalist and patient, better explanations of treatment options, and closer follow-up after hospital discharge to either home or a sub-acute facility, could greatly benefit patients and restore patient and family satisfaction.

I believe that research and education will be the key to the success or failure of the hospitalist model in the future. As this model is young, there is opportunity to expand research to determine how the hospitalist model is working from the patients' point of view. In less than two decades our health care system has made a major transition to hospitalist care, which necessitates this evaluation. When the impact of the hospitalist model is factored into the equation from all sides –doctors, hospitals *and* patients – then ways to optimize patient and family satisfaction may emerge.

One weakness has been a pervasive lack of awareness of the hospitalist model on the part of patients and the general public. Patients and family members learn of the hospitalist when they enter a hospital, which is sometimes via the emergency room, and when they may be anxious to see a familiar face. As the hospitalist model expands throughout hospitals in the U.S., patients need to be educated and prepared about how their inpatient care will be managed should they need it.

As this thesis has suggested, the days of family doctors making daily rounds on their patients in the hospital are effectively over. There is little time, nor incentive, for the community practitioner to be making hospital visits when he or she is busy in the office with patients. The hospitalist model addresses this by being present all day long, checking data on patients in an up-to-the-minute fashion. Although patients may be satisfied by the care and involvement of the hospitalist, they may still be disappointed that their physician is not participating in their care. The trade-off is in the changing relationship between patient and physician, and its importance lies in its impact on the hospitalized patient.

Hospitalization disrupts a patient's day-to-day life, leaving them feeling fragile and often helpless. Subsequently, the hospitalist model disrupts the care between the outpatient and inpatient setting. At the center of this turmoil is the patient. As I reflect on my many encounters, with hospitalists over the years, some positive and others not, I have tried to square it with what I have learned throughout my years studying Medical Humanities. My hope is that hospitalists and primary-care physicians can work to gain greater clarity in their communications, both with each other and with patients, while

keeping the value of the patient-physician relationship in the forefront. This, I believe, would be in the best interests of patients.

The essence of a doctor is an interest in humanity – true for the primary-care physician as well as the hospitalist. As Dr. Peabody reminds us, “the secret of the care of the patient is in caring for the patient.” As I see it, the greatest challenge to the hospitalist may be to get to know their patients well enough to be able to care for them in a way that brings comfort and humanism. The hospitalist model should not have to compromise continuity of care nor should it break established doctor-patient relationships at a time when patients are most vulnerable.

BIBLIOGRAPHY

Auerbach, Andrew D., Davis, Roger B., and Phillips, Russell S. "The Physician Views on Caring for Hospitalized Patients and the Hospitalist Model of Inpatient Care," *Journal of General Internal Medicine* 16, no. 2 (February 2001): 116-119.

Bardes, Charles L. "Defining 'Patient-Centered Medicine,'" *The New England Journal of Medicine* 366, no. 9 (March 2012). Accessed March 7, 2012, www.nejm.org.

Barken, Frederick M. *Out of Practice: Fighting for Primary Care Medicine in America*. Ithaca: ILR Press, 2011.

Bell, Chaim M., Schnipper, Jeffrey L., Auerbach, Andrew D., Kaboli, Peter J., Wetterneck, Tosha B., Gonzales, David V., Arora, Vineet M., Zhang, James X., and Meltzer, David O. "Association of Communication Between Hospital-based Physicians and Primary Care Providers with Patient Outcomes," *Journal of General Internal Medicine* 23, no. 3 (December 2008): 381-386.

Bodenheimer, Thomas. "Coordinating Care—A Perilous Journey Through the Health Care System," *The New England Journal of Medicine* 358, no. 10 (March 2008). Accessed February 16, 2012, http://www.nejm.org.

Bodenheimer, Thomas. "Primary Care—Will Is Survive?" *The New England Journal of Medicine* 355, no. 9 (August 2006). Accessed March 7, 2012, www.nejm.org.

Brody, Howard. "My Story is Broken; Can You Help Me Fix It? Medical Ethics and the Joint Construction of Narrative," *Literature of Medicine* 13, no. 1 (Spring 1994): 79-91.

Buser, Martin. "Hospitalist Programs in the Age of Healthcare Reform," *Journal of Healthcare Management* 55, no. 6 (November/December 2010): 378-380.

Centor, Robert M. "A Hospitalist Inpatient System Does Not Improve Patient Care Outcomes," *Archives of Internal Medicine* 168, no. 12 (June 2008): 1257.

Chakrapani, Raja M. and Diamond, Herbert S. "The Hospitalist Model of Inpatient Medical Care," *Seminars in Medical Practice* 5, no. 1 (March 2002): 20-28.

Cram, David L. *The Healing Touch: Keeping the Doctor-Patient Relationship Alive Under Managed Care*. Omaha: Addicus Books Inc., 1997.

Detsky, Allan S. "What Patients Really Want From Health Care," *The Journal of the American Medical Association* 306, no. 22 (December 2011). Accessed March 9, 2012, www.jama.ama-assn.org.

Fernandez, Alicia, Grumbach, Kevin, Goitein, Lara, Vranizan, Karen, Osmond, Dennis H., and Bindman, Andrew B. "Friend of Foe? How Primary Care Physicians Perceive Hospitalists," *Archives of Internal Medicine* 160, no. 19 (October 2000). Accessed March 6, 2012, http://archinte.ama-assn.org/cgi/content/full/160/19/2902.

Fincher, Ruth-Marie E. "The Road Less Traveled—Attracting Student to Primary Care," *The New England Journal of Medicine* 351, no. 7 (August 2004). Accessed May 15, 2012, http://www.nejm.org/doi/full/10.1056/NEJMp048054.

Frank, Arthur W. "How Can They Act Like That? Clinicians and Patients as Characters In Each Other's Stories," *Hastings Center Report* 32, no. 6 (November/December 2002): 14-22.

Freed, David H. "Hospitals: Evolution, Evidence, and Eventualities," *The Health Care Manager* 23 no. 3 (Sept 2004): 239.

Fulton, Bradley R., Drevs, Kathryn E., Ayala, Louis J., and Malott, Donald L, Jr. "Patient Satisfaction with Hospitalists: Facility-Level Analyses," *American Journal of Medical Quality* 26, no. 2 (March 2011). Accessed July 23, 2013, http://ajm.sagepub.com/content/26/2/95.

Gawande, Atul. "Cowboys and Pit Crews." *The New Yorker*, May 26, 2011.

Glabman, Maureen. "Hospitalists: The Next Big Thing?" *Trustee: the journal for hospital governing boards* 58, no. 5 (May 2005): 6-12.

Hamel, Mary Beth, Drazen, Jeffrey M., and Epstein, Arnold M. "The Growth of Hospitalists and the Changing Face of Primary Care," *New England Journal of Medicine* 360, no. 11 (March 2009): 1141.

Harris, Gardiner. "Family Physician Can't Give Away Solo Practice." *The New York Times,* April 23, 2011.

Harris, James. C. "Toward a Restorative Medicine—The Science of Care," *The Journal of the American Medical Association* 301, no. 16 (April 2009). Accessed March 9, 2012, www.jama.ama-assn.org.

Hartzband, Pamela and Groopman, Jerome. "The New Language of Medicine," *The New England Journal of Medicine* 365, no. 15 (October 2011). Accessed March 7, 2012, www.nejm.org.

Hruby, Milena, Pantilat, Steven Z., and Lo, Bernard. "How Do Patients View the Role of Primary Care Physician in Inpatient Care?" *The American Journal of Medicine* 111, no. 9B (December 2001): 21S-25S.

Kripalani, Sunil, LeFevre, Frank, Phillips, Christopher O., Williams, Mark V., Basaviah, Preetha, and Baker, David W. "Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians, Implications for Patient Safety and Continuity of Care," *The Journal of the American Medical Association* 297, no. 8 (February 2007): 831-841.

Linderauer, Peter K., Rothberg, Michael B., Pekow, Penelope S., Kenwood, Christopher, Benjamin, Evan M., and Auerbach, Andrew D. "Outcomes of Care by Hospitalists, General Internists, and Family Physicians," *The New England Journal of Medicine* 357, no. 25 (December 2007). Accessed February 16, 2012, www.nejm.org.

Lovinger, S.P. "David Meltzer, Physician and Economist, Discusses the New Hospitalist Movement," *JAMA: The Journal of the American Medical Association* 289, no. 4 (January 2003): 411.

Mainous, Arch G., Baker, Richard, Love, Margaret M., Gray, Denis Pereira, and Gill, James M. "Continuity of Care and Trust in One's Physician: Evidence from Primary Care in the United States and United Kingdom," *Family Medicine* 33, no. 1 (January 2001): 22-27.

Manian, Farrin A. "Whither Continuity of Care?" *The New England Journal of Medicine* 340, no. 17 (April 1999). Accessed February 18, 2013, http://search.proquest.com/docview/223939506?accountid=48847.

McAlearney, Ann Scheck. "Hospitalists and Family Physicians: Understanding Opportunities and Risks," *The Journal of Family Practice* 53, no. 6 (June 2004): 473-481.

Nuland, Sherwin B. *The Soul of Medicine: Tales from the Bedside*. New York: Kaplan Publishing, 2010.

Pantilat, Steven Z., Alpers, Ann, Wachter, Robert M. "A New Doctor in the House: Ethical Issues in Hospitalist Systems," *The Journal of the American Medical Association* 281, no. 2 (July 1999): 171-174.

Pantilat, Steven Z., Lindenauer, Peter K., Katz, Patricia P., and Wachter, Robert M. "Primary Care Physician Attitudes Regarding Communication with Hospitalists," *The American Journal of Medicine* 111, no. 9B (December 2001): 15S-20S.

Peabody, Francis W. "The Care of the Patient," *The Journal of American Medical Association* 88, no. 12 (March 1927): 878.

Phillips, Robert L. "Primary Care in the United States: Problems and Possibilities," *British Medical Journal* 331, no. 7529 (December 2005): 1400-1402.

Press Ganey. "Hospitalist Insights." Press Ganey website. Accessed July 30, 2013. http://www.pressganey.com/ourSolutions/hospitalSettings/satisfactionPerformanceSuite/hospitalistinsights.aspx.

Press Ganey. "Our Mission." Press Ganey website. Accessed July 30, 2013. http://www.pressganey.com/aboutUs/ourMission.aspx.

Sharma, Gulshan, Fletcher, Kathlyn E., Zhang, Dong, Kuo, Yong-Fang, Freeman, Jean L., and Goodwin, James S. "Continuity of Outpatient and Inpatient Care by Primary Care Physicians for Hospitalized Older Adults," *Journal of the American Medical Association* 301, no. 16 (April 2009). Accessed March 9, 2012, www.jama.ama-assn.org.

Society of Hospital Medicine. "Society of Hospital Medicine FAQs." Accessed March 26, 2012 and June 15,2012, http://www.hospitalmedicine.org/AM/Template.cfm?Section=FAQs.

Sox, Harold. "The Hospitalist Model: Perspectives of the Patient, the Internist, and Internal Medicine," *Annals of Internal Medicine* 130, no. 4 (February 1999): 368-372.

Truog, Robert D. "Patients and Doctors—The Evolution of a Relationship," *The New England Journal of Medicine* 366, no. 7 (February 2012). Accessed March 7, 2012, www.nejm.org.

Wachter, Robert M. "Hospitalists in the United States—Mission Accomplished or Work in Progress?" *The New England Journal of Medicine* 350, no. 19 (May 2004). Accessed March 7, 2012, www.nejm.org.

Wachter, Robert M. and Pantilat, Steven Z. "The 'Continuity Visit' and the Hospitalist Model of Care," *The American Journal of Medicine* 111, no. 9B (December 2001): 40S-42S.

Wachter, Robert M. and Goldman, Lee. "The Emerging Role of 'Hospitalists' in the American Health Care System," *The New England Journal of Medicine* 335, no. 7 (August 1996). Accessed March 15, 2012, www.nejm.org.

Wachter, Robert M. and Goldman, Lee. "The Hospitalist Movement 5 Years Later," *The Journal of the American Medical Association* 287, no. 4 (January 2002). Accessed May 15, 2012, jama.jamanetwork.com.

Young, Audrey and Schleyer, Anneliese M. "The Hospitalist Story," *The Journal of the American Medical Association* 296, no. 17 (November 2006). Accessed February 16, 2012, www.jama.ama-assn.org.

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