

PCP vs. Hospitalist

by Eric Weil, MD

Dr. Weil is Medical Director of the Massachusetts General Physicians Organization.

I recently saw a 1952 magazine ad portraying the archetypal physician. Under the picture of a man garbed in hat and overcoat carrying a black bag through a snowstorm, the caption reads, "Twas the night before Christmas and all through the house, not a creature was stirring, except for the doctor who was getting ready to make a house call." This was indeed the accepted image of the family doctor: someone as likely to come to your home as to see you in the office; someone who would offer care throughout the full spectrum of health.

Over time, the underlying structure changed. The burden of medical knowledge increased. The intensity of medical interventions magnified. The luxury afforded by the home visit fell to the wayside in the effort to see more patients and offer more complex care. Even so, the primary care physician (PCP) remained the caregiver who knew and followed a patient through the entire continuum of health. Instead of house calls, the MD was making early morning rounds at the hospital before going to the office. It was the dedicated physician seeing the patient in the intensive care unit. The location changed; the concept remained the same.

Now, with hospitalists on hand, the PCP paradigm is again in flux.

Massachusetts General Hospital (MGH), born, in part, of a rich primary care tradition, currently has a mixed model, employing hospitalists but also permitting internists to round on their own patients. As an academic institution, many of the medical services are covered by resident housestaff backed by their supervising attendings. Side-by-side, PCPs and hospitalists offer in-hospital care. Office-based physicians who do visit their inpatients work alongside peers who no longer make the daily trek to the wards. That highlights some tension in the PCP's role and exposes the pressures of balancing economics, quality of care, and quality of life. It also speaks to physician identity.

The traditional PCP model adds value to quality of care in several key ways. First, because the PCP knows the patient, and has managed the patient's care longitudinally, he or she is better positioned to anticipate patient responses and needs. For example, a longstanding PCP might remember that the last time a particular patient was hospitalized, he developed delirium to a specific medication. The PCP might know that another patient typically burrows candy bars in her mattress when hospitalized, making her diabetes deceptively hard to control. PCPs hold information that might not otherwise be available, and can more readily engage familiar patients in difficult conversations (e.g., who better than the longstanding PCP to discuss with patient and family issues around end of life).

All patients risk losing some continuity of care when they transfer into or out of the hospital. PCPs who round on their inpatients might argue that they are better informed about the care plans and medications at discharge than they would be if they weren't on site: the patient is changing location but not physician. Entrusting their patients to a hospitalist, they might argue, adds a transition in provider care. Even with a vigorous system of communication, information can be lost or missed (and vigorous communication systems are more the exception than the rule).

On the flip side of the quality of care debate, hospitalists point to several benefits for both patients and providers. First, hospitalists are on-site and are available for urgent inpatient evaluation, while the PCP in his or her office is forced to rely on others for triage and feedback. Second, the average hospitalist will manage more inpatients in a given year than the equivalent internist. The hospitalist's base of experience becomes greater and his or her skill set more focused on the inpatient arena. For an office-based PCP, hospital admission rates are likely to vary—posing a challenge for maintaining a rounding routine and keeping inpatient skills sharp.

Third, PCPs who use the hospitalist service free up time for the patients they see in the office. In a productivity-based primary care reimbursement model, more time for more patients means more income. Even in 1952, physicians with families, mortgages, and student loan debts, had an eye on the bottom line—today probably even more so. While inpatient rounding is appealing and role defining, that bottom line renders it a more difficult decision to make.

Fourth, in an environment that already overburdens PCPs, the decision to transfer inpatient responsibilities to a hospitalist has to consider the PCP's overall quality of life. Will that extra time (and reduced stress) give him or her an opportunity to be a better spouse, parent, colleague, or caregiver? Or will he or she feel incomplete as a physician, vulnerable to eroding skill?

What defines the PCP? Does it have to be the archetypal doctor walking out into the storm or rounding on his patients until after the children are asleep? Does one MD really need to follow the patient through all stages of health? Where do we as PCPs feel that we are adding our best value to patient care? In the end, the answers to these questions require individual introspection and a broad analysis of our profession. If we are unsatisfied with the answers, then it becomes the individual's responsibility to change locally and the profession's responsibility to make changes globally. ■