Hospitalist vs family physician

With ever-increasing numbers of family physicians giving up their hospital privileges, the large number of “orphaned” hospital patients has become a significant concern. Should family physicians look after their patients in hospital or is hospitalist-based care the better alternative? This question is examined from the perspective of the patient’s needs.

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Emergency admission

When Jane Patient presents to the emergency department of her local hospital, her main requirement is timely access to assessment and treatment. After triage and emergency physician attendance, if she is to be admitted to hospital, an attending physician is assigned to her by the emergency physician. More often than not, this physician is a hospitalist and the patient must relate her immediate and past medical concerns to a physician who is unfamiliar with her medical history. This communication may be hampered by conditions such as an illness affecting cognitive function or by the effects of substance abuse, and the hospitalist often must spend precious time tracking down information from the patient’s family members or the patient’s community family physician in order to complete an initial assessment. In such cases, the family physician, being familiar with the patient’s medical background, is better equipped to assess the patient’s current medical status in a timely manner.

Language barriers also can interfere with a timely assessment. Unless a family member remains at the bedside to translate, the patient may be unable to communicate. For this reason, many patients choose a family physician who is fluent in their native language.

Comprehensive care

Along with the daily medical decisions required in the treatment of hospitalized patients, there are several aspects of patient management that influence the success of a hospital stay. One concern is the patient with a chronic medical condition. This patient, particularly, needs liaison with community supports to prevent frequent recurrent hospitalizations. The family physician is in an ideal position to initiate these supports as well as ensure that they remain in the community by providing office follow-up. Though the hospitalist is able to initiate community support, he or she does not continue in the role of community care provider and, therefore, cannot ensure that ongoing community support is provided. With family physicians involved in the hospital care of chronic medical patients, the “frequent flyer” patient may be less of a burden to hospital emergency departments.

The hospital patient also needs a physician who is familiar with his or her social circumstances. “Social admissions” are very common in emergency departments. The term refers to those patients who are unable to manage themselves at home due to various concerns, the least of which may be actual medical problems. These concerns may include financial difficulties, placement delays, or family and caregiver stresses. Again, the family physician, by virtue of a long association with the patient and his or her family members, is aware of such circumstances. This awareness enables the family physician to anticipate obstacles that my affect the patient’s recovery and prevent successful discharge from hospital. Often, the hospitalist is not familiar with these social barriers and does not have the time to become acquainted with them.

Emotional care

Finally, and most importantly, the patient is entitled to a physician who can adequately meet his or her emotional needs when hospitalized with a serious medical condition. Nowhere is this more evident than with the “Do Not Resuscitate” issue. Through necessity, most physicians have developed skills to help patients cope with serious or life-threatening disease. For the family physician, these skills are

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ment. Under this provision, it is questionable whether a disability insurer would be allowed to conduct surveillance when it is still paying benefits. Where benefits have been terminated, and an action commenced, surveillance is allowed, but only on a limited basis—as a last resort, with the decision to spy being made at a very senior level. To date, few decisions have been made under either Act.

Damages for mental distress

In the *Warrington* decision, supra, the BC Court of Appeal held that because disability insurance contacts are designed to provide peace of mind, where they are breached, and the insured person suffers emotional distress as a consequence, damages for mental distress may be awarded. This is a departure from the historical position of the courts, which have held that because emotional suffering is so difficult to assess, nothing should be awarded. Legal critics have argued that where an important component of the contract includes intangible benefits, such as peace of mind, it is illogical and unjust to ignore the suffering caused by a breach of the contract. Damages for mental distress in disability insurance cases have traditionally ranged from nothing to $20 000. At the present time, Sun Life is appealing this line of cases in the decision *Fidler v. Sun Life,*[7] a case which is scheduled to be argued before the Supreme Court of Canada this December. Sun Life is alleging that in order to recover under this head, it is necessary to prove that the insurer committed an "independent actionable wrong," something in addition to not paying benefits. The argument on behalf of Ms Fiddler is that a wrongful decision to deny benefits often causes exceptional suffering because these patients are already struggling with physical or emotional illnesses and then face increased financial and/or emotional turmoil as a result of the denial of disability benefits.

Punitive damages

In a 2002 Supreme Court of Canada decision *Whiten v. Pilot Insurance Company*,[8] the law concerning punitive damages was given much greater prominence. In that case, which involved a fire insurance claim, the insurer had refused to pay insurance proceeds in the face of essentially undisputed evidence that the insured had not caused the fire and was entitled to the insurance proceeds. It was also clear that Ms Whiten needed the insurance funds in order to purchase another home. The Supreme Court of Canada upheld a $1 million jury award against the insurance company on the basis that it would deter insurers from improperly denying legitimate claims. The Court emphasized that insurance companies were under an obligation to adjudicate claims fairly and in good faith. These principles were applied in a disability insurance claim in *Fidler,* supra, where the BC Court of Appeal awarded $100 000 against the insurer for improperly withholding benefits for approximately 5 years, and only reinstating benefits 1 week before trial.

References

1. *Warrington v. Great-West* (1996), 139 DLR (4th) 18 (BC Court of Appeal).
2. *Thompson v. Zurich Insurance Co.* (1984), 7 DLR (4th) 664 (Ont. High Court).
3. *Sucharov v. Paul Revere* (1983) 2 SCR 541.
4. *Parslow v. Masters* (1993) SJ No. 210 (Sask. QB).
5. *McInerney v. MacDonald* (1992) 2 SCR 138 (SCC).
6. *Janiak v. Ippolito* (1985) 1 SCR 146 (SCC).
7. *Fidler v. Sun Life Assurance Co. of Canada* (2004) BCJ No. 982 (BCCA).
8. *Whiten v. Pilot Insurance Co.* (2002) 1 SCR 595 (SCC).

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partly based on a rapport that has been established with the patient over time. In a hospital setting, time to establish rapport is often limited by the need to make immediate medical decisions and the patient's emotional support is lost. In the event of cardiac arrest, hospital caregivers require guidelines and look to the attending physician to designate whether a patient is to be resuscitated. In such a case, the family physician often is better able to speak with the patient or designated family member about this issue. The topic of resuscitation may have previously been discussed in the office setting or the patient may have provided the doctor with a living will outlining his or her wishes. These circumstances can make it much easier for the family physician to address this issue in a way that is less emotionally distressing for the patient. Knowing a patient only a short time, hospitalists cannot possibly hope to broach the subject of "do not resuscitate" in as empathetic a manner as a patient's family doctor. Invariably, if there is some urgency to making the decision, the discussion with the patient or family member seems businesslike and somewhat cold.

For many patients and family members, the "do no resuscitate" discussion in the emergency setting is an emotionally distressing experience and is better carried out by their family physician.

Conclusion

From the perspective of the needs of the patient, there are advantages to family physician care of hospital patients. While the hospitalist program might better meet the needs of hospital staff requiring easy access to an "in-house" attending physician, the hospital patient is better served when he or she is treated by a family doctor.