



Family physicians find satisfaction as hospitalists, face challenges

By Joen Pritchard Kinnan

ILLUSTRATION TIM STANTON

Although the vast majority of physicians who practice hospital medicine in the United States are board certified in internal medicine, about 3% of hospitalists have their certification in family medicine.

How do differences in training, general outlook on the practice of medicine, or other factors affect their roles as hospitalists? Do practitioners of family medicine bring special skills to inpatient care? Why do they choose to become hospitalists instead of community-based family doctors? Does their certification in family practice give them a particular bond with the patient's primary care doctor who may also be a family practitioner? How do they fit into the hospitalist picture, which is—at least in the U.S.—so dominated by internists?

To find out, we asked six hospitalists certified in family medicine:

- **Jasen W. Gundersen, MD**, division chief of hospital medicine, University of Massachusetts Memorial Medical Center, and assistant professor, UMass. Medical School, Worcester, Mass.
- **Michael Kedansky, MD**, lead hospitalist at the Kino Campus of University Physicians Healthcare Hospital in Tucson, Ariz., and clinical assistant professor of family and community medicine at the University of Arizona College of Medicine;
- **Elizabeth Chmelik, MD**, director of the Inpatient Medical Program at Scott and White University Medical Campus at Texas A&M

University in Austin;

- **Echo-Marie Enns, MD**, a family practice hospitalist at the Peter Lougheed Center in Calgary, Alberta, Canada.
- **Felix Aguirre, MD**, vice president of medical affairs at IPC—the Hospitalist Company, San Antonio, Texas; and
- **Jennifer Cameron, MD**, a family medicine hospitalist with Central Texas Hospitalist who practices at St. David's Hospital, Round Rock, Texas.

Drs. Gundersen, Kedansky, and Chmelik are members of SHM's Family Practice Task Force.

Training And Decisions

Most of the experts we spoke with agree

training influenced their decision to become hospitalists. They cite the diversity of cases in family practice residency (adult, pediatric, and obstetric/gynecologic), which they felt they would also find in hospital medicine.

Dr. Gundersen, chair of SHM's Family Practice Task Force, suspects internists and family physicians probably share one motivator for opting into hospital medicine: the hospital environment. "Even in residency, I liked my time in the hospital," Dr. Gundersen says. Echoing that sentiment, Dr. Kedansky says he missed hospital work when he was in community practice.

Family medicine is about people and relationships, says Dr. Chmelik. "You can get that same satisfaction on an inpatient basis," she says. "I've always

SHM HIGHLIGHTS FAMILY MEDICINE

Family-medicine-trained physicians have an important role to play in SHM as well as the hospital medicine movement as a whole, says SHM CEO Larry Wellikson, MD.

“Since our inception, SHM has been committed to being the home for all hospitalists, regardless of their board certification” he says.

SHM recently formed its Family Medicine Task Force, chaired by Dr. Gundersen, chief of the hospital medicine division at the University of Massachusetts Memorial Medical Center, Worcester. Gundersen’s taskforce has worked during the past year to raise the profile of family medicine-trained hospitalists and ensure that their voice is heard throughout the Society.

Building off momentum as the American Board of Internal Medicine moves closer to establishing Focused Recognition of Hospital Medicine as part of its maintenance of certification

process, SHM leadership has been advocating similar considerations at the highest levels of the American Board of Family Medicine and the American Academy of Family Practice.

While Dr. Wellikson characterizes these discussions as “quite positive” but also as “first steps in a long road,” he is confident both organizations share SHM’s commitment to ensuring a growing role for family-medicine-trained physicians within hospital medicine.

“SHM looks forward to building on the work of our Family Practice Task Force and identifying new ways to support and expand this important group of hospitalists within our membership,” Dr. Wellikson says.

Anyone interested in getting involved in the work of SHM’s Family Practice Task Force is encouraged to contact Dr. Gundersen at gundersj@umhmc.org.

liked seeing the same patients from day to day. You get instant gratification.”

The higher levels of support and resources available in a hospital environment as opposed to those in a community-based practice appeal to Dr. Enns.

Dr. Gundersen adds that some physicians don’t like all the paperwork office practice entails; others favor the regulated hours of hospital practice. “People often evolve into it as they get more experience,” he says. “They feel that hospital medicine gives them a chance to really make a difference.”

Dr. Cameron agrees about the paperwork. “Out of residency, I became a primary care physician in Tucson,” she says. “When the local hospital group became unexpectedly short-handed, they asked me to fill in on weekends. Once I proved myself with my eagerness and team spirit, they asked me to join their group. The timing was just right: the office management, billings, paperwork, employee issues, and 24/7 schedule were just killing me, and I was ready to try something else.”

Dr. Aguirre says his hospitalist career grew out of his work with a primary care group. His primary aim was standardizing the care of the hospitalized patients in the group.

Whole-Patient View

What special skills do family medicine physicians bring to hospital medicine? The experts quickly pointed out that though training and backgrounds might differ somewhat between internists and family medicine hospitalists they view their respective skills as complementary.

“Family medicine physicians bring a wider breadth of general knowledge in more medical areas than a traditional internal medicine physician, but an internal medicine physician is expected to have a greater depth of knowledge in general adult medicine, which is the current mainstay of hospital medicine,” says Dr. Aguirre. But he suggests that the knowledge base tends to equalize with experience as internal medicine (IM) and family medicine hospitalists cover each other.

However, he also believes a family physician initially brings more knowledge and practical experience in gynecology, behavioral science, pediatric, orthopedic, and family medicine. “These experiences can be especially useful when crafting hospitalist programs to serve these specific target audiences and to help staff pediatric or

IM/pediatric hospitalist programs as well,” he says.

Family medicine covers a lot of bases, these experts say. “Family medicine hospitalists have training in family dynamics, end-of-life issues, and family counseling,” says Dr. Chmelik. “These skills frequently come into play with hospitalized patients.” For Dr. Kedansky, family medicine residency training focuses on treating the whole patient “from birth to death.”

Dr. Gundersen knows how broad that role is. “We have the ability to treat adult, newborn, pediatric, and obstetric/gynecologic patients,” he says. “Some family medicine hospitalists even do labor management,” he says.

According to him, a family practice hospitalist gives a hospital special value because one hospitalist can take care of children as well as adults.

Community is important in the hospitalist-patient relationship. “Family practitioners learn how patients fit into the community,” says Dr. Enns. “We can picture patients in a home setting. This helps us in getting patients ready for discharge.”

The outpatient perspective gives family practitioners more foresight, says Dr. Cameron. Family practitioners “see possible roadblocks to a successful discharge to the home and are more willing to jump through the necessary hoops to ensure things go as planned once the patient is discharged,” she says. “As prior outpatient physicians, we know the frustration of having a patient just discharged from the hospital land in our clinic Monday morning with many issues undressed.”

Many family physicians had office practices before becoming hospitalists. “We understand how the continuum works,” says Dr. Kedansky.

Bond with Primary Docs

Does belonging to the same “fraternity”—family medicine—create a special relationship between a primary care doctor and a hospitalist with a similar background and training?

From the Canadian perspective, Dr. Enns thinks it may. She says resource constraints may apply to the primary care physician working in the community. “When I am treating a patient, I sometimes find a condition that is unrelated to the patient’s hospitalization,” she says. “I have better access to resources, so I might be able to accomplish a lot for my col-

league. I’ll call and ask if the doctor would like me to run an appropriate test, for example. Usually the primary care doctor is extremely grateful for the help.”

In the U.S., Dr. Gundersen suggests that the specialty of neither the primary care doctor nor the hospitalist is particularly important. “Continuity of care is the critical thing,” he says. “The point is to have good communication and a smooth handoff back to the primary care doctor.”

Dr. Kedansky agrees on the necessity for good communication but feels a greater sense of connectivity with the primary care physician, partly because he has been one. “I also know many of the docs personally, so that helps,” he says.

For Drs. Aguirre and Cameron, having worked as a primary care physician helps them empathize with their concerns about continuity and quality of care.

“I have been in their shoes, so to speak,” says Dr. Cameron. “I know the

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—Elizabeth Chmelik, MD, director of the Inpatient Medical Program at Scott and White University Medical Campus at Texas A&M University, Austin

frustrations they deal with daily.”

Some primary care doctors seem pleased the hospitalist shares their background, Dr. Chmelik notes, but she also emphasizes that continuity of care is much more important.

Everyone agreed that, in most cases, primary care doctors are grateful hospitalists are there to take over inpatient care, but Dr. Kedansky notes that some family physicians still want to do it all. “I give those docs credit if they want to maintain care of their patients when they’re in the hospital,” he says. “But most simply can’t keep up with it.”

Improved Training

Dr. Enns says that in Canada, family physicians have training in palliative care, but internists don’t. (They do in the U.S.)

“Family physicians have training in

the broader aspects of patient care,” she says. “They view patients in terms of the goal to be achieved rather than the diagnosis.” However, she feels internists have superior training in differential diagnosis.

In her view, family physicians and internists learn skills they originally lacked as they evolve as hospitalists. “I know I’ve learned a lot about diagnosis since I’ve been a hospitalist,” she confesses. She feels that both groups—internists and family physicians—would benefit as hospitalists if they had cross-training in each other’s specialties.

More training on the business side would have been helpful, suggests Dr. Chmelik. “We learned how to be doctors,” she says, “but we also need to know how to function in a hospital setting.” She mentioned billing, length-of-stay protocols, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) rules as examples. She also would have liked more training in infection control.

Family practice physicians fear the specialty has been slower than internal medicine in developing a program that would offer credentialing for hospitalists.

The U.S. family medicine hospitalists worry that because they are such a small part of the hospitalist family their position will be further eroded unless they can offer a similar credential.

Further, all cited the urgency of expanding fellowships in hospital medicine as a means of training that could lead to credentialing.

It is unlikely any sort of joint credential will be developed, given that the certifying boards of family medicine and internal medicine are individual entities, they say.

In the Minority

Being a minority in the ranks of hospitalists has its disadvantages. Some family medicine hospitalists feel they have to struggle to achieve recognition. But all agreed there is no problem with colleagues.

“I manage a mixed group of internists and family physicians,” says Dr. Kedansky, “and there is no distinction.”

Patient respect is not at issue, either. The panelists say patients are curious about the term hospitalist but seem largely oblivious to any further distinction. If there is any preference for internist hospitalists—and not everyone agrees there is—it seems to be on the part of the people who hire hospitalists.

Some potential employers specify

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shoulder and ask my opinion.”

Proximity also presents an increased opportunity for hospitalists to seek a curbside consult from another physician in the hall. “I think hospitalists are more likely to ask for help from specialists they see in the hospital because hospitalists are generalists and can see a wide variety of conditions in the hospital,” says Clifford Zwillich, MD, professor of medicine at the University of Colorado and a hospitalist at the Denver Veterans Affairs Medical Center.

Widespread Practice

In an April 2006 study in the *Journal of the Medical Library Association*, hospitalists reported that they seek a curbside consultation for a variety of reasons. These include:

- Confirm what they already know;
- Get quick answers to a question;
- Continue their medical education;
- Determine if a formal consultation is called for;
- Negotiate an appropriate course of treatment for a particular patient;
- Spread the emotional risk during a difficult case;
- Create or sustain camaraderie with physician colleagues;
- Find like thinkers among their physician colleagues;
- Monitor their own knowledge; and
- Obtain help to get out of a difficult situation.

Hospitalists who provide curbside consultations reported doing so to provide good patient care, fulfill professional obligations, serve doctors, and encourage formal referrals.

Another study reported that 70% of primary care hospitalists and 68% of subspecialists surveyed participated in at least one informal consult in the previous week.

Critics say an enormous number of hospitalists put themselves at risk and potentially jeopardize patient care by taking part in these consultations. These dangers seem to increase when the consultation veers from the general educational question to advice on treating a specific patient.

“Medical errors are potentially a lot higher in curbside consultations because much is lost in translation,” Dr. Zwillich explains. “When a curbside is used as a substitute for the physician seeing the patient, it can result in an incorrect diagnosis and medical errors.”

Dr. Zwillich is concerned because a physician can give the best treatment advice, but if the underlying diagnosis is

“My biggest concern is when hospitalists don’t recognize the risk they take on,” she says. “We shouldn’t take a curbside consult without knowing the risks.”

Traditionally, medical malpractice liability for curbside consultations has hinged on an established physician-patient relationship, generally limited to hospitalists seeing a patient. “Courts have been reluctant to extend liability to specialists consulted informally by the patient’s primary physician,” writes Kim Baker, JD, a healthcare attorney with Williams Kastner, in Seattle, Wash., in an analysis of court rulings.

However, courts are allowing suits to proceed against the consulting hospitalist, trying to decide whether a physician-

a trend with curbside consults. She says trial attorneys are continually trying to find ways to bring more hospitalists into a suit. Baker sees a “discernible shift away from the longstanding policy that favors physician’s expectations over those of patients when determining whether a particular physician owed a duty of care to a particular patient.” She warns that hospitalists who engage in informal consults “may be at greater risk for medical malpractice liability.”

Can’t Stop Lawsuits

The reality of a litigious society is that even if you aren’t liable for malpractice you can still be sued. Attorneys routinely “paper the hospital,” naming in a suit everyone who came in contact with a patient or gave advice on his treatment, says Robin Diamond, MSN, JD, vice president of patient safety at The Doctors Company, Napa, Calif., a professional liability insurer of hospitalists and other hospitalists.

“Even if you have no responsibility, you still have to go through all the pain, expense, and heartache of getting yourself dismissed from the suit,” she explains. “What makes the curbside consultation easy and convenient for the consulting physician is what turns it into a legal nightmare for both of them.” Because the consult is on the run, the consulting physician may not give all the information that reveals the whole clinical picture.

So far The Doctors Company hasn’t seen a significant number of lawsuits against hospitalists—but this could increase as the subspecialty grows, Diamond says. The closest example she knows of is a pending case in which a hospitalist is being sued for advice he gave in a consult in an emergency department.

Two things concern Diamond most about curbside consults. The first is that because there is no documentation in a curbside consult, the physician giving

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—Janet Nagamine, MD, chair of SHM’s Hospital Quality and Patient Safety committee and hospitalist, Kaiser Permanente Santa Clara Medical Center (Calif.)

wrong patients can be harmed. Because curbsides are quick, one physician doesn’t know if the other physician is leaving out something critical or even if the underlying diagnosis is correct. “By taking a curbside consult, you are giving up your opportunity to make an alternative diagnosis,” Dr. Zwillich says.

When giving advice on a specific patient nothing beats a formal consultation in which the patient is seen and a complete history is taken, he says: “The best care is given at the bedside.”

Legal Liability

Dr. Nagamine also fears the risk hospitalists take for a medical malpractice lawsuit.

patient relationship existed—and if so whether the [consulting] physician’s advice led to the alleged malpractice. Particularly relevant to hospitalists is the legal question of whether a pre-existing contract between the consulting physician and the hospital creates a physician-patient relationship with patients in that hospital. On this question courts have been mixed. In other cases, liability turned on whether the consultant physician went beyond giving general advice to participating in the patient’s care.

Courts are continually revising their rulings and may change the way they interpret a physician-patient relationship. Baker cautions that this may be

in their employment ads that an applicant be certified in internal medicine, but Dr. Kedansky suggests that because most hospitalists are internists, many hirers assume that is the standard. “The person’s skills are what’s important, not the specialty,” he says. “If the doctor wants the job, he should persist.” But Dr. Gundersen, who thinks there is bias in some cases, says he has found that some hirers will not even interview candidates with family physician boards. “This situation limits a family physician hospitalist’s ability to move around or even get a job in the first place,” he says.

Dr. Cameron knows whereof he speaks. “I had a few hospital groups and hospitals dismiss my [resume] without even talking to me despite my experience and stellar references,” she says of her frustrating year-and-a-half search for her present position.

Family physician hospitalists may have a bigger hurdle to overcome, acknowledges Dr. Chmelik. “We may

have to prove more, but it is possible to earn recognition,” she believes. Dr. Aguirre concurs: “Respect is earned and not a predetermined right.”

In Canada there is no hiring issue because almost all hospitalists are family physicians, but Dr. Enns says her U.S. colleagues should “feel their own worth more. They add great value to the skills that internists bring.”

Outlook

Fewer doctors are opting to take the family medicine boards, but leaders are rising to the challenge to redefine and reassert the importance of the needs served by family physicians. At the same time, there is increasing demand for hospitalists.

According to Dr. Aguirre, demand may double—or go even higher—within the next 10 years.

“There are not enough internal medicine physicians, family medicine physicians, pediatric physicians, and

physician extenders completing training or leaving private practice to become hospitalists in the near future to fill the oncoming void,” he warns.

Even if this situation proves true and hospitalist jobs are everywhere for the taking, it’s unclear whether that will rekindle interest in family practice as a path to becoming a hospitalist. But one thing seems certain: There will be credentialing processes for family physician and internist hospitalists.

Dr. Kedansky is concerned that family medicine is playing catch-up on this issue, and he wonders what effect credentialing will have. “Now it’s on the radar screen, though,” he says.

Dr. Cameron shares his concerns. She fears that if family physicians lack equal footing with internists as hospitalists, many rural and smaller hospitals will be without hospitalist coverage.

Early on, the medical community in Canada considered that the role of family medicine hospitalist might be a

temporary one, taken to give family practice medicine time to regain strength, says Dr. Enns. “Now, there are no signs that it’s temporary,” she says. “It’s an effective method of patient care, and the community has embraced it. There are no more naysayers.”

Getting new physicians interested in the specialty is key, says Dr. Chmelik.

“Fellowships for further training are important,” she says. “We need to work with medical students too, show them there are options within the field. They want choices.”

Dr. Gundersen suggests that whether one is an internist or a family-physician hospitalist may not make much difference in years to come. “I think that in the future physicians will be classified on the basis of whether they are outpatient or inpatient doctors, rather than all these other designations,” he says. “It’s getting harder and harder to be both.” **TH**

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advice cannot prove later what was said. Insurers worry that because there is no documentation of curbside consults it can be one physician's word against the other's if the case goes to court. There can be disagreements about what was said, when, and the advice given—and no way to prove who is right, she says.

Her second area of concern is when the conversation goes from general to specific. A physician is easier to defend if it can be proved that the question asked was general and didn't have a specific application or sharing of clinical expertise. If a specific patient and a specific history is discussed, courts could establish that this constituted a formal consultation and established a patient-physician relationship. They could also establish that the consulting physician relied on the recommendation, which harmed the patient, Diamond says.

Despite the dangers, are hospitalists likely to stop doing curbside consultations? Even the critics answer with a resounding "no." They say such consults are a fact of life.

"Curbsides are a part of our professional community of care," Dr. Zwilllich says. "It's good to ask advice of other hospitalists. The danger comes when a curbside is used as a substitute for a needed full consultation."

Dr. Nagamine thinks curbside consultations are a good way for hospitalists to continue their medical education. "In the hospital setting, many knowledgeable hospitalists are nearby, and you can learn a lot from them. I don't think that's bad or wrong," she says. "The biggest problem we have is not asking for help when you're not sure. I'm all for

making it easy for hospitalists to ask for advice when they are not sure. But I'm in favor of full consultations when appropriate."

Safer Consults

If hospitalists are going to participate in curbside consults they can make them safer by following this advice: Tread carefully, keep it general, think before you speak, and consider documenting what you say. And never hesitate to ask to see the patient.

Keep the curbside consultation general and brief: Curbside consultations may be safer when they are more general and used for the physician's general education, experts agree. It's when the discussion gets complex or about a specific patient that it's time to think before you speak and be cautious.

Diamond says it is probably safe to say to another physician: "This is what I just saw. Have you ever seen it before?" But once the question goes from there to asking the physician what he or she did in such a case, "That's when you've got to say, 'Wait a minute, this is becoming so complex that it would be better if we did a formal consult.'"

Consider the risk of being wrong: "You have to ask yourself what is the downside—or the risk—of the question you're asking," Dr. Nagamine says. "If you know you're going to order some tests and want to know which one to do first, this is far less risky than [deciding] if ... we admit someone to the hospital or send him home." In the first case there's probably not much risk because you can order other tests if the first ones don't give you the results you need. But in the second, if

you send someone home and you are wrong, you can cause harm, she explains.

Dr. Nagamine also recommends considering the seriousness of the patient's condition. Patients rarely die from a rash but can if you're wrong about chest pain, for example.

"You need to ask yourself, 'What's the complexity of the case and the downside of being wrong and what, exactly [is my colleague] asking me?'" she says.

Ask specific questions: "Think very carefully about whether the situation is appropriate for a curbside consultation," Dr. Nagamine cautions. "Ask probing questions that assure you that the correct and complete information was gathered. What is the quality of the information you're being given?" If you don't have complete faith in the ability of the physician asking you for a consult, it's best to see the patient, she says.

Consider facts not given: Diamond recommends the hospitalists consider the facts not given before deciding to give advice in a curbside consultation. The physician asking for the consult is going to give the information he feels is important at the time. He may have left out or discounted important facts about the patient's history. Ask "What am I not getting here?" she recommends.

Don't hesitate to ask to see the patient: Dr. Nagamine urges hospitalists not to refrain from asking to see the patient involved. "Many times I feel like the other physician really wants me to see the patient but doesn't want to bother me. I find they are relieved when I suggest that I see the patient," she says. "Other times hospitalists don't like to admit they are in over their heads and

ask for help. In many cases when I see the patient I'm glad I did."

Document the conversation: The Doctors Company recommends hospitalists document curbside consultations. "Keep a brief record of it in a memo to yourself," Diamond says. However, that can be a Catch-22. "If you end up in court you have to supply all the information you have. So we say that if it gets to the point that you feel like you need to document a curbside consult, you need to bump it up to a formal consultation."

Know your responsibilities to the hospital: For those hospitalists who work at more than one hospital, Diamond recommends you make sure you are following hospital protocol and not doing more than the hospital expects from you. Some hospitalists think it's their responsibility to take a curbside consult from a facility's hospitalists, and it may not be the case. All hospitals don't have the same expectations of hospitalists, she says.

Dr. Nagamine thinks the stakes are higher for hospitalists taking curbside consultations because hospitalized patients are usually sicker than in an office setting. So the hospitalist may need to be even more cautious. **TH**

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Resources

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