Editorial

Bridging the Divide Between Hospital Medicine and Primary Care

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Abstract

An article on bridging the divide and delineating some of the differences between hospital medicine and primary care.

When I gather with internal medicine colleagues, we often reflect on the uncertain future of primary care. Not infrequently, someone will bring up the birth of hospital medicine as a reason for primary care's downward spiral. I disagree with that view; to the contrary, reorganizing how internal medicine physicians deliver care offers opportunities that can contribute to the "salvation" of primary care.

My experience with hospital medicine has taken many forms over the years. I started my career as a "comprehensive" general internist, beginning my day rounding in the hospital, rushing to the office for a full day of office visits, and sometimes returning to the hospital after my office hours. My first exposure to hospitalists was in the early 2000s when our group established a hospitalist team that took care of our patients in our two hospitals. Several years later, we disbanded our service for economic and logistical reasons and delegated inpatient care to hospital-employed hospitalists. Additionally, at the macro level, I served in leadership at the American College of Physicians during the early years of the hospitalist "movement,"[1] and more recently on the American Board of Internal Medicine, where hospital medicine's standing in our specialty has evolved further.

My decision to give up inpatient care was both easy and difficult. Limits on resident work hours and patient numbers increased the workload of admitting physicians when patients were "non-teaching" or not on the resident service. This created gaps in on-site care since patients did not restrict their acute problems to early morning during rounds. It was increasingly challenging and frustrating to manage sick inpatients miles away in the office with a full schedule of outpatients. Moreover, my inpatient census was usually low, which lightened my workload but created another challenge: staying up to date in inpatient medicine. I often asked myself: Who was better equipped to take care of my patient with sepsis: someone who admitted a few patients with sepsis in a year or a colleague who treated several each week (or day)? A cardiologist colleague lamenting the move towards hospital medicine asked me whether my knowledge of inpatient medicine would atrophy if I gave up inpatient care. I responded that it already was. The most palpable loss from giving up inpatient care was the discontinuity it created in the relationships that I had with my patients. I was no longer with them during their most difficult moments. Early on, I tried to address this by making "social" visits to my hospitalized patients, but that became more complicated as the hospital adopted an electronic health record system different from my office's. Hence, taking a peek at the chart became another task. Plus, the time it took to get to and navigate the hospital exceeded the time I spent with the patient. Eventually, the social visits stopped. My group has nurse care managers in the larger hospitals who check in with patients who are there for a few days or more, and they help to keep me connected.

While in the beginning, patients protested my giving up inpatient care, I hear fewer complaints today. Perhaps they have gotten used to my not being in the hospital, or they are not there long enough to notice. On the other hand, the patients that I saw in the office received more of my attention immediately. No more late arrivals at the office when rounds took longer than expected. Gone were the interruptions by phone calls from nurses reporting a fever or a low potassium. I no longer had to cancel an afternoon of patients at the last minute to rush to the hospital. Despite not seeing my smiling face every morning, my hospitalized patients were getting better care from the hospitalists than they would have gotten from me, and my outpatients were also benefitting.

All that said, there are things that I hope will improve. Despite all of us being electronic, communication still needs to be improved. While blaming it all on our non-interoperable health information systems is easy, this is also

a human failing. I am sure that being on the same information platform helps significantly, as I experienced during my first years with our own hospitalists. However, the telephone also works well for decreasing fragmentation and improving care transitions. Not being in the hospital has other downsides. When I started practice, the hospital was a social hub as much as a clinical hub. I knew my colleagues from all specialties who were taking care of my patients, catching up with them on the wards, in the physician lounge, or in the back of the cafeteria. Now, I recognize names on faxes or electronic referrals but do not know the faces. Similarly, my connection to the residents is minimal. Teaching residents in the office makes up for that to a small degree.

On the whole, I believe that the creation of hospital medicine is a good thing. As you may have heard, primary care is in "crisis." While there are many reasons for that, the physician experience is a major one. Trying to be in two places at once when it is hard enough to be in one place, with the second place having additional pressures from navigating another EHR, another set of yearly modules, traffic, parking, and less familiarity with inpatient diagnostics and therapeutics do not reduce burnout. Those of us who practice outpatient-only can better control our workdays and be more reliably available for our patients while taking pride in our in-depth knowledge of the manifestations and management of internal medicine conditions.

Disclosures/Conflicts of Interest

The author has no conflicts of interest to declare.

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