



## The Family Physician, the Patient and the Hospital

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### Abstract

**Background:** Family physicians coordinate the care of their patients and follow them in a longitudinal manner. Do they have a role to play when their patients are hospitalized? Does the system of care expect them to play a role, and how does it support or integrate it?

**Objectives:** To discuss the various models of relations between hospital and primary care physicians in the world as compared to those in Israel.

**Method:** Short cases are reported describing the author's personal experiences and difficulties encountered in a family practice.

**Discussion:** Identifying and defining problems encountered, as well as their origin and development within the history and evolution of the system of delivery of care in Israel, will lead to some suggestions for a possible solution. Maturation of the system, especially education of the junior staff within the hospital system, is still needed to facilitate the hospital-physician relationship.

**Conclusion:** More active participation of the family physician offers added value to patients' management during their hospital stay and is welcomed by them. The full implementation of a system promoting continuity of care requires further attempts at developing suitable models of cooperation between hospital and family physicians.

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The family physician is the coordinator of the medical care of his or her patients. He follows them over the years, supporting them through health and life crises. One of the major crises for any person living an active life is an interruption in that individual's routine of work and family, by hospitalization. In many cases, the personal physician is the initiator of this crisis. Sometimes the physician's role is to support the decision taken by a specialist colleague to admit a patient to hospital, and only in the eventuality of an emergency hospitalization will the family physician be informed about the hospitalization, later. How important is involvement of the family physician during the

hospital stay of his or her patient? Does the personal physician have any role inside the hospital? If the answer is yes, there are probably several levels at which he can become involved – from mere supportive visits to his patient to full involvement in decisions involving the patient's management, through direct participation in rounds or staff discussions. This article will explore the situation in Israel, where family physicians have no admission privileges but are expected to behave as gatekeepers.

### Existing models of family physician-hospital interface

Different countries have different models of cooperation between hospital and primary care givers. The variations have developed from local traditions within the developing systems of care, the final model being strongly influenced by health economic considerations.

In the United States, the vast majority (87%) of office-based members of the American Academy of Family Physicians surveyed in 1980 [1] and 1993 [2] had hospital admission privileges (non-metropolitan more frequently than urban ones, with regional variations of privileges in obstetrics and surgery). In rural areas, limited-service hospitals are reconverting to rural primary care hospitals through the development of "vertical" arrangements with ambulatory service providers and practitioners [3]. The expanding presence of managed care has further mandated that competent primary care providers have a significant presence in the hospital. This in turn affects the training of family medicine residents whether preparing for rural [4] or urban [5] practice, with competence enhanced in the management of inpatients. Gaspar [5] even suspects that this strategy might influence residents' attitudes away from the conservative biopsychosocial approach.

In Canada, bed reductions and hospital closures have recently resulted in restrictions in the number of physicians able to obtain hospital privileges [6]. Those losing these privileges are younger and better trained for their implementation.

Australia has recently evaluated its existing model of collaboration between general practice divisions and hospitals

[7,8]. This model was found to be beneficial for patients (improved access to services, reduced anxiety, and fewer post-discharge complications), for general practitioners (increased involvement in acute care and in-hospital decision making), and for service organizations (stronger working relationships, increased capacity and greater efficiency). On the other hand, another survey, which focused on guidelines for continuity of care in therapeutics from hospital to community [9], recorded many deficiencies, such as a lack of notification to general practitioners of patients' admissions, lack of verbal and/or written communication concerning medication changes on discharge, and lack of follow-up arrangements. General practitioners also reported having difficulties in communication with full-time hospital staff [10]. Despite significant dissatisfaction, there was much willingness to be more involved in liaison and communication with hospitals about patient care [11].

France has no tradition of admitting privileges, and most general physicians have little interaction with hospitals. Nevertheless, their viewpoint is now appreciated as part of the healthcare system's policy to evaluate quality of care in large university hospitals [12].

In Britain, there is no defined role or model of interaction between general practitioners and hospitals, as reflected by the lack of relevant publications on Medline during the last 20 years.

Many studies on admission privileges relate to certified nurses and their roles and functions. Issues of continuity of care, quality of care, and cost-effectiveness are also positively described in the advanced nursing literature. Concerning midwives, nurse practitioners and clinical nurse specialists, much emphasis is placed on administrative and political issues such as definition, autonomy, title protection, backup and reimbursement [13–15].

In the Israeli healthcare system, there has been no role for the primary care physician inside the hospital. He or she is supposed to write a good referral letter and to fulfill the recommendations written on the discharge letter. There is no expectation of any direct interaction between the personal doctor and the hospital staff. There is neither reimbursement nor any protected time or other incentive in the schedule of a family physician to visit his hospitalized patients or to establish such a direct interaction.

Some family physicians in Israel are concerned about this dichotomy and lack of continuity in care, especially in circumstances that are critical or traumatic for their patients. Physicians invest extra time to visit their patients and try to nurture bonds with the hospital through personal effort. They attend the academic activities of internal medicine departments (grand rounds, journal club, etc.), or they manage to organize their continuous medication education within a department. Some young specialists in family medicine, wishing to maintain the bond they had during their training rotation in a department, continue to do night duty for a few years. Some physicians feel that internal medicine was the most important hospital rotation of their residency training, for the following

reasons: it was of longer duration than others (12 months), and they felt most integrated in it because they worked harder, had night duties and more responsibilities. Internal medicine is usually the most "academic" rotation, the one in which they learn the most. This bond with a hospital department may be a good reassuring buffer against the fear of isolation and lack of academic support in the community.

Highly motivated physicians who maintain hospital connections are rewarded for their unilateral efforts through some updating of their knowledge, and the good feeling of having facilitated some procedural or therapeutic actions, but mostly through the beneficial effect on their doctor-patient relationship.

## Problems inherent to the Israeli model

Having discussed the motives for such a personal investment by some family physicians, I wish to elaborate on some of the problems encountered in the field that might explain why other physicians do not take this course of action or stop doing so over time. A narrative approach and the use of case studies are the methods chosen for a survey and definition of the situation in a qualitative manner.

Since my last hospital rotation 16 years ago, I have always felt that the interface with inpatient services is difficult to manage. Whenever I have to initiate some contact with the hospital staff, it usually generates some feeling of discomfort, some sense of uneasiness. Why does it feel difficult? Where is the problem? Is it *my* problem? Why do I feel as if I'm asking for personal help when in fact the intervention is for the benefit of a patient? Why does it make me feel as hesitant, lacking in confidence, and inexperienced as at the beginning of my career? I will illustrate and discuss these questions through some examples.

## The past

Like most residents in family medicine, I had invested considerable energy during my internal medicine rotation but had declined the offer to switch to that specialty and remain a resident in internal medicine. I opted to continue to nurture this relationship by taking night duties while in other rotations.

In my final year of residency training, I needed some support regarding a 55 year old male patient. One year earlier, he had lost his only sister who had died slowly of lung cancer in his home. He developed severe chronic headaches, vague abdominal pains, poor appetite and had lost 10 kg. All investigations were normal, and I had tried unsuccessfully to negotiate with him the issue of depression and pathological mourning. He could not accept this option as a working hypothesis and was very anxious that we were missing a malignancy somewhere in his body. I arranged for a consultation with the deputy head of "my" internal medicine department. I felt I had tied up the whole package very nicely: the patient was very satisfied with this option of a second opinion, and he was bringing to the consultation a very detailed referral letter including results of all

the investigations. I had also spoken to my consultant and clarified that I was referring to him as an authority to reinforce the needlessness of hospital admission and further investigations, and to support the importance of the emotional problem.

My first disappointment occurred when I heard that my patient had been seen by another internist, a senior resident, who in view of the main complaints decided to admit him. The second disappointment, which I felt as a hurtful deception, occurred 2 days later when I met a resident in family medicine doing his rotation in this same department. He reported that during the grand round with medical students, the department head had said: "It is very disappointing that this young family physician has referred this patient who obviously suffers from depression. She used to be very good at the time she was here with us..."

Sixteen years have passed and the time has helped me recover. I learned the hard way that this internal medicine department was not my second home. During those 16 years the status and academic standing of family medicine in Israel have changed. Family doctors are requested to coordinate the care of their patients, and they do as much as they can in the ambulatory sector where services have been developed. They are expected to function as gatekeepers and to carefully weigh the real need for costly and sometimes ineffective hospitalization. Hospitals have to become more attractive and efficient and to function as independent business centers. They are now more dependent on primary care givers – who provide work for them – and it is no longer "politically correct" to believe that good medicine exists only within the hospital walls.

Specialty training programs in family medicine have gained much prestige, with more demand than offer. But has the status of the family physician really changed in the eyes of the hospital doctor or only in those of the policy makers?

### The present

One year ago, a 12 year old girl came to my office complaining of tiredness, vague abdominal discomfort and poor appetite, of a few days. She denied having fever or urinary, gastrointestinal or other symptoms, and her physical examination was normal. Having known her for a few years, I noticed a minimal lower orbital swelling that she had not mentioned. A urine dipstick confirmed my suspicion: a positive reaction detected the presence of red blood cells. Her blood pressure was slightly elevated for her age and weight, and she confirmed having had a mild sore throat a few weeks previously. I sent a throat swab immediately, wrote a detailed letter with an assertive diagnosis of post-streptococcal glomerulonephritis, and phoned her mother. I explained to the girl's mother how important it was to take her to the hospital immediately and that we could not wait until after the weekend. The next working day, I obtained a phone result confirming the growth of *Streptococcus Group A* and faced the challenge of transmitting this information to the pediatric department to which the child had been admitted. After some struggle, I succeeded in reaching the senior physician who had just completed the morning rounds. By

pure chance he was also the pediatric nephrology consultant of the hospital. He told me how furious he had been with the pediatric residents who had started her on treatment for urinary tract infection. When calling the following day to hear how my patient was doing, I learned that she was about to begin hemodialysis for near anuria!

When will hospital residents start reading referral letters more attentively, bearing in mind that a family physician might have pertinent information about his or her patient, and has probably done quite a lot of clinical reasoning before sending the patient to the hospital? Why is telephone communication almost always unidirectional, with the family physician fighting his way through the department secretary or nurses in order to get a barely available house physician on line to ask timidly about his patient's status, management and progress? Why can I only remember five occasions in 16 years when physicians called me from the hospital to ask for information about my hospitalized patient?

Half a year ago, I found a 75 year old male patient with Parkinson's disease at home with a fractured hip after one of numerous falls and referred him for hospital admission. I spoke daily with the head nurse (the orthopedic surgeons were unavailable, either in the operating room or emergency room), who told me each time that she was not sure when he would be operated on because of a pulmonary problem that first had to be stabilized. On the third day, I finally spoke with the resident in charge, who clarified that the pulmonary consultant had discussed at length the hypotheses of infection, Procor lung or pulmonary embolism as causes of his dyspnea, and was delaying surgery. I explained that his well-known dyspnea at rest was episodic, had already been investigated, and had been attributed to psychogenic factors. Procor lung and significant chronic obstructive disease as well as cardiac origin had been excluded. We agreed that a lung scan and pulmonary function tests should be performed as soon as possible. Two days later, on a visit to the orthopedic department, I discovered that no scan or pulmonary function tests had been performed. I met the same resident in charge, seemingly helpless because "the lung department had not yet called the patient up for lung function tests." Encouraged by the department's physiotherapist who seemed to be the only person worried that my patient was still lying down I week after his fracture occurred, I went up one floor to the pulmonary department. I found the lung consultant, led him down one floor to the orthopedic department, insisted that he re-examine my patient, and explained that we needed his clearance for the operation. The patient underwent surgery the following day.

I decided that my best partner for following my patient's progress would be the physiotherapist. We discussed the difficulties associated with his slow pace of rehabilitation due to decubitus ulcers that had meanwhile developed on his heels, and the episodes of disorientation and delirium he had had after the anesthesia. I explained that in addition to the side effects of his medications for Parkinson's disease, he was suffering from severe insomnia and nightmares that were

related to him being a Holocaust survivor. At my next visit one week later, she suggested I speak with the resident in charge because a decision had almost been taken to transfer him to a chronic hospital for patients with dementia and a poor prognosis for rehabilitation. I was ushered into the “sanctuary” – the doctors’ room, wondering if this young resident’s skeptical and bored facial expression could be influenced by my stories about this patient. I believe it was only the additional pressure of my ally, the physiotherapist, that helped secure the patient transfer to a good geriatric rehabilitation center instead of a chronic nursing home. Another intervention on my part was to make sure the patient would be assigned to the center located near the hospital instead of the one close to his home. The reason for this additional manipulation was that I had just referred his wife for an emergency anterior resection of a colon carcinoma. This would simplify matters for their only granddaughter who had been called in to help from another city.

This intervention cost me much time on the telephone and at the hospital, as well as energy and assertiveness. It also raised questions about the role of the personal physician in the hospital. The results of my intervention were satisfying (both spouses are now well and at home), but I feel very uncomfortable about my attitude and behavior. By Israeli norms I was intrusive, interfering with internal hospital matters, disrespectful and manipulative.

## Discussion

What must change? Is there place for better use of the knowledge and understanding of the personal doctor? Can the system change and allow participation of the personal doctor in patient management decisions in a regularized manner, via the front door and with protected time? Can the residents, those who admit the patients and are in charge of their routine care, keep in mind that other physicians also know something about the patients? Could they consider a disruptive phone call from the family physician as possibly helpful? Could they envisage that a call from their side, with a request for additional information or a discussion, would be welcomed by the family physician? And if they are only trained to look for information on Medline, is it not the responsibility of the senior physicians and heads of departments (who usually know the family physicians) to include awareness of this “new” source of information in their training program?

What will the future interface between family physicians and hospitals in Israel be like? Some pilot models are being developed. The psychiatric liaison model has been successful [16,17]. With this model, psychiatric teams adopt family practice clinics, where they hold mini-psychiatric clinics that allow mutual consultation and support and guarantee that necessary hospital admissions are made with the same psychiatric team in charge [18,19]. Less comprehensive models are based on psychiatric counseling and support to family physicians in the community, without the hospital counterpart [20,21]. Similarly, some departments of internal medicine have adopted family

practices and send a consultant periodically to see patients conjointly and to give advice to the patients’ personal doctors. Unfortunately, most of these isolated initiatives fall short of cost-effectiveness since they are too time-consuming in terms of expert personnel. Issues such as quality of care rendered and long-term profitability of education are considerably more difficult to quantify than single consultation rates.

In addition, from our point of view, since these models are based on unidirectional relations, they still do not address the problem of the role of family physicians inside the hospital. An intervention inside the hospital remains a matter of good will and personal effort on the part of the family physician, based on the degree of mutual personal knowledge, respect and sympathy. A more comprehensive bi-directional model would ideally include:

- Mutual adoption of primary care clinics by defined internal medicine, pediatrics and surgical departments
- Periodic clinics held conjointly with hospital staff in the primary care clinic
- Periodic participation of primary care staff in hospital department rounds, staff meetings and outpatient clinics, with provision of defined admission privileges
- Reciprocal residency training rotations, with junior hospital staff coming for training in the primary care clinics
- Equivalent academic status and recognition
- Joint clinical research.

This model would not answer all the needs of patients and personal physicians. For example, it leaves out many hospital specialties. It would be wiser to evaluate where most patients from a given primary care clinic are hospitalized, and develop relations with specific wards accordingly. On the other hand, patients’ needs are not necessarily concordant with specialty training requirements. Curriculum and service needs require flexibility in planning.

The advantages of this model would be the facilitation of relations between junior hospital staff and primary care providers. Department heads often know experienced family physicians personally because they were residents in their departments, or because years of geographically stable work have finally established the relationship (usually the result of cumulative unilateral efforts, as reported earlier).

The cases presented here identify some of the problems of communication with junior hospital staff, as well as problems of accessibility. Given that junior staff members are at the interface, this model could modify their attitudes and widen their understanding of patients and the community where their personal doctors also reside.

## Conclusion

More active participation by the family physician in hospital medicine benefits patients during their hospital stay and is welcomed by them. The implementation of a system promoting continuity of care requires that suitable models of cooperation between hospital and family physicians be developed.

Reporting personal experiences can help locate and define the communication problems encountered at this interface. Previous models have been only partially successful. A comprehensive model of cooperation has been proposed, and evaluation of this model must include long-term cost-effectiveness parameters, based not only on staff remuneration but also on quality of care criteria such as hospitalization cost reduction, prevention, shortening of sick leave, and patient satisfaction.

Has the time already come for implementation of similar models in Israel? How would patients benefit from them? Are they acceptable to the medical community, to health authorities, to academic institutions? Has family medicine already done enough as a profession, in terms of its own rehabilitation, quality assurance, and academic and research standards?

If continuity of care is accepted as a cornerstone of a modern cost-effective system of healthcare, defining and facilitating the role of the personal physician when his or her patient is hospitalized seems logically to be a necessary step.

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