Continuity of care? Hospitalists? Who calls the family?: Corporate control makes health care worse.

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I was recently talking with a friend who was still (justifiably, IMO) furious at her local hospital. Last year her husband, 90, was admitted for an attack of diverticulitis. While hospitalized, he suffered a heart attack on a Sunday morning and was transferred to the Intensive Care Unit. The treatment was fine – indeed now, at 91, he is quite improved – but her complaint was that no one called to tell her! She found out when she went to visit him in the hospital that afternoon. I am sure that virtually any adult presented with this scenario would say "of course, as soon as possible, call the family!" Can you imagine that they didn't?

Sadly, I can. It reflects a lot of issues in the medical care system. One that my friend identified was the hospitalist system, where the doctor who is responsible for the care of a person in the hospital is not their regular physician, but someone employed by the hospital (usually an internist or sometimes a family doctor). In itself, this can be an issue, which I will discuss below, but the bigger problem she identified was the frequent change in who this responsible physician was, different on the weekends, and at night, and almost impossible for her to get to know. Indeed, she was not certain if the doctor she talked to later that day, the one who told her, not apologetically, that they were "trying to figure out what to do with him" (as if this was an excuse for not calling the wife of a 90-year-old patient to tell her that he had a heart attack), was the actual hospitalist or a resident working with them. If you don't know the attending physician *du jour*, or even know who they are, it is hard to be sure. I might add that my friend is a highly educated and well-insured person. When they suffer such indignities, and they do, it is certainly far worse and more frequent for people who are not.

Why would doctors not want to call the family of a person in the hospital, especially but not only if they are old and frail and suffer a particular acute life-threatening event, as soon as possible? Is it imaginable that they do not? Why would they not want – insist upon – the family knowing who the responsible physician is? Do they just want to be anonymous, not to be bothered?

Maybe, sometimes, but I do not think that this is the primary reason. Think about it. You are the "hospitalist," a hospital-based physician tasked with responsibility for the care of lots of people ("patients") who you didn't know before they were admitted. On top of that, you are not the *weekday* hospitalist, but the one covering for them on the weekend, a *weekendist* if you prefer (I sure don't!). Maybe you are even the *nocturnist*, the night-time hospitalist. In any case, you have a list of patients to see, and to get to know, and maybe you come into the hospital in the morning to see them all (which, of course, has to be one at a time—someone first, someone last) when all of a sudden you hear from the nurses that one of them has had a heart attack. Maybe someone you have seen already, maybe not. Maybe it is the afternoon, and you have already left the hospital. You tell them, the nurses and the residents working with you, to begin their well-practiced routine of treating an acute myocardial infarction (MI, heart attack) and give other instructions, including to call cardiology, and tell them to call you back. Do you specifically instruct them to call the family? Do you think that would be obvious to them? Does it even occur to you? Is it someone else's job? Whose?

In the "old days," when someone's family doctor took care of them even when they entered the hospital, it was almost certain the family would be called. The doctor knew the person, often had been seeing them for years, and knew the family. They knew, of course, that the family would want to know and felt it to be their responsibility to inform them. This changed with the creation of hospitalists as a separate specialty and has accelerated with the corporate takeover of medical care and the dramatic increase in physicians as employees of corporations (most often hospitals, sometimes physician-owned groups, sometimes for-profit, often owned by private equity). Different physician roles have been identified, such as caring for people in the office (and very rarely at home), in the hospital, in nursing homes. While these roles had always existed, often the same doctor filled the different roles for their patients; now different doctors would. The delivery system, which had been *patient-focused* ("I'm your doctor and take care of you wherever you need care") became *provider-focused* ("We, as the providers of care, will develop a system that works efficiently for us; unfortunately for you, that means you will not have the same doctor all the time").

Actually, there were many good reasons for this change. It is not easy, was never easy, to be a "full-spectrum" family doctor. To see people in the office both with appointments and as walk-ins, to do home visits for those who were ill and found it difficult (from age or disease) to get to the office, to see people in nursing homes and in the emergency room, and make "rounds" on and care for your patients in the hospital. And, often, get up in the middle of the night to deliver a baby. It was tough on the doctor, and tough on their families, as many books and films have depicted. In addition, these family doctors had (and have) much lower incomes than most specialists, including those who do shift work where they know exactly which hours they will work. Plus, as more and more things could be cared for in an outpatient setting (we will leave, for now, whether this

was always a good idea), the people admitted to the hospital were sicker and often required more specialized knowledge that a physician who focused only on hospital medicine could better stay up on.

But there were also bad reasons, many of them stemming from the movement of physicians from self-employed to employees, increasingly working for hospitals and even for corporations that had no health professionals in charge. This corporate model, based on the industrial concept called "scientific management" or "Taylorism," focused on increasing efficiency as the most effective way to generate maximum profit. It is more efficient to have some doctors who stay in the hospital all the time and some doctors who care for people in the outpatient setting ("ambulists," another term that fortunately hasn't caught on), and others who care for people in nursing home or even in their own homes. This not only reduces travel time, but allows more people to be scheduled ("speed up") and provides the basis for further increasing the number of patients seen and concomitantly decreasing the time spent with each.

The problem is that this is not always the best for the patient. Yes, it is good to have people who are expert and current on the care of people in the hospital ("inpatients") to take care of you. Just as, when you need one, it is good to have experts in an organ (cardiologists, nephrologists, and pulmonologists, for example, and various types of surgeons if you need surgery). But it is also good if the person taking care of you knows something about who you are, or at least your medical history. If they have never seen you before you show up in the hospital, they have nothing to compare your current situation with: are you worse? A lot worse? Better? About the same? And, by the way, if someone actually *knows* you – your family would almost certainly get a call!

Is it possible to have most of the good with little of the bad? The continuity (sometimes called "primary care") clinician – family doc, internist, pediatrician, family or adult or pediatric NP – can delegate the key medical decisions to hospital experts but stay as the leader of the team. The *leader*, not the pain-in-the-neck "local doctor." The professional who can fill their role as the one who cares for the whole person, not as the subspecialist for only one disease or organ. The one who cared for the patient before admission and will continue to do so afterward, not as the hospitalist for whom the patient was essentially born the day of admission and will disappear the day of discharge. Someone who can provide context, understanding, and, believe it or not, *continuity!*

Of course, we'd need more primary care clinicians, not fewer as is the current direction in which we have been and continue to be heading (See Incredible (Terrible) Shrinking Physician Supply, *Health Justice Monitor,* Sept 7, 2024). This would decrease efficiency, perhaps, but increase *effectiveness*. And while it might cost more money (thus lower profits for the corporations) it might actually save money for the overall system by having historical memory of the person when they go from home to hospital to home, and not change almost daily each time a new doctor is in charge.

Worth thinking about!

Pro tip: If you have to be admitted to the hospital, or have a heart attack, try to do it on Monday, or at least Tuesday. Do not wait for the weekend!