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– HOSPITALISTS –
The Evolving Model of Hospital Care

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MARCUS WELBY MD – IS THE TRADITIONAL MODEL OF HOSPITAL CARE EXTINCT?

In the 20th century a patient's hospital care was overseen daily by a dedicated family doctor who heralded the arrival at birth and pronounced passing at death. This traditional model of care was idealized in the popular weekly television show "Marcus Welby MD." The family doctor was intimately familiar with the patient's medical history, family background, place in the community and ongoing health problems. Both the patient and the family doctor expected that if the patient needed hospital care, the patient's hospital stay could be managed by daily visits from the family physician who would also continue to care for the patient after discharge from the hospital.

Continuity of patient care was and continues to be a critical component of our healthcare system. An uninterrupted relationship between patients and their care providers has been linked to better screening and treatment, improved identification of problems, fewer hospitalizations, decreased use of emergency rooms, and a reduction in healthcare costs.[1] As important as continuity of care is, it is also the Achilles' heel of the hospital medicine discipline. Historically, family physicians provided care for their patients throughout the entire spectrum of care. They would admit and oversee their patients in the hospital, and continue to do so after discharge. They were familiar with the patient's personal circumstances, their unique health background, and their social context and would advise the specialists and other members of the hospital team on these issues.

Partway through the second decade of the 21st century this traditional model of hospital care is fading as quickly as our memories of fatherly Marcus Welby. In this paper we focus on this change because it raises new issues that are almost certain to be litigated in future medical negligence cases.

AMERICAN INGENUITY: THE HOSPITALIST IS BORN

The term "hospitalist" was first introduced by Robert Wachter in an article written in the *New England Journal of Medicine* in 1996. Hospitalists are different from other physicians in that they practice in an institutional setting, often without having an office outside of the hospital. Because of this, the distinguishing characteristics of hospitalists are that they have an in-patient practice and are invariably present at the hospital. In fact, the entire specialty of hospitalist medicine is organized around the place where patients receive care, not by organ systems or any specific illness.

Ideally, hospitalists are on-site team players who are available for urgent consultations. They co-ordinate increasingly sophisticated patient care in hospitals and face the dual pressures of budgetary cuts and sicker patients. Hospitalists are quarterbacking the patient's team of emergency room doctors, specialists, interns, nurses and other professionals. In this way, hospitalists can have multiple roles in the hospital: they assist surgeons, emergency room physicians and medical residents in providing patient care. In the emergency room, hospitalists attend and assess incoming patients, treat them expeditiously and admit them, if necessary. In the inpatient ward, hospitalists are available to quickly evaluate changes in a patient's condition without the delay of waiting for a response from an on-call physician or resident. They make it possible for the primary care physicians ("PCP"), the American term for family physicians, to focus on their office practice. Finally, hospitalists assume care over patients who do not have a family physician – the so-called "orphan patients."

The west coast of the United States was the spawning ground for hospitalists in the mid-1990's. This practice model caught fire and the concept of hospitalists spread across America and

more recently into Canada.[2] In the United States, approximately 75% of hospitalists are specialists in internal medicine.[3] Their role within the system of hospital care is primarily focused on admitting, evaluating and discharging patients, assuming care of patients who have no PCP, and coordinating care. Coordinating patient care in the hospital includes making sure patients receive appropriate diagnostic evaluations and correctly prioritizing their treatment.

This specialization in internal medicine allows American hospitalists to provide acute care to the majority of patients attending at hospitals for treatment. Most of the patients requiring emergency hospitalization have medical issues that internists are trained to address; namely, circulatory, respiratory and digestive disorders.[4] Hospitalists have an overall positive impact on the delivery of medical care to hospital patients in the United States. Studies show that hospitalists' involvement decreases mortality, length of stay and re-admission rates of patients in the American hospitals. A Mayo Clinic study on co-management of care between hospitalists and orthopedic surgeons found that by working together they produced better post-operative outcomes than traditional orthopedic care. The study also found that orthopedic surgeons and nurses preferred the co-management paradigm of care and positively rated the hospitalists' involvement in patient care.[5]

HOSPITALIST, EH? THE CANADIAN MODEL

Hospitalists in Canada are not a separate accredited specialty, however, they may belong to the Canadian Society of Hospital Medicine ("CSHM"). CSHM, founded in 2001, is a chapter of the U.S. based Society of Hospital Medicine ("SHM"). CSHM defines a hospitalist as a physician whose primary focus is on providing medical care to hospitalized patients.[6]

CHSM and SHM support the American quality of care concept that hospitalists add value to the medical care that patients receive in the hospital setting. Hospitalists promote quality of care by expediting the admission and discharge processes for patients, enhancing the patients' progress through the continuum of care and through each department in the hospital, and maximizing the overall efficiency of the system.[7]

It is difficult to pinpoint the current number of hospitalists because there is not a separate code to track them in the United States. It is estimated that somewhere between 20,000 to 30,000 physicians are practicing as hospitalists in North America.[8] Since the majority of hospitalists in Canada are family physicians[9], it is even more difficult to identify Canadian statistics.

British Columbia, along with Ontario, has embraced the hospitalist concept.[10] HealthLink BC describes hospitalists as "medical doctors who specialize in hospital care, providing treatment in place of a primary care physician. Currently, there is no certification for hospitalists other than certification in an initial specialty area. They usually are general internists, family doctors, respirologists, or other specialists."[11]

In Canada, hospitalists are often younger than traditional specialists. According to the CSHM survey on hospitalist demographics 20% of hospitalists in Canada are under the age of 34 while only 10% of family physicians are under the age of 34. In addition, nearly 40% of Canadian hospitalists are between the ages of 35 and 44 while fewer than 30% of family physicians are between the ages of 35 and 44. More and more medical school graduates opt to pursue careers as hospitalists for better work-life balance, to be free of worries about office coverage, administrative and staffing problems, and for greater interaction with specialists and the new technology found within hospital settings.[12]

HOT POTATO – ANYONE WANT THIS PATIENT?

In Canada and the United States, hospitalists often provide care to orphan patients – those who do not have a family physician at the time of their admission to the hospital. Given that fewer and fewer family physicians have hospital admitting privileges,[13] hospitalists will play an increasing role of providing care to orphan patients.

The hospitalist becomes the orphan patient's most responsible physician ("MRP"), the physician who has the final responsibility and accountability for the medical care of the patient. As MRP, a hospitalist ensures that the patient is seen by the appropriate specialists, that appropriate tests are ordered, that the test results are followed up on, and that the patient's status is communicated to the family.

In the context of walk-in clinics, the College of Physicians and Surgeons of BC ("CPSBC") describes orphan patients as patients who do not have a designated family physician of record and who have on three or more occasions attended the same walk-in clinic. In these circumstances, these patients are assumed to be receiving ongoing care from the walk-in clinic, must be offered the opportunity to become a regular clinic patient, and be assigned an MRP.[14]

While the CPSBC policy is aimed at walk-in clinics, the College of Physicians and Surgeons of Newfoundland and Labrador ("CPSNL") has gone further and addressed the outpatient management of orphan patients upon discharge from hospital as follows:

> "[Physicians] who are aware that they are discharging a patient who does not have a family physician and who requires ongoing outpatient management, do have certain responsibilities to that patient. These responsibilities may not be simply deemed to terminate on discharge from hospital."[15]

Is it possible that the CPSBC policy on orphan patients attending walk-in clinics will be extended to apply to hospitals and hospitalists? Given the increasing number of patients without a family physician,[16] that could defeat the goal of moving patients in and out of hospital in an expedient way. The impact of the CPSNL policy on the hospitalist discipline also remains to be seen.

WHO IS IN CHARGE? CO-MANAGEMENT REALITIES

In the traditional model of hospital care the PCP was the most responsible physician in charge of the patient's day-to-day care in

the hospital as well as in the community. This dual role lessened the risk that a health professional treating the patient would not have the patient's prior health history or a physician to transfer care to once the patient was ready for discharge.

One court has described the MRP as being...

> ...the practitioner most responsible for the in hospital care of a particular patient. The MRP is responsible for writing and clarifying orders, and providing a plan of care, obtaining consultations as appropriate, coordinating care, as well as the discharge process. (para. 37)[17]

Physicians working as hospitalists become knowledgeable about the common illnesses that present at emergency departments. They develop and implement protocols for dealing with common conditions, speeding up the admission and diagnostic processes and significantly improving patient flow through the system and reducing length of stay.[18] While knowledge about common presenting illnesses is important, *Manary* v. *Straban* illustrates the need for the MRP to be aware not only of what they know, but of what they don't know. As the Court in *Manary* warned:

> An MRP is not absolved of responsibility with respect to a medical condition simply because that medical problem is beyond the expertise of the MRP...the MRP is responsible for a plan of care.[19]

In the context of a revolving schedule of hospitalists, it may not always be clear who the MRP is. The hospital may have a policy that describes the role of the hospitalist as it relates to the MRP. These policies, as well as policies or protocols relating to changes in MRP during handovers, referrals out to other hospitals, and other key transition points, are important documents in developing a liability case.

Co-management requires delineation of responsibilities among the team and advance discussions as to who will make a decision and how those decisions are to be made, how to resolve disagreements, and what the hospitalists are and are not going to do.[20]

WHAT'S UP, DOC? – PROBLEMS INHERENT IN THE HOSPITALIST MODEL

The traditional model has been slowly eroding, with more and more family physicians giving up their hospital admitting privileges.[21] Hospitalists emerge at the receiving end of this trend, admitting and taking over the patient's care at the hospital. Most of the time, the admitting hospitalist has never seen the presenting patient before, and is not aware of his or her health circumstances. When the patient is discharged back into the community, the discharge summaries often do not make it to the family physician's office, leaving the primary healthcare provider in the dark about the details of their patient's stay at the hospital, the treatment administered there and the care plan.

More significantly, even within one single hospital admission, a patient is likely to be cared for by several physicians and hospitalists. Discontinuity of care is an inevitable consequence of hospital care. Even though hospitals do provide 24/7 coverage, no medical

professional can stay at the hospital around the clock. Typically, nurses change shifts every 8 to 12 hours, residents are usually on 36 hour shift rotations and hospitalists are often scheduled for 7 to 10 day rotations of 8 to 12 hours shifts.

The system of transferring responsibility for care between members of a medical team is called the "handoff." The word "sign-out" is used to denote the transfer of information about the patient. The purpose of a handoff or a sign-out is to provide the receiving healthcare provider with patient information to enable the efficient provision of the required care. Increased numbers of handoffs and sign-outs have been associated with adverse events in a clinical setting.[22] In one study, care by a house officer who was not the patient's usual intern and not a member of the usual intern's patient care team was found to be an independent predictor of errors and adverse outcomes.[23]

Another study found that almost 20% of patients suffered an adverse event within three weeks of hospital discharge with almost three quarters of these adverse events being preventable.[24] The most common complications related to adverse drug reactions and hospital-acquired infections. Discontinuity in care and failure to communicate pertinent information were often found to be at the root of these problems.

Hospitalists are especially vulnerable to being implicated in adverse events following poor handoffs and sign-outs. The nature of hospitalists' practice exposes them to perhaps the most frequent cross-coverage in a hospital. Two studies conducted at North-Western Memorial Hospital in Chicago demonstrated that hospitalists spent most of their time (69%) on indirect patient care activities. One indirect activity, communication, accounted for nearly 25% of their time at work. Communication was further broken down as 44.5% of time spent communicating with other physicians and 18.1% of time spent communicating with nurses.[25]

The key area of risk for hospitalists is failure to communicate; up to 80% of lawsuits arise from miscommunication.[26] Because hospitalists work in multi-disciplinary teams and typically work five or seven consecutive days of 10-12 hour shifts followed by five or seven consecutive days off, they often rely on handoffs and sign-outs to fulfill their duties. As a result, hospitalists often are involved in caring for patients for whom they lack first-hand knowledge. Given the nature of the environment they work in, they are at increased risk for making errors.

DR. HOUSE – QUARTERBACKING GONE AMOK

As both team leader and communicator, hospitalists are at higher risk for liability. Typical situations that can lead to negligence allegations against a hospitalist include failing to obtain timely consultation to avoid permanent injury to the patient, failing to order timely imaging of the patient, failing to properly examine or serially examine a patient who deteriorates, and failing to aggressively treat a patient.[27] While these types of errors are not unique to hospitalists, it is the combination of quarterbacking and being the physician most readily available that allows these errors to occur. Proactive hospital policies and guidelines can minimize the risk of these errors.

Studies demonstrate that handoffs, particularly when they are not done face-to-face, often miss important information such as the patient's medications, acute problems and pending tests.[28] Poor handoffs open doors to unjustified modifications to therapeutic goals, plans and priorities and fail to arrive at a shared understanding between the physician who is sending the information and the physician who is receiving it.

Double handoffs can be especially problematic. A double handoff occurs where one hospitalist admits and evaluates a patient and then hands the care over to a covering hospitalist who assumes the care over the patient during the day until the night float arrives. The second handoff occurs between the day-covering hospitalist and the night-covering hospitalist; it is this second handoff that is particularly prone to errors because neither physician has primary knowledge of the patient.[29]

One study found that communication failure errors could be classified as falling under one of two categories: "content omission" or "failure-prone communication process."[30] Examples of content omission included not reporting an ongoing medical problem, not reporting administered medication, and not reporting a pending test or consult.

In the second category, failure-prone communication processes, the process errors contributing to failure in communication included lack of face-to-face communication, ineligibility of written notes, and the double-handoff situation. All these were found to lead to uncertainty regarding patient care decisions.[31]

Elements of good handoffs and the consequence of bad handoffs are part of risk management for hospitalists. Dr. Eric M. Siegal provides a succinct overview of handoffs including the SHM's Handoff Policy that states:[32]

- The hospitalist of record is responsible for contacting the ambulatory provider, when he or she can be identified.
- The hospitalist or team member must be available for inquiries in the immediate post discharge period.
- The ambulatory provider is responsible for the care of the patient upon discharge from the hospital.

HOW COULD THAT HAPPEN? – COGNITIVE BIAS ERRORS

In *How Doctors Think,* Dr. Jerome Groopman provides an in-the-trenches case-based perspective of how doctors should think and how their thinking can go astray.[33] Cognitive pitfalls should be in the forefront of a lawyer's mind when analyzing a possible hospitalist medical malpractice claim for errors in the differential diagnosis process.

Cognitive pitfalls have also recently been highlighted by the Canadian Medical Protective Association in the CMPA's Good Practices Guide entitled "Common Cognitive Biases."[34] The guide briefly defines, provides case examples, and offers better thinking strategies for the following eight common cognitive biases:

- Anchoring – focusing on one particular symptom, sign or piece of information, or a particular diagnosis early in the diagnostic process and failing to make any adjustments for other possibilities – either by discounting or ignoring them.
- Premature closure – uncritical acceptance of an initial diagnosis and failing to search for information to challenge the provisional diagnosis or to consider other diagnoses.
- Search satisfaction – when one abnormality has been found, calling off the search and failing to look for others.
- Zebra retreat – backing away from a rare diagnosis by thinking "if it's uncommon, this isn't it."
- Bandwagon effect (diagnostic momentum) – when diagnostic labels stick to a patient because if everyone else thinks it, it must be right!
- Attribution error – a form of stereotyping to explain a patient's condition on the basis of his or her disposition or character rather than seeking a valid medical explanation.
- Authority bias – declining to disagree with an "expert."
- Availability heuristic – when recent or vivid patient diagnoses are more easily brought to mind and over-emphasized in assessing the probability of a current diagnosis.

While interns in the Arora study[35] described their frustration in "starting from scratch" due to poor communication during handoffs, the cognitive biases above point out the risks inherent with simply accepting all of the conclusions made by previous practitioners and not taking a fresh look at the situation. In an environment where frequent handoffs to new physicians become a regular feature of practice, cognitive biases may be more likely to rear their head.

The court in *Manary* stated the idea in this way:

> While the honest and intelligent exercise of judgment has long been recognized as satisfying one's professional obligation, a failure to exercise objective and critical judgment can constitute negligence.[36]

Clearly there is a balance to be struck between blindly accepting the opinion of previous caregivers, and reinventing the wheel on each shift change. This may present one of the greatest challenges for a hospitalist, as it is an area where liability may occur.

SHERLOCK HOLMES – SLEUTHING FOR CLUES TO FIND LIABILITY

When reviewing a potential case against a hospitalist, counsel should search for the following clues:

- Are the hospitalist's notes, orders, treatment, or the observations of other health professionals consistent with a cognitive bias?
- Do the records or other witnesses' recollection of events indicate that the hospitalist failed to utilize the "how to think better" strategies to avoid the risk of common cognitive biases?
- How many handoffs were there at the critical time (time of injury)?
- What was the level of experience of the hospitalist?
- Should the patient have been transferred out to a higher level hospital? If not, why not?

- Did the hospitalist exceed the vertical and longitudinal limits of a hospitalist in caring for the patient?
- Did the hospitalist follow the SMH's Handoff Policy?
- Are the hospitalist's actions or lack of action consistent with hospital protocols and policies?
- Did the hospitalist make decisions outside their area of expertise?

ELLERY QUEEN – HAVE YOU FIGURED IT OUT YET?

Are hospitalists another patch in the patchwork approach to healthcare that continues to evolve both in the USA and Canada? The patchwork approach is driven by a number of factors, including the need for primary care physicians to achieve maximum productivity in their office practice while leaving the increasingly complex inpatient management of patients to hospital experts.

A review of a Canadian administrative database of 938,833 patients found that the relative risks for readmission and death 30 days after discharge from a hospital were significantly decreased (by three and five percent, respectively) when patients were seen after discharge by the same physician who provided their care in the hospital. Given this data hospitalists should ensure that care is not compromised during transitions from hospital to the community.[37]

In many cases the obligations of a hospitalist may be no different than those of the most responsible physician or attending family physician. Although there is no formal certification for hospitalists at the moment, certification does not necessarily define a specialist. A doctor gradually restricting his or her practice to a particular type of patient may be found to have become a *de facto* specialist.[38] Whether this will have the effect of raising the standard of care expectations for hospitalists will remain to be seen. As the hospitalist track becomes more specialized, the standard of care expected of a hospitalist may approach that of a specialist as described in *Crits* v. *Sylvester* where the court noted that "a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability."[39]

It is not yet clear what the standard of care is for hospitalists: will they be held to the same benchmark as their family physician colleagues with hospital admitting privileges, or will the hospitalist mantle become recognized by the courts as a specialty requiring a higher standard of care? As lawyers litigate cases involving hospitalists the courts may clarify these issues.

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