In the middle of an extremely busy week, I received a call from the Emergency Department about a 72-year-old patient of mine who needed to be admitted for an exacerbation of severe chronic obstructive pulmonary disease. Should I admit her to the hospital under my name, or should I admit her to the hospitalist service? For 24 years, I routinely accepted responsibility for being the attending of record whenever one of my patients was admitted to the hospital. My clinical practice was small enough that it did not impose an unreasonable burden on my time. Of course, it helped a lot that I was able to admit patients to a service covered by superb housestaff. Over the years, I came to realize how much my patients appreciated my presence when they were sick enough to require hospitalization. Being there for my patients when they were sickest became part of my professional identity. In my mind, it was linked closely to why I chose a career in medicine—and general internal medicine in particular. What should I do now that we have a well-established hospitalist service that is more than willing to take care of my patients when they need to be hospitalized?

What should I tell my family about my role as primary care physician? I pulled out one of Barbara Starfield's classic articles on the contribution of primary care to health systems and health. I reviewed the four basic functions of an excellent primary care provider: first contact access for each new health problem, continuous long-term person-focused care, comprehensive care for most health needs, and coordination of care when health care services must be sought elsewhere.

So how do I grade myself as a primary care physician?

In terms of providing first contact access, I carry my pager 24 hours a day, seven days a week, except when I am out of town. I am willing to reply when patients contact me by e-mail, although I remind them to call if they have an urgent problem because I might not be able to answer e-mail until the end of the day. My patients know they can reach me anytime, and I do my best to answer calls promptly. My limitation in providing first-contact access is that I only see patients in the outpatient center one morning a week. That means that I sometimes refer patients to an urgent care center instead of asking them to come in to see me. On a 5-point scale (excellent, very good, good, fair, poor), I give myself a rating of “very good” for providing continuous care. The continuity of care would be diminished if I was not involved when patients were hospitalized.

As a general internist, I take very seriously my responsibility for providing comprehensive care. Most of my patients, especially the older ones, have numerous health problems. I generally give attention to every active problem at each visit in addition to routinely addressing health maintenance and preventive care issues. My commitment to providing comprehensive care is one of the factors motivating me to be the attending of record whenever a patient is admitted to the hospital. I give myself a rating of “excellent” for providing comprehensive care but only if I continue to be involved when my patients are hospitalized.

Coordination of care accounts for much of the time I spend on patient care that is not fully documented or reimbursed. Fortunately, our electronic medical record system makes it easier to coordinate care than was the case years ago. Even so, coordination of care continues to be a challenge in a health care system that does not give primary care providers enough support for this vital function. From SGIM’s work with specialty organizations on the High Value Care initiative of the American College of Physicians, I have become more attuned to ways of providing comprehensive care. The continuity of care would be diminished if I was not involved when patients were hospitalized.

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Regarding provision of continuous long-term person-focused care, I have seen many of my patients for more than 20 years, including the patient who prompted this column. I try to understand how their medical problems affect their lives and those around them. I admit that time pressure in the clinic keeps me from spending as much time as I would like on asking about other aspects of their lives. I give myself a rating of “very good” for providing continuous care. The continuity of care would be diminished if I was not involved when patients were hospitalized.

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that I could improve communication with the specialists to whom I refer patients. My commitment to coordination of care is the other major factor that motivates me to be the attending of record when a patient is hospitalized. On a few occasions when my patients were admitted to the hospitalist service, I noticed how difficult it was for the hospitalist to determine the full history of each complicated patient and to anticipate the challenges that will be faced after discharge. I give myself a rating of “very good” for coordination of care but again only if I continue to be involved when my patients are in the hospital.

When I reflect on my role as a primary care physician in this way, I find myself wanting to remain involved in the care of my patients whenever they are hospitalized. The competing concern is whether I can keep my inpatient knowledge and skills sharp enough to justify being the attending of record when highly skilled colleagues who specialize in hospital care are available. I also recognize that the question about how well I am doing as a primary care provider is different from the question of what will lead to the best quality of care. Perhaps the expertise and dedicated attention of a hospitalist will enhance the quality of inpatient care enough to compensate for sacrificing part of my role as a primary care provider. In this particular case, I decided to accept the responsibility of being the attending physician when the patient was admitted. While she was in the hospital, I had a long discussion with her and her family about her grave prognosis and how to manage her care in the limited time that she had left. During that discussion, I felt reassured that I made the right decision. It was best for me to be the one directing her care in the hospital.

What are the implications of my reflections for SGIM? First, I believe we should give explicit attention to supporting those general internists who want to continue providing comprehensive inpatient and outpatient care to their patients. This group includes faculty who have the option of admitting patients to a service covered by housestaff and who thus have unique opportunities to teach about coordination of care. Second, we need to acknowledge that the hospitalist movement and the organization of care within our health systems will continue to push more general internists into concentrating their efforts in the ambulatory care setting. For general internists who do not have the option of admitting patients to a service covered by housestaff, this may be the only realistic option for managing a busy practice. Third, we need to recognize the important role that our hospitalist members have in developing better ways to deliver comprehensive coordinated care in our evolving health systems. Recently, the American Board of Internal Medicine (ABIM) informed us of their plan to give internists a choice of exams for recertification: the traditional one that combines inpatient and outpatient medicine, a new one that concentrates on ambulatory care, and one that focuses on hospital medicine. Although SGIM and the American College of Physicians opposed this approach when it was suggested years ago, my own feeling is that this approach makes a lot of sense given how the practice of general internal medicine has evolved. I would welcome feedback on whether the SGIM Council should officially support the ABIM’s plan.

In addition to supporting the interests and needs of each of these groups, my hope is that SGIM will be a place to work together on improving the training of the next generation of general internists who will practice in ways that differ from how most of us were trained. Our patients should expect to receive high-quality acute care without sacrificing the vital functions of having an excellent primary care provider.

References