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Academic General Internal Medicine: Where a Primary Care Internist Can Still be a "Bridge" on the Inpatient Wards

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As we head into the SGIM national meeting, the theme topic of "bridges" arises. It is worth considering that bridging inpatient and outpatient medicine can be a source of job satisfaction for primary care generalists. Recalling plenary sessions at previous SGIM national meetings, several speakers reported that others had expressed to them that primary care is so difficult that those who practice it must be depressed and discouraged. Some studies have supported this notion, showing a decrease in satisfaction among primary care physicians (PCPs) over time.[1]

So why do many of us in academic general internal medicine feel so lucky in the face of these challenges? One reason is the bridging of worlds—inpatient and outpatient—that we are privileged to still be a part of. In the current era, even generalists are becoming specialists as physicians choose either a hospitalist (inpatient specialist) or primary care (outpatient specialist) career. While some communities still have internists who round on their inpatients in the morning and see their clinic patients during the day, that model is on the downswing in many regions. Yet in academic general internal medicine, many PCPs still attend on the general medicine wards. This practice provides an opportunity to maintain those inpatient and outpatient links that multiple forces seem destined to sever. Consider the following benefits:

1. *Seeing unusual cases*. Because of the acuity of presentations, and in some cases, the referral population of the hospital, we have the opportunity to see a higher percentage of unusual syndromes that we may seldom (or never) see solely in outpatient practice. Uncommon paraneoplastic syndromes, endocarditis with an unusual organism in an immunosuppressed patient, new onset Takayasu's arteritis—these cases may appear in the clinic initially, but in the hospital we benefit from an enriched sample. As internists we can enjoy the common, but it's often the rarities that keep us talking even after our work is done.
2. *Not forgetting the common inpatient cases*. Not only do the unusual cases provide stimulation, but without the inpatient service, our practice becomes more restricted. We would no longer evaluate and treat many of the routine conditions that we trained for as general internists—the cirrhotic patient with a GI bleed and encephalopathy, the elderly patient with community-acquired pneumonia requiring inpatient care, and the patient in acute alcohol withdrawal.
3. *Knowing our housestaff on a different level*. Working with residents in the primary care clinic is but one snapshot of how residents perform. Like it or not, not all of our residents will become generalists, and of the generalists not all will become PCPs. While residents still need to excel in continuity clinic, it is perfectly acceptable for their true passions to flourish elsewhere, and we may have the opportunity to witness that spirit on the inpatient wards. Seeing interns' excitement teaching a medical student on rounds yields another dimension of their doctoring that may not be evident during their harried continuity clinic day. Furthermore, as residency programs consider new models of balancing ambulatory and inpatient training, when we attendings also work on the wards, we can better empathize with the challenges confronting residents on a busy inpatient service as they try to manage their continuity clinic panel.
4. *Acuity of illness*. As PCPs, we may see acutely ill patients who require hospitalization and then provide input as their PCP while the inpatient team handles the medical care. But in the hospital, as the inpatient providers, we are there for patients in the most difficult times and share with them the ups and downs as different tests come back or their conditions change. In the clinic setting, we have longer continuity of care but less often find that compressed intensity of care as experienced in the hospital.
5. *Bringing primary care into the inpatient wards*. We can look backward to how the illness unfolded prior to hospitalization and appreciate the myriad ways in which the "present" illness began from a primary care perspective. We can assess the current outpatient therapy—for example, "Why is Mrs. Lee on that expensive medication for

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dementia, and does she really have dementia?" And in preparing for discharge, we are a bridge back to the outpatient world where patients spend the vast majority of their days. In recent years, there has been increasing focus on reducing readmissions and a growing interest in improving care transitions. It is difficult to do transitional care when you don't know what you're transitioning to, but PCPs on the general medicine wards can better assess whether a follow-up plan is realistic.

Is there a successful model for PCPs—academic and non-academic alike—to build those bridges and stay involved in inpatient care? The ideal mix of inpatient and outpatient practice remains uncertain and likely varies by person and institution. Surveys from early on in the hospitalist movement suggest that trying to do both inpatient and outpatient medicine may have been a source of stress and burnout for general internists.[2] In one article, internal medicine physicians were less satisfied compared with subspecialists; notably they spent 20% of their time on hospital practice.[3] It is possible that much of the stress was due to practicing inpatient and outpatient care concurrently rather than doing "on service" periods on the inpatient wards. Additionally, being an academic inpatient ward service attending is different from being alone as a hospitalist in a community hospital. A follow-up study is needed on assessing work-life satisfaction in the hospitalist era, both in academic and community practices.

Still, general internists should continue to consider ways to maintain these bridges. Is it uncomfortable sometimes being a PCP on the inpatient ward service? Sure. Every time I am back on the wards it seems there is a new emerging organism, a new quality measure, a new CPOE challenge. But far from being depressed and discouraged as a PCP, I not only look forward to the patient-centered medical home and other innovations but also appreciate looking backward, to inpatient care, as part of what is rewarding about being a generalist. And besides, when I'm done on the inpatient service, I have my panel of clinic patients waiting for me, and I can appreciate them that much more.

References

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