

Where's My Doctor? The Impact of the Primary Oncologist's Visit with Their Hospitalized Patients

BRIANNA R. BAKOW, MD; FRED J. SCHIFFMAN, MD; ANTHONY E. MEGA, MD

ABSTRACT

BACKGROUND: Continuity of care is a cornerstone of the patient-practitioner relationship. Previously, patient satisfaction has been related to perceived provider communication skills and competence. Our study assessed the relationship between the inpatient continuity visit (ICV), a face-to-face patient-provider interaction with the primary oncologist, and patient satisfaction.

METHODS: Subjects were adult inpatients on the oncology unit at The Miriam Hospital who had an oncologist at the hospital-based cancer center. A survey, given at discharge, included a 5-point Likert scale ranging from greatly worsened to greatly improved satisfaction to assess the impact of the ICV on patient satisfaction.

RESULTS: Of 75 participants, 43 (57.3%) reported a visit by their outpatient oncologist. Of these, 39 (90.7%) reported that this visit either greatly or somewhat improved satisfaction with their hospital stay. Of subjects who had a single ICV, 93.7% reported either greatly or somewhat improved satisfaction compared to 88.9% who had more than one visit. Of 32 (43.3%) subjects who did not receive a visit, 15.6% reported that the lack of visit either greatly or somewhat worsened their satisfaction during their hospital stay, while 84.4% reported no impact.

CONCLUSIONS: Our study suggests that an ICV improves satisfaction of care in cancer patients on a hospitalist service, and a lack of ICV negatively impacted satisfaction. There was no improvement in satisfaction for multiple versus single ICVs. While the practicality of this intervention should be reassessed with the emergence of more accessible telehealth modalities, the efficacy of a single visit to improve satisfaction is informative.

KEYWORDS: patient satisfaction; continuity of patient care; oncology; hospitalist

INTRODUCTION

Continuity of care is a central element of the patient-practitioner relationship, and thus at the heart of healthcare delivery. Previous research has shown that continuity of

care impacts level of patient satisfaction,^{1,2,3} interpersonal and functional aspects of healthcare delivery,^{4,5} and health outcomes.⁶ As the field of medicine continues to expand, this continuity has been challenged by the widespread adoption of the hospitalist system. Hospitalists, physicians who work full-time in an inpatient setting, have replaced the traditional practice of outpatient doctors managing the hospital care of their outpatients. Although this responsibility of care has transferred hands, the importance of the outpatient practitioner to understand the hospital course and integrate this into the outpatient care plan remains. This knowledge can come from a discussion with the inpatient attending physician, a letter or electronic communication from the inpatient medical team to the outpatient provider, or an in-person visit by the provider to their patient in the hospital, known as an inpatient continuity visit (ICV). The continuity visit can range from a brief face-to-face "social/continuity visit" to a comprehensive patient assessment between an outpatient provider and one of their hospitalized patients. The encounter encompasses a discussion regarding care and decision-making and may or may not also include a physical exam and interface with the hospitalist.⁷

The link between continuity of care and patient satisfaction is also important given that levels of patient satisfaction with care have been related to patient perception of physician conduct, including communication skills.⁸ In the oncology population, meta-reviews have showcased the importance of multi-professional support in the setting of advanced cancer.⁹ However, to date, no studies have shown the impact of a continuity visit in the oncology inpatient population. The oncology inpatient frequently is afflicted with acute complications from disease or treatment that threatens to disrupt the care plan, which emphasizes the need for seamless continuity of care with the outpatient provider.

There is wide practice variation in the utilization of the inpatient continuity visit by primary oncologists once their patient is admitted to the inpatient oncology hospitalist service. The current study assessed the relationship between overall patient satisfaction with care and the ICV. The authors hypothesize that subjects who report one or more continuity visits by their outpatient oncologists will report higher satisfaction ratings.

METHOD

Participants

The study population was comprised of adult inpatients on The Miriam Hospital, Providence, RI, oncology service admitted from January, 2016 to May, 2019. All subjects followed with an outpatient oncologist at the Lifespan Cancer Institute at The Miriam Hospital, located across the street from the main hospital. The inpatient attending physician was a dedicated oncology hospitalist who was not involved in the clinical outpatient care of the patient. Subjects were provided with an informational letter and given opportunity to ask questions of study staff. Exclusion criteria included patients who did not speak English, Spanish, or Portuguese and those patients who did not have a primary oncologist at the Lifespan Cancer Institute at The Miriam Hospital.

Procedure

The study received approval from the Institutional Review Board (IRB) of The Miriam Hospital. The data for this study was collected using a de-identified survey on the day of discharge. Trained study staff provided each potential participant with a consent form that included the name and contact information for the principal investigator and IRB. Study staff were available to answer any questions about the project or survey should they arise. English information letters and surveys were transcribed into Spanish and Portuguese by trained medical interpreters.

Questionnaire

The survey was developed in collaboration with the hospital's biostatistics department and local practicing oncologists. It included a 5-point Likert scale ranging from greatly worsened to greatly improved to assess the impact of the ICV on patient satisfaction (Figure 1).

RESULTS

A total of 82 surveys were completed with 75 unique participants. Surveys that were duplicated by the same participant at a second separate, inpatient visit were not included in analysis. Patient demographics are shown in Table 1. Overall, more male patients participated in the study than female patients, with a large proportion identifying as White. The most common malignancies represented were gastrointestinal and hematologic.

Out of the 75 participants, 43 reported that they had received a visit from their outpatient oncologist during their hospitalization, while 32 subjects reported they did not receive a visit. The study showed that for the 43 inpatients who received a visit by their outpatient oncologist, 90.7% (n = 39) of them reported that this visit either greatly or somewhat improved their satisfaction with care. The remaining 9.3% (n = 4) of patients with an ICV reported no impact. None reported that the ICV greatly or somewhat

Figure 1. Study questionnaire

Date of Birth: _____
 Gender: Male Female Other _____
 Race: (Circle one): a. White b. Black or African-American c. Asian d. American Indian or Native Alaskan e. Pacific Islander f. Other _____
 Ethnicity (Circle one): a. Hispanic or Latino b. Non-Hispanic or Latino _____
 Date of admission to The Miriam Hospital: _____
 Date of discharge from The Miriam Hospital: _____
 Reason for admission: _____
 Who was the attending INPATIENT oncologist during your hospitalization?* _____
 Who is your OUTPATIENT (primary) oncologist?* _____
 For how many years have you been seeing your OUTPATIENT (primary) oncologist? ____
 During that time, how often did you see your primary oncologist? (Circle one):
 a. Daily b. Once a week c. Once a month d. Once a year _____
 Did your OUTPATIENT (primary) oncologist visit you during this hospitalization? (Circle one)
 YES or NO _____
 If YES, please respond to the following questions:
 a. How many times did your OUTPATIENT oncologist visit? _____
 b. Did this visit from your OUTPATIENT oncologist impact your overall satisfaction with your hospital stay? (Check One)
 GREATLY IMPROVED satisfaction with hospital stay.
 SOMEWHAT IMPROVED satisfaction with hospital stay.
 NO IMPACT on satisfaction with hospital stay.
 SOMEWHAT WORSENERED satisfaction with hospital stay.
 GREATLY WORSENERED satisfaction with hospital stay.
 c. Please explain the above answer selection: _____
 If NO, please respond to the following questions:
 a. Did the lack of visitation by your OUTPATIENT oncologist impact your overall satisfaction with your hospital stay? (Check one)
 GREATLY IMPROVED satisfaction with hospital stay.
 SOMEWHAT IMPROVED satisfaction with hospital stay.
 NO IMPACT on satisfaction with hospital stay.
 SOMEWHAT WORSENERED satisfaction with hospital stay.
 GREATLY WORSENERED satisfaction with hospital stay.
 b. Please explain the above answer selection: _____

Table 1. Demographics of study population

Characteristic	N (Total = 75)	Percentage
Gender		
Male	44	58.7
Female	31	41.3
Age		
Mean (range)	67 (32–90)	
Race		
Black/African American	3	4.0
White	69	92.0
American Indian/Native Alaskan	1	1.3
Other	1	1.3
Chose not to answer	1	1.3
Ethnicity		
Hispanic/Latino	1	1.3
Non-Hispanic/Latino	47	62.7
Chose not to answer	27	36.0
Malignancy Type		
Gastrointestinal	17	22.7
Thoracic	10	13.3
Genitourinary	15	20.0
Breast	5	6.7
Hematologic	17	22.7
Chose not to answer	11	14.7
Months with Outpatient Oncologist		
Mean (range)	35 (0–384)	

worsened their satisfaction. For the 32 subjects who did not receive a visit, 15.6% (n=5) reported that the lack of visit either greatly or somewhat worsened their satisfaction with the hospital stay, while 84.4% (n=27) reported no impact. We also compared responses of patients whose oncologist visited once during their hospital course versus more than once. It showed that of patients whose oncologist visited once, 93.7% reported either greatly or somewhat improved satisfaction compared to 88.9% who had more than one visit.

DISCUSSION

Our study showed that a visit or lack of visit by the outpatient oncologist during an inpatient stay on an oncology hospitalist service did have an impact on patient satisfaction.

The utilization of an ICV by oncologists is often dictated by logistical factors including constraints of time and distance of the hospital from the outpatient clinic. For oncologists that practice in an outpatient clinic located on the hospital campus, such is the case of our facility, the primary limiting factors then becomes time and resources. These results suggest that even a single inpatient visit can improve satisfaction of care in cancer patients on a hospitalist service. Insurance reimbursement of the ICV may also be available if the patient was not seen that day by an inpatient oncologist and a note documenting the visit is placed by the outpatient oncologist. As the use and availability of telehealth products and services increases, investigation of these modalities as potential alternatives to the face-to-face ICV would be informative.

Initially, the primary goal of looking at the impact of the ICV on patient satisfaction was to demonstrate for outpatient providers the importance of this visit to help promote its use. Although further research is needed, the powerful results of this pilot study prompted us to pursue larger interventions to improve the experience of cancer patients receiving inpatient care. First, data was presented to outpatient clinical teams to encourage inpatients visits. We then hired inpatient oncology hospitalists who would be responsible for caring for these inpatients and help to bridge the gap between the inpatient and outpatient care teams. These interventions are not only important for our institution alone, but also for other organizations who are moving towards a hospitalist oncology service. It is noteworthy that our study showed an impact of the ICV for inpatients being cared by a hospitalist trained in oncology rather than internal medicine, which is becoming more prevalent.

Limitations of our study include a small sample size, predominantly White population, and lack of representation of certain types of malignancies especially female gynecologic and head and neck. The single-institution model also limits evaluation as to the feasibility and generalizability of this type of intervention at other academic institutions. We also acknowledge potential bias of only including patients

who spoke English, Spanish, or Portuguese although to our knowledge, there were no patients prevented from participating in our study due to language barriers.

Being able to pursue further research to establish the efficacy and importance of this intervention to maintain continuity of care and improve patient satisfaction and clinical outcomes will provide the data needed to encourage other institutions to make similar efforts.

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Authors

Brianna R. Bakow, MD, Warren Alpert Medical School of Brown University; Division of Hematology/Oncology, Rhode Island Hospital, Providence, RI.

Fred J. Schiffman, MD, Warren Alpert Medical School of Brown University; Division of Hematology/Oncology; The Miriam Hospital, Providence, RI.

Anthony E. Mega, MD, Warren Alpert Medical School of Brown University; Division of Hematology/Oncology, The Miriam Hospital, Providence, RI.

Correspondence

Brianna R. Bakow, MD
Rhode Island Hospital
593 Eddy St., Providence, RI, 02903
401-444-9375
Fax 401-444-4184
brianna_bakow@brown.edu