From teaching hospital to community hospital: one physician's experience

Eric Letovsky, MD

Three years ago, I left an administrative position at a downtown teaching hospital emergency department (ED) for an administrative position at a community hospital ED. The decision was not an easy one. I had, after all, spent 17 years at my former hospital. I had developed an excellent academic portfolio and built a local and national reputation. My colleagues were good friends, and the people I worked with were collegial and supportive.

When faced with the opportunity to move, difficult questions arose. What would medicine be like in the suburbs? What would the clinical environment be like without housestaff? What would it be like working without all the backup? In short, was there life after a teaching hospital?

I quickly discovered some major differences between the two hospitals and the working environments. First, the patient population differed. Whereas my teaching hospital serviced primarily adults, community hospitals treat a large numbers of kids, so I had to reacquaint myself with pediatrics very quickly. Fortunately, kids get the same old problems they've always gotten: croup, gastro, head injuries and asthma. I had forgotten how much fun it is to treat kids: Now I get to play with finger puppets, dole out popsicles and blow bubbles. There is something special about taking care of kids in an ED.

People really smash themselves up in the suburbs. Being right beside the highway, our hospital sees a large volume of major trauma and, in a community hospital, the emergency physician *is* the trauma team. No luxury of having 4 or 5 other specialty physicians to assist. You get a profound sense of satisfaction when you hear the trauma team leader at the other end of the phone at the trauma hospital say, "sure, send him down," and you quickly discover that receiving physicians at teaching hospitals have limited knowledge of what resources are available in a community hospital. It is immediately apparent that all specialty residents should spend a lot more time on community rotations to see the "other" world.

Referrals are different. No more do I have to pry residents out of bed to see patients. Now I pry consultants. You tend to think twice when that consultant is at home, and it seems like more things can wait until morning. It's funny, but at my previous hospital, there were consultants I rarely spoke to and rarely saw. There were some I'd *never even met*. It's nice to be able to speak to colleagues directly (especially since I had trained so many of them when they were residents or medical students!). You get to the point of referral more directly.

A major difference between the hospitals is the importance of the emergency program. Whereas EDs are not usually priority programs in teaching hospitals (often superseded by tertiary or even quaternary care programs), community hospitals tend to revolve around their EDs. When the ED is overflowing, everyone knows it.

My fears of becoming less academic were unfounded. Despite moving to the community, I've retained my university positions and responsibilities, with major administrative and teaching commitments, so I still get to work "downtown" quite a bit — and I still live in the centre of the city. Medical students and residents still do electives with me, I still lecture widely, and I am just as "academic" as I used to be.

Do I miss my previous hospital? Of course. I cherish the memories of my 17 years in a teaching hospital. Am I glad I moved? Absolutely. The move has been personally invigorating and professionally challenging.

Most important, I have discovered that there is life after a teaching hospital.

Correspondence to: Dr. Eric Letovsky, Credit Valley Hospital, 2200 Eglinton Ave. W, Mississauga ON L5M 2N1; 905 813-4530, fax 905 813-4548, eletovsky@cvh.on.ca

Chief, Department of Emergency Medicine, The Credit Valley Hospital, Mississauga, Ont.; Associate Professor, Department of Family and Community Medicine, University of Toronto, Toronto, Ont.

Received: Mar. 8, 2001; accepted: Apr. 10, 2001