

The Ethics of the Hospitalist Model

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The hospitalist model was founded on the premise that it could improve the quality and reduce the cost of hospital care. Many randomized studies have all but definitively proven this original assertion. Nevertheless, the hospitalist specialty raises lingering classical ethical issues: protecting the patient-physician relationship in an environment of increasing specialization and discontinuity of care, preserving patient autonomy and choice when structural changes are made in the provision of care, and ensuring that a model founded on efficiency and cost-effectiveness does not erode the public trust in hospitalists to always serve their patients' best interests. This work aims to serve as an update of these initial criticisms, showing how some questions have been answered, while some have not. *Journal of Hospital Medicine* 2010;5:183–188. © 2010 Society of Hospital Medicine.

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Wachter and Goldman¹ first described hospitalists in 1996 as a new breed of physicians who devote blocks of time exclusively to the care of hospitalized patients. Since its definition, the hospitalist model has prompted 2 major debates. First, does the hospitalist system improve clinical efficiency, quality of care, cost effectiveness, and patient satisfaction? A series of large and small randomized trials have all but definitively proven the hospitalist model's advantage. Yet whether the hospitalist model is good for patient care has proven to remain contentious, as most recently demonstrated by the discussion between Williams² and Centor³ and others like it.^{4,5} What is clear in these exchanges is that the debate has shifted to the second great debate: does the hospitalist model pose inherent conflicts in clinical ethics? What are the implications of the purposeful discontinuity in care, the autonomy issues raised by mandatory hospitalist use, and the structural management issues that potentially pit hospitalists against patients in fiduciary and financial conflicts of interest? These important issues are certainly not new, and the hospitalist model has made much effort to address some of them.^{6,7} This work aims to serve as a review of these important ethical concerns, demonstrating how some questions have been answered, while some remain unanswered.

The Hospitalist Model's Founding Premise

A growing threshold for hospital admission in the last 3 decades caused primary care physicians (PCPs) to see a diminishing number of inpatients. A survey in 1978 found that PCPs spent 40% of their time in the hospital, rounding on 10 patients per day.⁸ By 2001, PCPs spent 10% of their time in the hospital on average, and most PCPs rounded on fewer than 2 inpatients per day.⁹ The cost of inefficiencies associated with primary coordination of care in the hospital

increasingly outweighed the tradeoff of preserving the patient-PCP relationship in the hospital. Converging with increasing attention on cost controls through the restructuring of service provision, the hospitalist was born. Wachter¹⁰ argued that the hospitalist model could alleviate inpatient demands placed on PCPs while improving the outcomes and lowering the cost of care for hospitalized patients.

Early on there were setbacks to proving Wachter's¹⁰ case. Small studies found hospitalists to have higher hospital charges and longer length of stays.¹¹ A survey of PCPs found only 56% were satisfied with communication with hospitalists and that most believed that patients generally preferred to be cared for in the hospital by their regular physician.^{12,13} Meltzer and Herthko¹⁴ found 70% of people sampled said they would prefer care by their own physician to that of a hospitalist if they were hospitalized for a general medical condition. Yet this study found in a national random-digit phone survey that only 10% of the respondents would pay \$750 for their PCP to follow them to the hospital, the cost savings of the hospitalist system proven by the only 2 randomized trials performed at the time.^{15,16} To 90% of respondents, the value of the PCP at the bedside was not worth the cost tradeoff to keep them there.

The meteoric rise in the number of hospitalists reflects the many studies and reviews that affirmed the premise that hospitalists improved inpatient efficiency without harmful effects on quality of care.^{17,18} In a large retrospective cohort study of over 75,000 patients in 45 hospitals across the country, Lindenauer et al.¹⁹ found that hospitalists had a \$268 lower cost when compared to internists, \$125 lower cost when compared to family physicians, and a shorter hospital stay by about one-half day when compared to both groups. The group found no significant difference in rates of death or readmission rates. While called "modest" in the

text, these savings over time and volume add up for hospitals. Patients benefit from hospitalist care, researchers hypothesize, because of their familiarity with hospital systems, their increased availability to patients, and their experience with common hospital problems. Though the Lindenaue et al.¹⁹ study was criticized for design flaws, it prompted the editorialist McMahon²⁰ to assert that the question was sufficiently answered, and it was “time to move on” away from the studies focusing on cost and comparing outcomes. As Wachter²¹ wrote, “the demand for hospitalists is now relatively de-linked from the field’s original premise—efficiency advantages—and is now both more diversified and more robust.” The model has become an accepted mode of care for hospitalized patients, with up to 20,000 hospitalists currently practicing in 29% of all hospitals and in over one-half of hospitals with over 200 beds in the United States.^{22,23}

The Patient-Physician Relationship

Purposeful discontinuity of care in the hospitalist system has the potential to diminish the doctor-patient relationship.¹² This relationship is built on a bond of loyalty, confidentiality, and trust. Handing off care to a hospitalist when the patient is most vulnerable can be viewed as a violation of this covenant. According to Meltzer,²⁴ the hospitalist model pits Francis Peabody’s²⁵ intimate personal relationship between patient and physician against Adam Smith et al.’s¹¹ benefits of specialization. Peabody²⁵ observed that physicians’ lack of understanding of their patients as persons is especially acute in the hospital, where

one gets in the habit of using the oil immersion lamp instead of the low power, and focuses too intently in the center of the field. . . . The institutional eye tends to become focused on the lung, and it forgets that the lung is only one member of the body.

This movement toward patient-centered medicine fits into an ever-growing sentiment to value the social as well as the physiological, a holistic approach to the patient as a person. This emphasis was the original justification for PCPs to coordinate increasingly specialized hospital care and translate recommendations suitable to patients. Can the long-term relationship between patient and PCP be replaced by the hospital generalist, or would hospitalists be inherently deficient in their abilities to coordinate care appropriate for patients? Hospitalized patients are frequently in no position to make complex decisions regarding their care.²⁶ Lo⁷ argues that PCPs who know patients over extended periods of time are in a better position to respect patient wishes by individualizing discussions with patients and checking that patients’ decisions are consistent with their core values. The long-term relationship is also critical for designing a complex discharge plan suitable to the patients’ ability and resources. Information about long-term patient compliance with medications is much more available to PCPs. Patients trust physicians to keep promises made concerning end-of-life issues, and these assurances are vulnerable during hand-

offs of care. Pantilat et al.⁶ provide a case study of an outpatient Do-Not-Resuscitate order ineffective in the hospital. These scenarios occur because most written advance directives are unavailable in acute situations, and when they are, hospitalists unfamiliar with the patient’s wishes may hesitate to act on directives not specific enough to answer the acute clinical question.²⁷

Hospitalists’ broadened responsibility to systematically improve the care of patients may potentially improve end-of-life care. Patient values can be better communicated to hospitalists by encouraging inpatients to complete advance directive surveys and then asking hospitalists to discuss those directives with their patients.⁶ Significantly, Auerbach and Pantilat²⁸ found that end-of-life care was improved with hospitalist care. This chart review found hospitalists more likely to have discussions with patients and their families regarding care and providing comfort care more frequently at the time of death than community-based physicians. The authors hypothesize that hospitalists may have better communication with dying patients and their families because they spend more time in the hospital each day, using frequent meetings to better understand the preferences of patients. These preferences often require clarification and often change after admission, making previous discussions about end-of-life care with PCPs moot. Greater expertise in hospital care may also allow hospitalists to better recognize patients who are nearing death and may explain the fewer symptoms documented by Auerbach and Pantilat²⁸ at the end of life among patients cared for by hospitalists compared to community-based physicians.

Hospital medicine has taken continuity of care issues seriously, and responded by making pragmatic recommendations to preserve the patient-PCP relationship in the hospital and assuage the perception that patients have been dropped. Harlan et al.²⁹ identify important issues around good communication between pediatric hospitalists and PCPs including the content and timing of communication beneficial to the patient. Hospitalists can use a standard script for introducing themselves to patients, explaining their role, and their continued coordination with the PCP.³⁰ PCPs can still be involved in the care of their patients in hospitals through “continuity visits” or phone calls with patients and through better communication with hospitalists.³¹ Generally, reimbursing PCPs for their increased role in the hospitalist system can encourage better communication with hospitalists.¹⁹ Potential disagreements between PCPs and hospitalist regarding the care of the patient can be resolved through explicit conflict resolution procedures within the hospitalist system.⁶

These procedural solutions are only as successful as they are used. A large review by Kripalani et al.³² found communication between hospitalists and PCPs occurred infrequently (3%-20%), affecting the quality of care in approximately 25% of follow-up visits and contributing to PCP dissatisfaction. Sharma et al.³³ found that continuity visits decreased from 50.5% in 1996 to 39.8% in 2006. In a survey

of patients cared for in a hospitalist system, Hruby et al.³⁴ found that 33% of hospitalized patients had some contact with their PCP directly and 66% of patients were satisfied with the contact they or their relative had with their PCP. When probed, patient satisfaction is too vague a measurement to assess the complex value of the patient-physician relationship. Studying these issues may require relying more on individualized narratives rather than generalized statistics, or may require years of follow-up. As Centor³ argues, we need this broader perspective of the patient's experience in order to understand the effects of the hospitalist model on patient trust in their PCP and in their overall care. Studies by Davis et al.³⁵ and Halpert et al.³⁶ assert that rising quality of care and patient satisfaction with the hospitalist system rebuts coordination of care concerns. Yet we need more studies investigating the relationship between improved communication and patient outcomes, as evidence is currently conflicting on this subject.^{32,37,38}

The *Journal of Hospital Medicine* has pursued this research agenda; the April 2009 issue presents several studies describing best practices in the discharging of hospitalized patients. Manning et al.³⁹ describe a tool to assess patient mobility after discharge, and O'Leary et al.⁴⁰ used electronic health records to create a better discharge summary. Project BOOST (Better Outcomes for Older Adults Through Safe Transitions) has shown improvements in discharge transition procedures⁴¹ and the use of transition coaches for vulnerable older patients has been proven cost-effective and has been scaled up to more than 100 health-care organizations.^{42,43}

Inpatient care handoff to PCPs is not entirely novel, as surgeons, oncologists, cardiologists, and other specialists have always grappled with continuity of care. It would be prudent to investigate what can be learned from these efforts, and which practices can be best applied to the hospitalist model. More longitudinal studies need to investigate the prevalence and success of the procedural recommendations to preserve the patient-physician relationship. We need to know more about what works and what does not. How have hospitals found novel ways in implementing these approaches, and how can they be applied to a diversity of hospital settings? We need a better outcome measurement than patient or physician satisfaction for probing the subtleties of the patient-physician relationship. There is a sizeable population that does not have a PCP to care for them before hospitalization or after discharge, and discussions about continuity of care must address these patients. Last, these best practices and patient centered values need to be incorporated into the core competencies of residencies and fellowships for a new generation of hospitalists.

Maintaining the continuity of the physician-patient relationship is an integral part of the original premise of the hospitalist model. Importantly, Meltzer²⁴ found that this discontinuity within the hospital has the potential to eliminate the savings of the hospitalist system. Yet concerns about continuity of care do not sufficiently encompass the com-

plex—and at times fragile—relationship between physician and patient. The survival of the physician-patient relationship depends on the hospitalist model's affirmation of the values of coordination and Peabody's²⁵ approach to patient-centered care. If the hospitalist model is to thrive, it needs to emphasize its duty as steward of the PCP-patient relationship as much as it focuses on efficiency and cost-effectiveness.

Patient Autonomy

The mandatory transfer of patients into the hospitalist model raises serious ethical issues. A survey in 2000 of PCPs found that 23% were required to use hospitalists for all admissions.⁴⁴ Other surveys found this prevalence to be as low as 2%.¹² Nevertheless, several high profile cases of Health Maintenance Organizations (HMOs)—Prudential HealthCare—South Florida, Prudential, Humana, and Cigna Corporation—all using mandatory hospitalists, prompted protests from professional organizations and there were even legislative efforts to ban the practice of the mandatory use of hospitalists in 2000 and 2001.⁴⁵ Today, most insurance plans, as well as the Society of Hospital Medicine (SHM), support voluntary rather than mandatory hospitalist use.⁴⁶ Yet while not mandatory, the hospitalist is the default provider in many settings, giving a de facto mandate for hospitalist care. As Royo et al.⁴⁷ point out, the rise in physician employment by hospitals has “facilitated a self-selecting progression toward a structural network that closely resembles the mandatory model.”

While PCPs and internists contested mandatory hospitalist plans as infringements on their autonomy, they overlooked the harm to the patient's autonomy. When healthy in the ambulatory setting, the patient has the opportunity to choose his or her doctor to provide longitudinal care. When the patient is admitted acutely to a hospital, the patient does not have the freedom to choose a physician; the patient is assigned to the hospitalist on duty that night. This call for patient autonomy is of utmost importance in the hospitalized patient, where patients are increasingly sicker, their diseases under a high-powered lens, and their options diminished. This freedom of choice is integral to the patient-physician partnership. Yet this freedom of choice is largely hindered by the employer's choice in the health plan for their employees or an individual's ability to pay for a health plan. These represent some of the many barriers to choice facing patients in the American model of health insurance.

As the hospitalist system grows to become the accepted mode of hospital care, more patients need to be informed about the transition of care to another physician and what steps are taken to ensure appropriate continuity of care. Transfers of patients from PCPs to hospitalists must be voluntary, with the decision left to patient care preferences.⁴⁸ Educating patients in the outpatient setting about the hospitalist model, its benefits, risks, and alternatives, is necessary

for them to make informed decisions about hospital care. This will require the collaboration of PCPs and hospitalists together. The continued success of the model depends on the nurturance of the partnership between the PCP, the hospitalist, and the patient.

Meltzer and Herthko¹⁴ have proposed that patients pay a premium for the option to choose a PCP that is not mandated to transfer their care to a hospitalist, in order to offset cost savings with the hospitalist system. Yet Meltzer and Herthko's¹⁴ study suggests that many patients could not afford to pay this premium and, in effect, patient autonomy would be preserved for the affluent. This raises the oft-neglected professional ethic of justice for low-income patients. Alexander and Lantos⁴⁹ were resigned to see this infringement on patient autonomy as an inevitable consequence of balancing the desires of patients with the drive to lower cost and improve outcomes. If the hospitalist model grows to be the predominant mode of care, it is unclear if patient choice can survive. Investigators need to test whether the advantages of hospitalist care can coexist with voluntary programs. If it proves that they indeed cannot, then the hospitalist system will need to respond to concerned patients with honest answers and find pragmatic solutions to diminishing patient choice.

Conflict of Interest

The hospitalist system's main benefit of cost-savings prompted Pantilat et al.⁶ to wonder whether hospitalists would face a conflict of interest between what is best for the patient and what financial incentives and utilization review encourage or require them to do. The financial support provided by many hospitals to meet the operating expenses of hospitalist programs is often associated with explicit or implicit incentives to reduce the length of hospital stay and costs.⁵⁰ With hospitals employing hospitalists and increasingly pressuring them to decrease length of stay and discharge patients quickly, patients may have no advocate to protect them from discharge planners. Many hospitalists supplement their income by supervising discharge planners, and a dispute would put the hospitalist in the uncomfortable position of advocating for his patient against his employer and colleagues. While conflicts of interests occur in many managed care arrangements, they may be more acute in hospitalist systems. A weakened patient-physician relationship may put the patients' best interest inferior to the employer's interests. Hospitalists do not immediately deal with adverse consequences of premature discharges in the outpatient setting and virtually no malpractice case law considers the obligations and practices of hospitalists in these settings.⁵¹

The SHM identified a core competency of hospitalists to

recommend treatment options that optimize patient care, include consideration of resource utilization, and are formulated without regard to financial incentives or other conflicts of interest.⁵²

Ethical issues concerning conflict of interest remain unanswered, largely because no information about organizational features such as explicit incentives for reductions in length of stay is available to researchers or to patients. This is the wrong approach and only feeds the fear that hospitalists may weigh patients' best interest with financial incentives. Abbo and Volandes⁵³ have argued that ambivalence to cost considerations is hazardous. If the hospitalist model cannot be forthright with the active considerations of costs in daily clinical practice, it is unlikely to truly make strides at cost savings, and may even raise the cost of care in the long run.

Jonsen et al.⁵⁴ provide ethical standards for considering costs in clinical decisions. First, a physician's first priority should be to provide patient-centered care that focuses on medical indications and patient preferences. Second, quality care does not mean all available care; quality care reflects what is not only diagnostically sound and technically correct, but also appropriate. Third, conflicts of interest are most vulnerable when there is a failing of the patient-physician relationship. Health care organizations should expect physicians to argue for policies that provide all services that have a reasonable likelihood of benefiting the patient. Fourth, patient and physician autonomy and freedom of choice should be maximized within the limits of the system. Persons should be fully informed of the constraints of the system before choosing it. Plans need to disclose any financial incentive arrangements that exist between the plan and the physician. And incentive arrangements should be based on quality of care rather than on underutilization of care services. Fifth, the system should reflect principles of just distribution, ensuring that all who have a fair claim to service should receive it without discrimination. Last, capitation plans should share risks among physicians, not patients, while incentives are provided for improvements in access, prevention, and patient satisfaction.

Conflicts of interest have been a concern for as long as physicians have been paid for services. Fears about interference into the doctor-patient relationship, whether they are from government or business, continue to stall real efforts to lower skyrocketing medical costs. The hospitalist model rebuts conflict of interest claims with improved outcomes, efficiency, and quality of care in the many reviews cited above. These arguments do prove that the hospitalist model's emphasis on medically indicated and appropriate care does address Jonsen et al.'s⁵⁴ first and second standards. Yet, as Jonsen et al.⁵⁴ point out, without strongly emphasizing the patient-physician relationship and patient autonomy, it leaves itself vulnerable to creating conflicts of interest. Hospitalist systems need to be forthright about their explicit or implicit incentive structures and disclose this information to patients in a timely manner for them to make informed decisions. These incentives should be linked to quality of care and patient satisfaction, not cost savings. Last, hospitalist training programs should make ethical cost considerations a core competency of their curriculum.

Conclusions

Hospitalism was founded on the premise that it could improve the quality and reduce the cost of hospital care. Many randomized studies have all but definitively proven this original assertion. It is now time for the model to prove that these gains are not to the detriment of the patient-physician relationship. Hospitalism must define itself as the steward of this relationship, valuing it as much as it values outcomes and costs. This is of particular concern in the United States as Medicare Part A (payment for inpatient care) is scheduled to go bankrupt in 2019, leading to potentially reasonable fears of hospital-motivated cost containment.⁵⁷

Investigators must find an outcome that encompasses the complexity of the patient-physician relationship, and methods to improve it must be studied and improved upon. Preserving the patient-physician relationship is a systemic issue, and full-time hospitalists may be in the best position to implement systemic reforms to improve communication and continuity of care. Pham's⁵⁶ case study of a hospitalist piecing together disparate parts of the patient's story illustrates this point. This should include more investigation into the prevalence of use and success of methods aimed at protecting the patient-physician relationship at critical points in the handover of care. When proven successful, The SHM should propose new standards and safeguards to insure that these methods become standard practice in patient care. This effort, led by Snow et al.,⁵⁷ is currently underway.

A hospitalist model that does not emphasize mitigating the effects of the diminishing patient-physician relationship leaves itself exposed to further infringements on autonomy and choice. It is unclear whether patient autonomy and choice can coexist in a successful hospitalist system. The consequences of these unanswered ethical questions need to be explored. The professions of primary care need to be more proactive in educating patients about choice of care in hospitals, and hospitalists need to provide that choice, allowing voluntary programs in hospital care when feasible.

When combined, a wounded patient-physician relationship and impaired patient autonomy leave the hospitalist model vulnerable to claims of financial and fiduciary conflict of interest. These concerns need not be inherent to the hospitalist systems, but hospitalists will need to be forthright and honest about incentives structures, and link them to quality of care and patient satisfaction, not to efficiency and cost savings.

It is indeed time for hospitalism to "move on"—away from proving its founding premise, and toward addressing these lingering ethical issues. Hospitalism's continued growth and success depends on it.

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