Ethical and Policy Implications of Hospitalist Systems

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Hospitalist systems raise ethical and policy concerns regarding informing patients about the hospitalist system itself, communication between primary care physicians and hospitalists, continuity of care, and conflicts of interest. Patients may worry that hospitalist systems are intended to achieve cost savings and that the role of the primary care physician as coordinator of care may be undermined. These concerns may be particularly salient for certain subgroups of patients. Hospitalists and health-care organizations that set up hospitalist systems should take steps to reduce the foreseeable risks that discontinuity of care might cause. Practice standards should be set for communication between primary care physicians and hospitalists and for involvement of primary physicians in inpatient care under certain circumstances. By setting such standards and monitoring performance, hospitalist systems can improve the quality of care and reassure patients.

Hospitalist systems have the potential to improve the quality of care as well as enhance efficiency. However, because they create discontinuity of care when patients are sickest and least able to look after their own interests, hospitalist systems also raise ethical and policy concerns. Furthermore, patients dissatisfied with hospitalist systems have few alternatives. In the United States, changing providers is an accepted and common response when patients are dissatisfied with their care.[1] However, when patients are hospitalized, transfer of care to another hospitalist or to another hospital may be unfeasible, for clinical or administrative reasons. This article first analyzes how fundamental

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principles of medical ethics apply to hospitalist systems, then discusses responsibility for addressing these issues.

Ethical Issues Regarding Hospitalists

Established principles in medical ethics have significant implications for hospitalist systems.

Respect for Persons

Respect for persons, a fundamental principle of medical ethics, holds that people should be treated as "ends," not merely as the means to achieve other ends. The primary goal of medical interventions should be to benefit patients. Generally, hospitalist systems are introduced to achieve greater efficiency,[2,3] which primarily benefits health-care providers, integrated health systems, physician groups, or individual physicians. Patients also may benefit, because hospitalists are more available or have greater expertise in inpatient care than ambulatory-based physicians. However, such patient benefits are not the driving force behind hospitalist systems. Furthermore, patients bear most of the risks and potential adverse effects of hospitalist systems. Thus, patients may fear that inpatient care is being altered primarily to achieve cost-containment for the managed care organization or hospital.

Respect for persons includes respect for patient autonomy. Autonomy refers to the power or right to control one's own life and body. Autonomy usually entails making informed decisions about medical care, such as choosing a physician and choosing among options for care. Because patients usually cannot choose whether to use a hospitalist system and have no choice of inpatient physician, hospitalist arrangements may diminish patient autonomy. Hospitalist systems may also hinder patients' ability to make informed choices on clinical issues by reducing the role of primary care physicians (PCPs). PCPs often can promote informed decision making, because they may have known a patient over an extended time and have a clearer understanding of the patient's values, attitudes toward risk, and preferred level of involvement in decision making. Using this knowledge, PCPs can support patient autonomy by individualizing discussions with patients and checking that patients' decisions are consistent with their core values.

Balancing the Benefits and Burdens of Interventions

The ethical principle of beneficence requires physicians and hospitals to act for the benefit of patients. The overall benefits of interventions should be greater than the risks or side effects. Furthermore, health-care

providers should take steps to reduce the burdens and risks of interventions. These guidelines should hold for both clinical and organizational interventions.

Studies indicate that hospitalist systems yield similar clinical outcomes in mortality, readmissions, and patient satisfaction as conventional care, while reducing length of stay.[4–6] The outcomes assessed to date have been mostly "hard" benefits, such as readmission rates and length of stay, which can be measured through readily available administrative data. Less attention has been given to "soft" outcomes. Although global patient satisfaction has been measured, other soft outcomes, such as failure to communicate important information within the patient–PCP–hospitalist triad or a weakening of the relationship with the PCP, have not been extensively studied.[7] Relationships are important for both intrinsic and instrumental reasons. Patients may value a long-term relationship with a PCP, because it makes them feel understood and cared for, reduces anxiety, and enhances confidence in their care.

Equitable Distribution of Benefits and Burdens

The benefits and burdens of hospitalist systems should be equitably distributed. As with any health-care intervention, it is important to examine not only the aggregate benefits and burdens in the population as a whole, but also the distribution of benefits and burdens across subgroups. Hospitalist systems may work well for the majority of hospitalized patients, but problems may occur with particular subgroups. For example, discontinuity of care may be unimportant in admissions for such conditions as uncomplicated community-acquired pneumonia, in which the medical treatment is straightforward, most people have good outcomes, and the hospital stay is brief. The technical aspects of care are more important in this situation than an ongoing relationship with a physician who knows the patient well. However, a strong ongoing relationship with a PCP may be essential for several groups of patients[7]:

- Patients with complicated chronic illness, where a new physician may not comprehend how different features of the illness are related, what tests and therapies have been tried in the past, and what approach to care has been selected.
- Patients who have just been diagnosed with a serious illness, such as cancer. A PCP might help the patient cope with the new diagnosis.
- Patients who face major decisions, such as decisions to adopt a palliative care approach or to withdraw or withhold life-sustaining treatment. Such patients or their families may want to discuss these

important decisions with a primary physician whom they know well and trust.

- Patients with long hospital stays, who may feel abandoned if their PCP does not visit them in the hospital.
- Patients at the end of life. PCPs who have long-term relationships with patients may be better able to help them reach closure and find meaning in their final days than physicians who have just met them.
- Patients with complicated psychosocial problems. Because such problems often are not well documented in the medical record, a new physician may need considerable time to understand them. Unless such problems are identified and dealt with, patients' well-being may suffer, decisions may be more difficult, and implementation of plans may be impractical.

For these patients, the PCP should play a more significant role, because the relationship with the physician may be as important as the biotechnical aspects of care.

Keeping Promises

Keeping promises is important, because it makes the future more predictable, relieves anxiety, and promotes trust.[8] People expect others to keep promises and make their plans accordingly. Because a hospitalist system involves a new physician caring for the patient, a patient may perceive that promises are being broken regarding the physician's role or about specific plans for care.

How are promises about the physician's role made? Most managed care organizations encourage or require patients to have a PCP, whose role is presented not simply as a gatekeeper to control costs, but also as the coordinator of the patient's care.[9] Thus, managed care organizations implicitly promise that PCPs will provide appropriate continuity of care. Patients who have selected a PCP whose philosophy of care is congruent with their own may expect that this approach will continue in the hospital.

In hospitalist arrangements, patients may believe that promises about the role of the PCP have been broken. The hospitalist may have a different style of communication than the PCP, for example, providing less information and decision-making power than the patient would like. Depending on the system, the patient may have no ability to change hospitalists or have the PCP play a more active role. Patients upset at the discontinuity of care may believe that managed care organizations promote the role of the PCP when it saves them money, but reject it when care becomes too expensive, even if it could benefit patients.

Promises may also involve specific clinical decisions. The PCP and the patient or family may have come to agreement on such difficult issues as whether to attempt further chemotherapy for metastatic cancer, whether to withhold tube feedings in a patient with severe dementia, or whether to respect family requests not to tell a patient the diagnosis of cancer. Ethical dilemmas may occur in this situation, because hospitalists are professionals who make independent clinical and ethical judgments. They need not be bound by prior approaches and decisions of PCPs. Of course, such disagreements may occur whenever several physicians share care for a patient. What is different in a hospitalist system is that the patient or family cannot readily change physicians if they disagree with the hospitalist's approach to care.

Conflicts of Interest

In many managed care arrangements, physicians face conflicts of interest between what is best for the patient and what financial incentives and utilization review encourage or require them to do. Hospitalists may face dilemmas when clinical interventions that they believe are appropriate, including continued hospitalization, are not authorized by a healthcare organization. Patients may be concerned that hospitalists may be less forceful than PCPs in appealing such cases.

Why might conflicts of interest be more troubling with hospitalist systems than with PCPs? First, pressures from organizations are stronger. Because relatively few hospitalists generally practice at each institution, it may be easier to enforce practice guidelines through peer pressure, profiling of individual physicians, targeted interventions, and financial incentives. The small number of hospitalists may make it easier to implement clinical guidelines to improve the quality of care.[10] This small number, however, also makes it easier to implement guidelines to improve efficiency even in situations where quality of care is likely to be compromised. Second, because hospitalists have no ongoing relationship with patients, countervailing forces that promote the patient's best interests may be weaker. A hospitalist who discharges the patient prematurely does not have to deal with the adverse consequences of this decision in a follow-up outpatient visit. In contrast, a PCP would have to deal with problems of medical complications, and patient or family dissatisfaction.

Another concern about conflicts of interest is lack of information about financial incentives to hospitalists. The public fears that financial incentives in managed care strongly influence physician behavior and that some incentives may create inappropriate pressure for physicians to act

contrary to the best interests of patients.[11] State and federal legislation requires certain physician financial incentives in managed care be disclosed to patients.[12] Disclosure may help patients choose a physician, physician group, or plan, because some patients may want to avoid certain types of reimbursement arrangements. Knowing how physicians are reimbursed may help patients put physicians' recommendations into context and decide whether to appeal or pay out-of-pocket when coverage is denied. In addition, disclosure and adverse publicity may help eliminate problematic financial arrangements. Although ethical guidelines for financial incentives to physicians in managed care have been discussed,[13–15] little is known of the specific types of incentives that hospitalists may face. Do hospitalists commonly have a bonus or withholds linked to utilization? If so, what types of incentives are ethically problematic? For example, concerns about incentives would be stronger if incentives are pooled over a small number of patients or when a large percentage of the hospitalist's base compensation is at risk. We can expect that the public and patient advocates will want to know more about the financial arrangements hospitalists work under.

Responsibility for Ameliorating Risks of Hospitalist Systems

Health-care organizations and physicians that set up hospitalist systems should be responsible for taking steps to reduce or mitigate the foreseeable risks that might result from discontinuity of care, just as clinicians must take steps to reduce foreseeable side effects of tests and drugs. Such accountability is appropriate for several reasons. Providers who control hospitalist systems are in a far better position to take such steps than are patients who would suffer the adverse consequences of a poorly designed system. Furthermore, providers most directly accrue the benefits of increased efficiency in hospitalist systems.

Disclosure of Information to Patients

Respect for persons requires that people be informed of what will happen to them, even if they will have little or no control over it. Patients should know that a hospitalist system is in place, what this means if they should be hospitalized, and what steps are taken to ensure appropriate continuity of care. More attention needs to be given to how to inform patients about the workings of the hospitalist system. To the extent that physician financial incentives to PCPs are disclosed to patients, financial incentives to hospitalists also need to be disclosed. Providing such information respects patients and may also assuage their anxiety.

Even if there is general agreement that disclosure is desirable, several pivotal questions remain:

- When should patients be informed: at enrollment or first clinical contact, upon discussion of the option of hospitalization, or on admission to the hospital?
- Who should inform the patient: the health-care organization, the PCP, or the hospitalist providing inpatient care? Patients may need information at multiple points in their care, from various sources. Repeated disclosure may improve patient understanding of hospitalist systems and reassure patients about continuity of care.
- How should physicians respond to tough questions from patients? Both hospitalists and PCPs need to anticipate that patients may pose difficult questions or comments about the hospitalist system. It may be helpful for physicians to identify the hardest questions and comments from patients regarding the hospitalist system, then consider how they might best respond to them.

Continuity of Care for Hospitalized Patients

Patients may not be able to have their PCP supervise their hospital care. However, PCPs still can be involved in inpatient care in meaningful ways. At a minimum, they should telephone hospitalized patients. Such telephone calls may suffice to communicate caring and reaffirm an ongoing doctor–patient relationship. However, PCPs should play a more active role when hospitalized patients need to cope with a serious condition or make major decisions about their care. PCPs should visit hospitalized patients who have a complicated chronic illness, receive a serious new diagnosis, face major decisions, have a prolonged hospital stay, are dying, or have a complex psychosocial situation.[16]

Hospitalist systems should have procedures to deal with cases in which the hospitalist disagrees with the plan of care that the patient and PCP have agreed upon and which they will reinstitute after discharge. The role of an institutional ethics committee or the chief of service in helping to resolve such disagreements needs to be clarified. Hospitalist systems need a process by which patients can change hospitalists in cases of intractable disagreement.

Organizational Arrangements

Individual PCPs have an ethical duty to ensure continuity of care for their hospitalized patients. However, it is unrealistic to expect individual physicians to do so in the face of strong organizational disincentives.

Physicians may become frustrated and cynical if there is a large discrepancy between the ideal of continuity of care and actual organizational policies and practices. Although PCPs could add an occasional unforeseen hospital visit to a busy outpatient schedule, such visits should be accounted for when future outpatient schedules are drawn up and compensation calculated. More work needs to be done concerning how such visits are best scheduled and compensated.[16]

Organizational arrangements must be consistent with the goals of a hospitalist system. An important rationale for hospitalist systems is that hospitalists are more available to inpatients than are physicians with a busy out-patient practice. However, the hospitalist's availability depends on the workload. With a heavy patient load, hospitalists may not be able to monitor the patient's condition over the course of the day or to spend time talking to the patient or family. More discussion is needed regarding the appropriate case load for a hospitalist.

Expertise in Inpatient Medicine

Hospitalists have the opportunity to develop expertise in inpatient problems. Such expertise is a great potential benefit to patients. However, individual hospitalists need to endeavor to develop such expertise, and health-care organizations need to encourage and monitor its development. Creating a subspecialty of hospital medicine, with certification, has been suggested as 1 approach to fostering and monitoring such expertise.[17] Other approaches should also be considered. Scorecards comparing outcomes for different providers have been useful in improving the quality of care in coronary artery bypass surgery.[18] Similar measurements of hospital-specific and physician-specific outcomes for common inpatient problems allows the quality of inpatient care to be monitored and may stimulate quality improvement.

Standards of Care

Standards of care regarding ethical and policy issues need to be established for hospitalist systems. The concept of practice standards is familiar to hospitalists. Indeed, an advantage of a hospitalist system is that clinical practice guidelines for such common inpatient conditions as community-acquired pneumonia can be established and implemented. Standards should also be established for delivering care, particularly regarding such issues as communication within the patient–primary physician–hospitalist triad and continuity of care. Such standards can help improve the quality of care and prevent foreseeable adverse consequences. Standards should be considered flexible guidelines rather

than ironclad rules, because exceptions are inevitable in clinical medicine. Several questions about standards for continuity and communication warrant attention.

How can standards be developed? The procedure will differ from the development of evidence-based guidelines for clinical management. First, paradigmatic cases need to be identified and discussed. Consider "hand-offs" between PCPs and hospitalists. In which situations do physicians and patients agree that the PCP should play a greater role in inpatient care than making a social call? Similarly, in which situations is there agreement that a phone call or social visit to the patient suffices to maintain continuity? Such cases set benchmarks for care. Second, what considerations lead people to conclude that face-to-face visits by the PCP are indicated or not? Third, more complex, less clear-cut situations should be analyzed to identify points to consider in particular cases and provide an approach to the PCP's role. With such analyses, physicians faced with complex situations do not have to work out a response de novo. These analyses can also identify situations and issues that deserve further discussion and deliberation.

Who should set standards? Generally, expert physicians within a health-care organization or professional society set standards for clinical practice. However, on such issues as continuity of care and communication between hospitalists and PCPs, the perspective of patients is also essential. Patients may place different weight on these issues than physicians. Thus, panels that set standards for health-care organizations and professional organizations should include patient representatives or advocates.

How should performance be monitored? A fundamental tenet of the quality improvement movement is that measuring outcomes stimulates a process of continuous quality improvement. With regard to continuity of care, health-care organizations need to determine how to monitor such outcomes as visits by PCPs to inpatients in cases of serious new diagnoses, major clinical decisions, or prolonged hospital stays. Such monitoring presents a challenge, because data on these outcomes are not routinely collected. Because hospitalist systems are an innovation, the potential for improvement is tremendous. Health-care organizations and physicians need to ascertain both how adherence to standards can be increased and how standards themselves can be improved.

Conclusion

In conclusion, hospitalists are a growing response to the need to deliver inpatient care more efficiently. Hospitalist systems raise ethical and

policy concerns regarding informing patients about hospitalist systems, communication between PCPs and hospitalists, continuity of care, and conflicts of interest. By addressing these concerns, physicians and health-care organizations can improve the quality of care and reassure the public about an important innovation.

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