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The Ethics of Efficiency in Hospital Medicine: Developing a New Paradigm for the Patient-Physician Relationship

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One largely unappreciated change brought on by the emergence of hospital medicine [1, 2] has been the transformation in the ethical paradigm of the patient-physician relationship. For decades now, medical students have been taught ethics using the professional paradigm of medical ethicists: nonmaleficence, beneficence, and respect for autonomy [3]. Under this model, the doctor is to work tirelessly to promote the health of each patient to the fullest extent possible [4]. The principle of justice, though mentioned, has generally taken a secondary role in traditional teaching of medicine ethics. Of course, medical students and physicians have been instructed to treat all patients equally regardless of their race or sex, but tough questions about the allocation of scarce resources were left for ethicists, policymakers, insurers, and the purchasers of insurance to resolve—not physicians. The role for physicians has been to pursue for each patient all care that might possibly benefit him or her, regardless of cost, and rationing at the bedside was frowned upon [5, 6].

Whether this professional paradigm was ever tenable is debatable, but questioning it today is irrelevant because cost is so inescapably part of modern medical practice. Hospitalists not only accept this reality, they have embraced responsible use of resources as a core principle of the profession. In fact, the first hospitalists evolved from the experiment of managed care and developed a more efficient model for inpatient practice [2] which was then followed by an early, rapid expansion of the field, as hospitals developed hospitalist programs while they struggled to balance the needs of patients [7].

The hospitalist's focus on efficiency is very much rooted in an ethic of justice. By spending so much time shepherding their patients through the maze of today's hospitals, hospitalists recognize the limits on resources within the closed system and are willing to balance the medical needs of many patients against each other.

Hospital beds are scarce resources in today's medical environment, a scarcity that will persist. In the short term, the number of beds available is fixed since the ability to scale up is severely hampered by large infrastructure costs. And when beds are available, nurses may not be. Nursing costs are easily the largest piece of a hospital's budget, so maintaining a full nursing capacity for empty beds is financially prohibitive, particularly in light of the current nursing shortage that has driven up wages. Since length of stay is the primary driver of all hospital costs, reducing unnecessary days of hospitalization decreases costs and frees precious capacity to

care for sicker patients. Thus, expediting discharge becomes the key to more cost-effective care, and hospitalists have made discharge planning a goal early in the course of a patient's hospitalization.

Hospitalists' value to the hospital system is that they see themselves as part of its overall operation and, in many respects, as physician stewards of hospital resources. For example, hospitalists' concern about expeditious discharge is at least partially motivated by their direct knowledge of patient backlog in the emergency department, an all-too-common problem today [8]. Taking care of patients boarded in the emergency room for lack of beds on the floor motivates hospitalists to identify bottlenecks in expedited discharge for their own patients and resolve them, which they can do because of their broad network of alliances within the hospital. But perhaps more importantly, since hospitalists see themselves as part of the hospital operation, they are also more likely to dedicate themselves to solving work-flow problems at the systems level by working directly with the administration.

Prior to the emergence of hospitalists, hospitals lacked physician allies who could respond to the need for greater efficiency. Primary care physicians and specialists practicing under the traditional model were essentially unaccountable for costs. For a primary care physician whose patient needed to be hospitalized, the goal was simply to marshal the resources of the hospital for the benefit of admitted patients. Beyond serving on an occasional committee and accepting ward call from the emergency room for uninsured and unassigned patients as a condition of maintaining hospital privileges, the primary care physician had little concern about overall hospital operations. In turn, the hospital had little control or recourse over the utilization patterns of individual physicians. Similarly, specialists rarely concerned themselves about efficiency and, it can be argued, have been even less beholden to hospital administrators. Administrators, willing to tolerate the decreased efficiency for patient volume, were reluctant to push specialists to improve and thus risk losing access to the lucrative revenue streams specialists provide from complex procedures. Primary care physicians and specialists, then, buttressed the traditional ethic of medical practice without consideration for efficiency.

Of course, concern for efficiency in medicine is not new. Many primary care physicians agreed to care for patients under the capitated payment mechanisms of managed care. But the hospitalist orientation is markedly different from the capitation approach tested under managed care. Doctors working in managed-care organizations were far too removed from the operational decisions of insurers that affected actual practice, and ultimately, they resisted the emphasis on efficiency in that setting because they did not have the flexibility to respond to individual patient needs. Perhaps more importantly, the benefits of the efficiency did not obviously accrue to patients in need. Hence, managed care never accomplished a change in the professional ethic of caring for patients because the concern for efficiency was not really grounded in a concern for justice by the individual physician. Hospital medicine, on the other hand, has been able to quietly transform this ethic by elevating efficiency to a concern of justice because the reality of scarcity is readily

apparent to the hospitalist. Whereas physicians resisted bureaucratic rules set by distant insurers that did not respond to the individual needs of patients, hospitalists make nuanced trade-off decisions about where to save resources, and they do so without rigid and inflexible rules. This sort of rationing exemplifies ethical decision making on the part of hospitalists working within the constraints of the relatively fixed and closed system of the hospital.

Today, hospitalist programs rarely exist without some sort of financial support from their hospital [9]. This support is provided in return for the variety of services that are not compensated through professional billing—services such as managing patients who lack insurance, providing 24-hour on-site coverage, or working on administrative matters. But some may worry that this direct financial support creates dual allegiances to the patient and the hospital system that undermine the traditional medical ethic of unfettered patient advocacy.

Sometimes allegiances do conflict, but the conflict is both necessary and desirable; it prompts development of a new layer of accountability for resource utilization that has been entirely missing from the traditional model. That is not to say that hospitalists practice in unorthodox ways that deviate from the standard of care for managing acute medical problems. The acute management of medical problems is not compromised when patients are admitted in unstable condition or develop complications. Disposition planning, however, toward the end of the hospitalization, presents an opportunity for efficiency gains without compromising medical safety. Recognizing this, hospitalists focus on developing plans that lead to a timely and efficient discharge and then work cooperatively with the larger team, including physical therapists, case managers, and social workers, to achieve this goal. One of the hallmarks of hospital medicine is the recognition that hospitalists are part of a larger team working to provide high-quality care to patients. By utilizing resources that are present within the hospital more effectively, hospitalists are able to decrease length of stay without compromising quality of care [10].

Teaching the New Professional Paradigm

If we are to prepare medical students to practice today's medicine effectively, we must present a model of medical ethics that reflects and responds to real practice. Medical students must learn that physicians play an active role in the allocation of resources and that such a role is integral to the routine practice of medicine [11]. Resource questions cannot be addressed by policy and administrative decisions made by those who are not at the bedside. Only physicians caring directly for individual patients are in a position to understand the full needs and desires of any patient and then balance these needs against the needs of other patients. This calls for a new understanding of what it means to provide medical care justly.

At the very least, practicing medicine justly means freeing up resources that are being used unnecessarily so they can help those who truly need them. Some experts estimate that as much as 30 percent of medical spending is unnecessary, given the large variation in health care expenditures we see across geographic areas with little

benefit in outcomes in the high expenditure areas [12, 13]. As a group of physicians who have dedicated themselves toward practicing medicine safely, effectively, and efficiently, hospitalists represent a true change in the professional role of the physician and patient-physician relationship. Growth in the number of hospitalists has already helped stem the rise in hospital costs, which have decreased as a portion of total medical expenditures despite an increase in admissions and the complexity of patient illness; fuller ramifications are yet to be seen.

Hospitalists are now poised to change the practice of hospital medicine beyond the traditional domain of caring for medical patients. They are expanding their roles in hospitals and have earned the trust and credibility of their specialist peers. As a profession, hospitalists are starting to argue for stature and authority within their local institutions to assert their brand of medical decision making more broadly. Given the intensity of hospital medicine, burnout has been a persistent issue [9]. If senior hospitalists leave the profession at the time they develop this institutional authority, the reach of the hospitalist approach focused on efficiency will be more limited.

Nevertheless, the field's improvements, with the increased intensity of services provided within a shorter timeframe [14], are unlikely to disappear. And with this change, the model of unfettered patient advocacy is rapidly becoming anachronistic. Physicians do need to care about the efficiency of the medical care they provide, and those willing to accept this reality will be rewarded, which is part of the reason for the rapid growth in hospitalists. This rapid growth is also a testament to the reality that hospitalists can effectively manage the concerns of dual loyalty to patient and system. In fact, studies have consistently shown no increase in mortality or readmission rates for patients cared for by hospitalists [10, 15]. Patients have largely embraced the new model and have benefited from greater access to a physician at the hospital. Our physician colleagues and the larger health care system of hospitals and insurers have also embraced hospitalists. So now it is time for our understanding of medical ethics to catch up to where we are today and where we will be tomorrow.

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