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Op-Ed

Practical and Ethical Implications of Hospitalists as Subspecialists

by Erin Egan, MD, JD

Specialization and subspecialization are increasingly common in medicine. Medical subspecialties like cardiology offer additional training to "sub-sub-specialize" in areas like interventional cardiology or electrophysiology. As the amount of technical knowledge of medicine increases in all areas, experts must narrow their fields progressively to maintain true expertise. Specialties often begin as "pseudospecialties" while practitioners take time to generate standards of practice and training requirements necessary to make the emerging field a board-certifiable specialty. Emergency medicine underwent this process of pseudospecialty status and evolved into a board-certified specialty. Hospital medicine is somewhere on that continuum, for better or for worse. In a health care system that is prone to losing sight of the patient's best interest, this trend of increasing specialization and narrowing of expertise deserves close examination.

Hospital medicine, practiced by "hospitalists," began developing a cohesive identity in the late 1990s. Traditionally, internists cared for a panel of outpatients and provided inpatient management for those patients if needed. However, the skills and knowledge base needed to deliver acute inpatient care differ significantly from those needed to provide primary care, health maintenance care, and stable chronic disease management to outpatients. In 1997 a group of physicians met and later formed the Society of Hospital Medicine, devoted to continuing education and the professional interests of hospitalists [1]. The society grew to a current membership of 4900, and it's estimated that 15 000 hospitalists were practicing nationally in 2005. According to the Society, hospitalists are "physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research and leadership related to hospital care" [2].

The Need for Specialties and Subspecialties

The body of medical knowledge is expanding rapidly, facilitated by online reference materials and the trend toward establishing an evidence base for common medical decisions. Knowledge and judgment are the competencies that justify the physician's status as a professional. Physicians have a fundamental ethical duty to maintain and add to their knowledge and judgment throughout their professional careers. When the body of knowledge becomes so large that no individual can reasonably master it all, it is ethically essential to narrow the focus of expertise to ensure that they maintain a truly expert level of knowledge. Specialization and the higher cost of specialty care are

justified on the grounds that more expert care results in better outcomes. No one would pay more to see a neurosurgeon if a general surgeon could consistently achieve the same outcomes. Since neurosurgeons provide, with notable success, services that general surgeons cannot and do not provide, neurosurgery is firmly entrenched as a specialty.

The hospitalist movement raises a question about the scope of expertise and specialization necessary in hospital medicine. Inpatient and outpatient medicine each has a knowledge base large enough to justify focus on that single field of clinical expertise. This, certainly, is my experience in internal medicine. Hospital medicine differs from outpatient medicine. Yes, a hospitalist needs a good understanding of chronic disease management and follow-up guidelines so he or she can provide ideal care to patients who interface with both aspects of the system. But substantial investment in professional development is necessary to maintain competence and expertise in either facet of internal medicine. Some internists want to practice in both arenas and are willing to invest the time and energy needed to maintain expertise in both, but the professional challenge of maintaining competence and expertise in either is sufficient to warrant practical specialization. Given that it is reasonable and practical for physicians to limit their professional development to inpatient or outpatient medicine, specialization seems justified. Whether this remains a practice preference for internists or progresses to the point of specialty certification is under discussion.

Because specialization is built upon expertise, it is essential to advancing quality, safety, and discovery in medicine. It is true that access to specialist care is related to socioeconomic status and geography and thus exposes another example of the inequity in our health care system. But specialization is not the cause of the problem—it is just 1 layer in the tiers of inequality in health care for the poor, minorities, women, and residents of underserved areas. The solution is to fix the system, not limit specialization.

Advantages of Employing Hospitalists

Having hospitalists has been shown to improve quality measures—including length of stay, mortality, and 30-day readmission rate—in several common inpatient diagnoses. Evidence also shows that hospitalists reduce costs and length of stay while achieving the same or better patient outcomes achieved by nonhospitalists [3-6]. It is important to note that the benefits of hospitalist care are shared by the patient and the hospital, a relatively rare basis for the development of a new subspecialty. Decreased length of stay helps patients because they are less likely to develop hospital-associated complications and are generally more comfortable out of the hospital. At the same time, shorter lengths of stay correspond directly with increased profits for the hospital. Decreased 30-day readmission rates mean that patients have received complete and adequate care on their first admission under a hospitalist's care. And these decreased readmissions help the hospital because readmission within 30 days increases a hospital's costs and lowers its profits. Most of the sources cited above attribute the achievements of hospitalists to early implementation of appropriate management strategies and improved management of concomitant conditions. In sum, initiating proper therapy early is good for patients and returns financial gains to the hospital.

Hospitalists as Physicians in a Subspecialty

The ethical concern that specialization can exacerbate injustice and inequality of access to care applies uniformly to all specialties. The hospitalist trend poses additional concerns because it combines the unequal access associated with all specialized medicine with financial benefits.

There is nothing ethically problematic about the fact that hospitals benefit from having hospitalists on staff as long as quality of patient care is unaffected or, as some evidence indicates, improved in the process. Indeed, even the hospital's financial gains benefit the patient population indirectly by allowing the hospital to continue to function and to invest in quality-improving infrastructure. However, this direct financial benefit must be acknowledged and monitored, because, if it were to become the primary driving force of the hospitalist movement, the potential ethical pitfalls would be immense.

There are problems with basing the need for specialization on financial gains that accrue to third parties (not directly to patients). First, the initial gains realized by improving and streamlining care will ultimately be maximized, and from that point forward the financial benefits will plateau. It is easy to foresee that pressure for continued gains may be exerted, perhaps at the expense of quality patient care. The market pressures will be the same as those exerted in the managed-care, cost-containment era, where financial benefits favor withholding necessary care, promoting premature hospital discharge, and other potentially unsafe practices. It is up to the hospitalists and the hospitals to ensure that medical expertise, quality, and patient safety remain the focus of this specialty movement.

Second, the patient must always be the center of care. The patient-physician relationship must supersede all other interests in the provision of health care. In the hospitalist model, the physician often works for the hospital and is therefore more directly involved in its cost-containment and quality-improvement practices. Bringing physicians' expertise with inpatient care to bear on system improvement processes is another strength of the hospitalist movement. Here again, it will be up to the hospitalists and the hospital to ensure that these contributions are encouraged and allowed only as long as they do not interfere with the patient-physician relationship.

The tension between a hospitalist's interest in the system in which he or she works and the primacy of the patient-physician relationship certainly requires vigilance on the part of both hospitalists and hospitals. To date the movement has handled the tension ideally, improving outcomes for individual patients as well as providing financial benefit to the hospital [7]. There may come a day when further cost-containment efforts compromise safety and quality efforts. Both major players must be prepared to advocate for patients on that day. When conflict arises between the benefits of hospitalists as medical experts and the benefits of hospitalists as a cost-containment mechanism, the hospitalist must be a specialist like all other specialists—committed to expertise and the well-being of each individual patient.

Conclusion

Hospital medicine requires specialized knowledge and expertise to achieve good patient

outcomes. For that reason, practitioners will continue to limit the scope of their practice and will continue to seek expertise limited to care of hospitalized patients. In the practical sense, subspecialization has already occurred in hospital medicine. Whether that practical specialization is formalized into board-recognized subspecialization is a professional issue. Given that the profession will have an increasing interest in ensuring that physicians claiming hospitalist expertise actually have the requisite expertise, some type of certification or licensure exam is likely to develop. However, evolution of the functional specialty and the potential development of board-recognized specialty status should only follow after examination of the unique ethical issues that hospital medicine creates. Focusing on these ethical issues prospectively, while they have yet to cause any ethical compromise, is ideal. Fortunately, these concerns are recognized among the leadership and practitioners in the field, and the participants have an opportunity to ensure that the ethical evolution of the specialty is integral to the evolution of the specialty as a whole.

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