

# Virtual Mentor

American Medical Association Journal of Ethics  
December 2008, Volume 10, Number 12: 813-816.

## POLICY FORUM

### **Hospitalist Medicine: Voluntary or Mandatory?**

Marc B. Royo, Laura L. Kimberly, MSW, MBE, and Alexandria Skoufalos, EdD

The hospitalist model has evolved rapidly into an established, site-based specialization that serves as the pillar of inpatient care for a number of facilities across the country. In the 10 years since the advent of the hospitalist movement, there has been significant growth in the field, with approximately 20,000 hospitalist clinicians in the United States today [1]. Despite this remarkable expansion, questions about the model of care remain. With a growing repository of encouraging cost and outcomes data, inquiries about hospitalist medicine have slowly moved away from the merits of the model. A significant debate now centers on whether the use of hospitalists should be mandated at institutions or remain a voluntary practice.

### **Evolution of the Hospitalist Model**

The voluntary hospitalist model represents a logical progression from the traditional physician-hospital relationship under which primary care physicians coordinated care of their office or clinic patients in hospitals where they (the physicians) had admitting privileges. Under the new model, hospitalists serve on hospital staffs in place of primary care physicians and coordinate acute care for all inpatients. In a voluntary hospitalist model, primary care physicians retain the option to manage their patients throughout each hospitalization [2]. A mandatory hospitalist model obligates primary care physicians to relinquish their inpatient-care services and transfer acute-care management to a hospitalist. Understandably, there are few mandatory models in practice.

If history is any indication, the likelihood that insurer-mandated hospitalist systems will become widespread appears slim. Major health insurance companies across the country began requiring physicians to transfer care of their hospitalized patients to hospitalists in the late 1990s, citing shared benefits for both hospitals and primary care physicians. The directive, however, did not allow for the systematic and mutual evaluation of the hospitalist model and naturally evoked physician opposition and resistance [3]. In a partial attempt to protect the interests of nonhospitalist internists, the American College of Physicians (ACP) responded by affiliating with the National Association of Inpatient Physicians—a burgeoning hospitalist medical association that is now recognized as the Society of Hospital Medicine (SHM)—and formalized an official position for both organizations that supports only voluntary patient transfers to hospitalists.

While both the ACP and SHM continue to oppose a mandatory hospitalist framework, it is interesting to note that the voluntary model appears to be declining

in favor of increased physician employment by hospitals [4]. Underlying this trend are strong economic forces, impinging on physicians and hospitals alike, that have facilitated a self-selecting progression toward a structural network that closely resembles the mandatory model originally proposed by insurers. This emerging model represents an alignment of physician and hospital interests driven by the recognition of mutual benefit.

### **Contributors to the Movement**

Cost pressures have dramatically influenced primary care physicians' willingness and ability to manage their hospitalized patients. Among the most-cited pressures are: inpatient reimbursement rates that have not kept pace with rising practice costs, heightened pressures of malpractice that accompany the delivery of care in a setting of increased liability, and costs associated with the time-based tradeoff between outpatient volume and the continuity of ambulatory and inpatient care. As a result, an increasing number of primary care physicians have recognized value in a hospitalist model [5, 6].

Health care systems, subjected to similar cost constraints, are basing decisions to invest in hospitalist programs on a growing body of literature that demonstrates the cost-effectiveness of the hospitalist model [7]. The 24-hour access to an on-site physician provides a level of care that has translated into reductions in patient length of stay and lower hospital costs, while maintaining a standard of quality equivalent to that delivered by primary care physicians [7, 8]. And, because hospitalist models limit the multiplicity of physicians who oversee inpatient care, hospital systems view the framework as an ideal means for supporting the implementation of quality and safety initiatives [5].

### **Patient-Centered Initiative**

As primary care physicians elect to provide a diminishing share of inpatient services, and health care systems seek to improve quality and efficiency, we are seeing a restructuring of the traditional physician-hospital paradigm, one in which the interests of primary care physicians and hospitals seem to have found common ground. What is lost, however, in the oversight of acute inpatient care is the most critical aspect of any health care delivery model—the patient. While a hospitalist model that is built around the goals of improving quality and efficiency does not necessarily conflict with patient care interests, the potential for these goals to diverge certainly exists. A great breadth of literature has validated the hospitalist model as a means to improve the efficiency of inpatient care, but the extent to which quality outcomes truly benefit from this model remains unclear [8].

The question, then, is not whether a hospitalist model should retain its predominantly voluntary status, but rather how the hospitalist model can be designed to ensure that the patient-centered initiatives of quality and safety remain on equal footing with the economic drivers of cost and efficiency. As we adopt this new framework, physicians must evolve in a manner that preserves their ethical commitment to the patient's well-being. Like the concerns that emerged with the introduction of the

managed care model in the 1990s, when fiscal constraints and limited patient choice impinged on physician autonomy in determining care, hospitalist systems present their own intricacies [9-11]. The hospitalist model introduces the potential for diminished patient autonomy, poses challenges for the continuity of care and patient-physician communication, and even raises possible conflicts of interest when financial incentives and patients' interests do not align [12].

Given current upheavals in the financial markets, it is likely that health care cost-containment measures, with which the hospitalist model is finding itself increasingly entwined, will take on greater importance in the national and global economies. While the long-term impact of today's economic climate on health care delivery remains to be seen, it is clear that, as fiscal pressures grow, the significance of safeguarding patients' best interests becomes paramount. Assessments confirm a general acceptance of the hospitalist model [13, 14]. Patients appreciate improved access to a physician dedicated to their care, even if it is one with whom they are less familiar. For their part, hospitalists, as newly devoted stewards of inpatient care resources, must expand on this opportunity to preserve the focus on the patient. Further research will gauge the hospitalist model's capacity to improve clinical outcomes, but the parallel progression of quality, safety, cost, and efficiency, in a manner that upholds Hippocratic ideals, can only be achieved through the watchful dedication of hospitalists themselves.

## References

1. Society of Hospital Medicine. *Growth of Hospital Medicine Nationwide*. 2007. [http://www.hospitalmedicine.org/Content/NavigationMenu/Media/GrowthofHospitalMedicineNationwide/Growth\\_of\\_Hospital\\_M.htm](http://www.hospitalmedicine.org/Content/NavigationMenu/Media/GrowthofHospitalMedicineNationwide/Growth_of_Hospital_M.htm). Accessed October 23, 2008.
2. Wachter RM. An introduction to the hospitalist model. *Ann Intern Med*. 1999;130(4 Pt 2):338-342.
3. Maguire P. Use of mandatory hospitalists blasted. *ACP Observer*. 1999. <http://www.acpinternist.org/archives/1999/05/hosps.htm>. Accessed October 23, 2008.
4. Casalino LP, November EA, Berenson RA, Pham HH. Hospital-physician relations: two tracks and the decline of the voluntary medical staff model. *Health Aff (Millwood)*. 2008;27(5):1305-1314.
5. Pham HH, Devers KJ, Kuo S, Berenson RA. Health care market trends and the evolution of hospitalist use and roles. *J Gen Intern Med*. 2005;20(2):101-107.
6. Pham HH, Devers KJ, May JH, Berenson R. Financial pressures spur physician entrepreneurialism. *Health Aff (Millwood)*. 2004;23(2):70-81.
7. Bishop TF and Kathuria N. Economic and healthcare forces of hospitalist movement. *Mt Sinai J Med*. 2008;75(5):424-429.
8. Lindenauer PK, Rothberg MB, Pekow PS, Kenwood C, Benjamin EM, Auerbach AD. Outcomes of care by hospitalists, general internists, and family physicians. *N Engl J Med*. 2007;357(25):2589-2600.

9. Emanuel EJ, Brett AS. Managed competition and the patient-physician relationship. *N Engl J Med*. 1993;329(12):879-882.
10. Balint J, Shelton W. Regaining the initiative: forging a new model of the physician-patient relationship. *JAMA*. 1996;275(11):887-891.
11. Emanuel EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. *JAMA*. 1995;273(4):323-329.
12. Lo B. Ethical and policy implications of hospitalist systems. *Am J Med*. 2001;111(9B):48-52.
13. Wachter RM, Katz P, Showstack J, Bindman AB, Goldman L. Reorganizing an academic medical service: impact on cost, quality, patient satisfaction, and education. *JAMA*. 1998;279(19):1560-1565.
14. Davis KM, Koch KE, Harvey JK, Wilson R, Englert J, Gerard PD. Effects of hospitalists on cost, outcomes, and patient satisfaction in a rural health system. *Am J Med*. 2000;108(8):621-626.

Marc B. Royo is a third-year student at Jefferson Medical College of Thomas Jefferson University in Philadelphia, and Widener University in Chester, Pennsylvania.

Laura L. Kimberly, MSW, MBE, is director of special projects for health policy at Jefferson Medical College of Thomas Jefferson University in Philadelphia.

Alexandria Skoufalos, EdD, is vice chair for education and assistant professor for health policy at Jefferson Medical College of Thomas Jefferson University in Philadelphia.

#### **Related in VM**

[The Ethics of Efficiency in Hospital Medicine: Developing a New Paradigm for the Patient-Physician Relationship](#), December 2008

*The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

Copyright 2008 American Medical Association. All rights reserved.