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Op-Ed
Caring Comportment and the Hospitalist Model
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The hospitalist model of inpatient care is associated with cost-effective and high-quality care, but this result may come at the cost of patients' own expressed values. Certain procedural changes can reemphasize patient values, but they must be accompanied by shifts in the comportment of hospitalists, whose current practices have the potential to undermine the model's benefits.

There are 2 primary benefits created by shifting the responsibilities of some doctors largely or entirely to inpatient care. First, by being available throughout the day, hospitalists can be more efficient [1]. Moreover, the specialization that results from the hospitalist model can increase the skill of physicians, standardize the quality of inpatient care, and thereby improve patient care [2]. Generally, patient satisfaction with the care in hospitalist systems has been very high [1].

Granting that these benefits do in fact accrue in the aggregate from the hospitalist model of patient care, ethical concerns remain, independent of the desired health outcomes. Because this model requires a handoff between the primary care physician (PCP) and hospitalist, it generates concerns about continuity of care. Discontinuity can interfere with the expression of patient values by dissolving or undermining the relationship between patient and his or her PCP [3]. This relationship is important because its duration and intimacy allow the physician to have greater knowledge of the patient's values, attitudes toward risk, and willingness to engage in the intricacies of health decisions. Weakening this bond reduces the patient's ability to express her or his values regarding medical treatment [4].

While cost structures and time constraints prevent even PCPs from fully realizing the potential for long-term contact, PCPs still have greater familiarity with patients' and their families' values than hospitalists do. Modifications to procedures for physician reimbursement and training would make it possible for PCPs to move closer to the ideal form of the relationship.

The potential of the hospitalist model to undermine the expression of patient values does not fall equally on all patients. Some hospitalized patients face decisions regarding major surgery or end-of-life issues, both areas in which knowledge about the patient's values takes on added significance. When overspecialization and discontinuity of care weaken the relationship between patient and PCP, there is a danger that the PCP's role

in helping the patient toward self-determined treatment decisions can be minimized or even eliminated.

These concerns have long been recognized. In response, a range of procedural modifications has been suggested to reduce and better distribute the costs of specialization and discontinuity of care. PCPs can still be involved in the care of their patients under the hospitalist model through visits or phone calls with patients and through better communication with hospitalists [5]. Potential disagreements between PCP and hospitalist regarding the care of the patient can be resolved through explicit conflict resolution procedures within the hospitalist system [4]. Transfers of patients from PCPs to hospitalists can be voluntary, with the decision left to patient care preferences [6]. End-of-life values can be better communicated to hospitalists by requiring inpatients to complete advance directive surveys and then asking hospitalists to discuss those directives with their patients [7]. Generally, reimbursing PCPs for their increased role in the hospitalist system can encourage better communication with hospitalists [5]. While this model is built around efficiency, communicating these end-of-life values is often time-consuming, necessitating family meetings or ethics consults for which physicians are not reimbursed. Nonetheless, a good hospitalist will address these issues with every patient admitted.

These procedural changes have the potential to offset some of the losses in ability to express preferences that patients experience as a result of discontinuity of care and overspecialization. Procedural changes alone, however, will not sufficiently offset the detrimental effects. They must be accompanied by changes in hospitalists' comportment toward their patients and in their capacity to establish relationships of trust with patients. With the compartmentalization of medicine into multiple subspecialties, it is the duty of hospitalists to establish this relationship early during the admission.

Consider the particular challenges faced in end-of-life situations. Requiring patients to complete surveys and asking physicians to hold discussions regarding end-of-life values will not in themselves facilitate informed choices by patients. End-of-life values are typically held deeply and privately, so the hospitalist's ability to establish a relationship of trust in a short amount of time will be essential, as will his or her attitude of openness to the patient's values, needs, and reservations. Merely filling out a form will not achieve these ends. While there is reason to hope that frequent contact with patients facing end-of-life decisions will increase the ability of hospitalists in these situations and generally strengthen the patient-physician relationship, changes in their training will be crucial as well. Moreover, procedural changes must emphasize that the mission of hospitalists is to facilitate informed choices of patients and families regarding their medical care and not merely to execute the physician's own medical judgment effectively and efficiently. Hospitalists must weigh families' personal values with objective data regarding prognosis, risk, and benefit.

These kinds of changes of attitude together with procedural changes may genuinely support the expression of patient values, but they may erode the benefits of the hospitalist model. Since the hospitalist's responsibility is to serve as the manager for the patient's numerous specialists, greater attunement to the values of patients will

predictably create tension between cost-effective provision of medical services and the informed choices of patients. Not only does this form of attention to patient values take time that could otherwise be used for the provision of services, but a genuine change in comportment requires that hospitalists shift focus away from efficiency and toward supporting the expression of patient values. Thus, while the actual practice of both hospitalists and outpatient physicians falls short of their ideal forms, only for the hospitalist model will addressing the need to be open to expressions of patient values require a significant change in that model's aims and ideals.

Without further research it is difficult to say whether the hospitalist model can support benefits in efficiency and efficacy while still maintaining acceptable levels and distributions of the ability of patients to express their preferences regarding medical care. What we hope to emphasize instead is that competing models of patient care should not be measured merely by their ability to extend patient life as cheaply as possible. Rather, the aim of patient care should be to facilitate the patient's own standard of a healthful life—a standard of care that is of high quality, that is cost-effective, and that represents the patient's values regarding medical care. While there is no reason to think that the hospitalist model cannot be modified to meet these concerns, it may not be possible to do so without losing some or all of the advantages that are put forward in its favor.

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