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Medical Education

The Rise of Hospitalists: An Opportunity for Clinical Ethics

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ABSTRACT

Translating ethical theories into clinical practice presents a perennial challenge to educators. While many suggestions have been put forth to bridge the theory-practice gap, none have sufficiently remedied the problem. We believe the ascendance of hospital medicine, as a dominant new force in medical education and patient care, presents a unique opportunity that could redefine the way clinical ethics is taught. The field of hospital medicine in the United States is comprised of more than 50,000 hospitalists—specialists in inpatient medicine—representing the fastest growing subspecialty in the history of medicine, and its members have emerged as a dominant new force around which medical education and patient care pivot. This evolution in medical education presents a unique opportunity for the clinical ethics community. Through their proximity to patients and trainees, hospitalists have the potential to teach medical ethics in real time on the wards, but most hospitalists have not received formal training in clinical ethics. We believe it is time to strengthen the ties between hospital medicine and medical ethics, and in this article we outline how clinical ethicists might collaborate with hospitalists to identify routine issues that do not rise to the level of an "ethics consult," but nonetheless require an intellectual grounding in normative reasoning. We use a clinical vignette to explore how this approach might enhance and broaden the scope of medical education that occurs in the inpatient setting: A patient with an intra-abdominal abscess is admitted to the academic hospitalist teaching service for drainage of the fluid, hemodynamic support, and antimicrobial therapy. During the initial encounter with the hospitalist and his team of medical students and residents, the patient reports night sweats and asks if this symptom could be due to the abscess. How should the hospitalist approach this question?

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INTRODUCTION

Teaching medical ethics to medical students and residents presents a perennial challenge to educators. The difficulties of translating ethical theories into clinical practice are well documented, and while many suggestions have been put forth to bridge the theory-practice gap, none have sufficiently remedied the problem.[1] We believe the ascendance of hospital medicine as a dominant new force in medical education and patient care presents a unique opportunity for the teaching of clinical ethics in real

time that could redefine the translational movements that occur between ethical theory and practice.[2] While other clinical educators can and will contribute to the professional formation of students and trainees, the growing prominence of hospital medicine warrants a consideration of how and why they might bring medical ethics closer to the bedside.

First described in 1996 as the physicians dedicated to the delivery of comprehensive medical care to hospitalized patients, "hospitalists" have since become one of the fastest growing medical professional groups in the U.S.[3] There are more than 50,000 hospitalists in the U.S. today, which makes this new field larger than any specialty except internal medicine and family medicine, and all highly ranked academic health centers in the U.S. now employ them.[4] It is widely appreciated that, given their continuity and accessibility in inpatient care, the use of hospitalists has diminished the role of specialists and researchers on teaching services.[5] Thus, in addition to playing a central role in clinical care, hospitalists increasingly serve as primary educators during the clinical years of medical school.

This evolution in clinical practice implies a change in the present educational paradigm and offers a unique opportunity for collaboration with the clinical ethics community. Since hospitalists have become role models for medical students and trainees, cross-training them in medical ethics, normative reasoning, and professionalism could help inculcate a professional ethos into an increasingly complex and fragmented healthcare system, creating an opportunity to inform professional formation in medical education.[6]

Teaching on the wards is essential to professional development. In that context, students and trainees are exposed to ethical quandaries, which many may feel unprepared to handle, given the stress of clinical work and the complexity of real cases versus those presented in the classroom in their preclinical work.[7] On the wards, trainees develop a new perspective on the complexity of these issues that necessitates more sophisticated normative reasoning in the clinical context.[8] Finally, ethics education, absent a robust clinical component, is fruitless and erodes the explicit curriculum taught during preclinical years. Without the endorsement of practicing clinicians, ethical theory, often grounded in principlism, may be damaged by the hidden curriculum, to be described later in this article.[9]

For hospitalists to address ethical issues in real time on the wards, they must be familiar with theory *and* practice. Understanding how an ethicist approaches a clinical conundrum enables hospitalists to engage more fully with difficult issues—especially those that do not rise to the level of a formal ethics consult—to identify conflict and to reason through possible resolutions and to use this as a teaching opportunity. Properly trained hospitalists may provide an intellectual framework for discussing medical ethics in real time on the wards.

For these reasons, a unique opportunity exists for hospitalists to teach medical ethics, professionalism, communication, and normative reasoning to trainees and their colleagues on the ward.[10] These competencies cannot be taught solely in a classroom; they require clinical experiences and so fit into the purview of hospital medicine. To fill this role, however, hospitalists must be properly trained.[11]

Bringing hospitalists into the educational mix is a way to address what has been described as the hidden curriculum. The hidden curriculum is broadly defined as the processes, pressures, and constraints that fall outside the formal curriculum that are often not articulated or explored.[12] The hidden curriculum is an enduring problem in medical education and teaching professionalism, in which formal education on ethics and professionalism in the undergraduate medical years may be undone when students get to the wards.[13] Hospitalists, by teaching ethics and modeling professionalism, can help counter this.

In this article, we examine why hospitalists must be an essential element in ethics education and how the emerging subspecialty can learn from and work with clinical ethicists. This will prove to be a fruitful synergy in the formation of trainees and, most importantly, to the patients who are entrusted to them.

WHY HOSPITALISTS?

As the field of hospital medicine has matured, its members have taken on an ever-expanding scope of educational opportunities and objectives.[14] On teaching services, hospitalists often serve as the attending of record as well as evaluators and role models for the medical team.[15] In many institutions they serve as residency and clerkship directors. Across the country, hospitalists are at the center of educational contact and patient care, which allows them to interact with patients and students in real time.[16]

Since hospitalists do the bulk of clinical teaching, they could serve as the center of medical ethics education in the clinical setting. Hospitalists confront many controversial topics on the wards, where they learn to handle ethical quandaries in clinical

practice in real time. Hospitalists must bring conflicting values into balance and prioritize them in the context of patients' and family members' preferences, established legal precedents, and the norms and beliefs of the medical team.[17] Learning to do this is a challenge for any healthcare provider; it is even more difficult for the inexperienced practitioner.

Properly trained hospitalists would be able to identify and examine the ethical and professional issues frequently encountered (and often overlooked) in the inpatient setting. They may become the "conscience" of the clinical team and integrate discussions of norms, values, and preferences into routine clinical work.[18] To achieve this, however, the ties between clinical ethics and hospital medicine must be strengthened. Hospitalists should be invited to participate in hospital-based ethics committees, and clinical ethicists should be invited to join daily ward rounds. Given their unique vantage points, both groups could partner in preclinical and clinical medical ethics education.

Hospitalists' concern about these issues can bring questions of clinical ethics and professionalism to the bedside, not theoretical musings. Every case can become a classroom. This connection to the needs of real patients and the biomedical science undergirding diagnosis and treatment can affect patient care and trainees' educational experiences.

Hospitalists' central role in clinical transactions, coupled with their standing as the attending physician, gives them a greater impact on the educational environment and the sociological variables that influence learners. This influence is amplified by hospitalists' power as students' and trainees' evaluators. If questions of ethics and professionalism are discussed on rounds, medical students and residents will follow their lead, if only to please their supervisor. Ethics is more than a mode of analysis for explicit conflict. It is a way to interact and do things. The formation of "ethical habits," over time, in the context of regular work experience, is critical. A good grade should not be the motivation for virtuous behavior, but the evaluative power wielded by hospitalists helps explain why they are well positioned to have a significant educational influence on clinical training.

In sum, the central role played by hospitalists in medical education and patient care places them at the center of clinical education for medical students and trainees.[19] Hospitalists may help to consolidate curricular elements that have been emphasized in the preclinical years. Through case-based teaching and practice, hospitalists may be able to counter the erosive effects of the hidden curriculum on professional development, and to model more constructive archetypes of care and comportment. The framework is for real students to talk about real issues that pertain to professionalism in real time.

We hope this educational ethos expands to other specialties and subspecialties, much as the hospitalist model has spread to pediatrics, surgery, neurology, and obstetrics. A preliminary role for hospitalists and the hidden curriculum in pediatric training has already been advanced.[20] To do this, hospitalists must become conversant in clinical ethics.

EVERY CASE A CLASSROOM

Because the influence of hospitalists on medical education will be felt through their impact on individualized patient care, it is useful to highlight the potential educational value of the case presented above. Even the most mundane medical case has ethical content that can be explored by hospitalists, even those cases not traditionally considered to be "ethics" cases.

Hospital medicine is laden with ethical quandaries and includes often-overlooked opportunities for discussions about professionalism. Consider a case drawn from our own experiences that illustrates how "routine" cases can be employed as vectors for professional education. The patient presents to the emergency room with an intra-abdominal infection and is admitted to the hospital for paracentesis, antibiotics, and hemodynamic support. The patient has a question about night sweats, a straightforward issue with a broad differential diagnosis. In response, the hospitalist shares his thinking with the team of students and residents. He explains that, while night sweats can be due to the abscess, they could also be explained by malignancy, tuberculosis, the human immunodeficiency virus, or hormonal disorders. The possibilities are open-ended, but the hospitalist is confident that the sweats are from the abscess.

The ethical question is, should the hospitalist discuss all of these diagnostic possibilities with the patient? Does the patient have a right to know? Is it wrong to withhold information? Is information an absolute right? If so, would nondisclosure violate the patient's right to self-determination? What about making a choice about what to disclose? Is that a physician's professional prerogative? If it is, how should a doctor make a judgment about *selective* disclosure? Is it a question of burdens and benefits and proportionality? Is this culturally determined? And, on the extreme of harm, is it ever justified to

completely withhold information because of a patient's emotional fragility? If that is reasonable in theory, how might a doctor know that a threshold has been reached in practice? A simple case, with a straightforward question, can result, if properly curated, in wide-ranging discussions with trainees regarding (1) truth-telling, (2) proportionality, (3) disclosure, (4) autonomy, and perhaps most importantly, (5) how we translate scientific information into value choices.

In our experience, medical students and residents have remarkably different approaches to these questions. Airing them needs to accommodate the learning styles of all involved. Logistically, the conversation could happen in a variety of places—outside a patient's room, on chart rounds, or even at the bedside, when appropriate. Hospitalists may or may not feel comfortable leading such discussions, but even cursory exposure to clinical ethics might allow a more informed conversation with trainees—one with specific educational objectives.

Temporally, the discussions can happen over time, during the course of a patient's hospitalization and over the duration of a trainee's rotation. In this way, conversations can be iterative and reflective, with students and trainees revisiting earlier decisions as new medical data come in. When these themes are integrated into rounds, conversations about ethics and practice can evolve over time in an organic manner linked to care.

The longitudinal nature of these discussions has an advantage over conventional ethics consultation. They are episodic and bring new teams into the mix. While formal ethics consults have great value, to limit ethics deliberations to times of conflict and crisis misses opportunities for education.[21] Logistically, there are far more ethics issues than ethics consultants, and that is why hospitalists as ethics educators are indispensable. If the only time ethics is discussed on rounds is when there is a formal ethics consult, a lot of "case material" that is important to professional formation remains unaddressed. Hospitalists may serve as the beacon to detect novel trends in ethically challenging clinical problems that may not yet have reached the clinical ethics team, but would benefit from their insight.[22]

If we return to the case of the patient with night sweats, we can see the role that may be played by hospitalists in bringing ethical dimensions of care to bedside teaching. For example, if the decision is to be more beneficent than enfranchising, a hospitalist may shield the patient from unlikely diagnoses that might cause emotional distress (an act of beneficence) rather than inform the patient of every diagnosis under consideration (an act of enfranchisement). That decision could be revisited if new data suggest a heightened possibility of cancer. These developments point to the contingency of ethical judgments and the old adage, "good facts make for good ethics."[23]

By living through these disclosure decisions, trainees will come to appreciate the complexity of ethical judgments when situations are fluid, and the importance of moving beyond theory. To achieve this educational mission, we call on clinical ethicists to help train hospitalists in normative reasoning to facilitate these conversations.

This vision poses challenges for hospital medicine, founded on a model of efficiency. Hospitalists must balance patient care with clinical education, administrative duties, and expanding requirements for documentation. The idea of turning "every case into a classroom" may seem untenable. In our experience—we are in year two of a hospitalist/ethics collaboration—teachable moments at the bedside need only last a few minutes and may actually save time (resolving conflicts before they emerge, fewer family meetings, and so on). Nonetheless, any new objective introduced to hospital medicine must be balanced against the demands of the job.

EVIDENCE-BASED MEDICINE, CLINICAL ETHICS, AND HOSPITALISTS

Beyond questions of individual case analysis, bringing medical ethics and value choices to clinical thinking is especially important, because medical reasoning is often reductionist and dominated by evidence-based medicine. This too is part of the hidden curriculum that endorses an objective reality, based on clinical outcomes research, that can be more fallible than practitioners care to acknowledge.[24] Despite our best efforts to remove uncertainty by standardizing medical care through the use of checklists, performance measures, electronic medical records, and consensus statements, clinical ambiguity remains, and this needs to be appreciated and recognized.[25] There are still gray zones, where judgment is necessary.[26] Clinical decisions inevitably blend evidence-based and normative reasoning, culminating in professionalism in practice. This may be a life lesson for novice practitioners.

This is an important lesson, that may seem to run counter to the tenets of evidence-based medicine, but it is wholly consistent with David Sackett's famous admonition, "Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the

care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[27] This can be modeled for trainees.

Skilled hospitalists can follow Sackett's counsel and stress that a plurality of methods should be employed, to allow a blended approach of objective and subjective dimensions of care. They could make the point with the quip, "having the right medicine for the wrong patient." When there is little or no good evidence to inform care decisions, clinicians should appreciate epistemic limits and respond professionally.

When there is ambiguity regarding the proper course of action, physicians are more likely to draw on personal experience, defer to an expert consultant, or defer to the will of the patient.[28] These choices—the ones for which there are neither evidence nor formal guidelines—are the most difficult to make and require professional judgments that cannot be made without a grounding in the art and science of medicine.[29] These dynamic moments, so important in the care of patients, are excellent occasions for teaching (and modeling) professionalism.

When hospitalists embrace the moral complexities of modern medical care, using evidence when it is available and deviating from guidelines and consensus statements when evidence is not available, they do more than improvise. They engage in a translational activity that marries numbers and values.[30] They act humanely, using medical knowledge, in the service of their patients, in the pursuit of the good.[31] When trainees and students watch their mentors provide care under these circumstances, the lesson can be a profound and enduring one about professionalism and physicians' obligations.

THE HIDDEN CURRICULUM AND THE SOCIOLOGY OF LEARNING

Let us return to the hidden curriculum and why hospitalists may be positioned to counter its effects. The hidden curriculum influences the sociology of the learning environment.[32] It implicitly influences a learner's educative goals and priorities, distorting the explicit curriculum. Hospitalists alter the sociology of the clinic and exert their influence over that learning environment by their presence. Their name, *hospitalist*, is a powerful reminder of where they are and where their influence is felt. Their actions and role modeling can be picked up as silent cues by students and trainees, and implicit forces in the professional formation process.[33] If medical students were "let free" after their preclinical years into the uncontrolled world of the hospital, hospitalists can do more to positively influence students' development. The influence of hospitalists is amplified when they "walk the walk" *and* "talk the talk." In this way, explicit and implicit curricular elements may come together and reinforce each other. This synergy can help transform the modern clerkship and residency and realize William Osler's vision of the hospital as a college.[34]

This is not unexpected. For more than a century, social scientists have understood how social structures and informal group culture can influence norms and individual behavior.[35] The great educational reformer and mid-century pragmatist John Dewey hinted at this concept in his work on "collateral learning"—that is, knowledge that is gained while doing other things—anticipating what would come to be understood as the "hidden curriculum" by the 1960s.[36]

Dewey argued in *Experience and Education* that "collateral learning in the way of formation of enduring attitudes, of likes and dislikes, may be and often is much more important than the spelling lesson or lesson in geography or history that is learned. For these attitudes are fundamentally what count in the future."[37] But more critically, when considering the negative effects of the hidden curriculum, if the learning environment is adverse, education can be undermined. Dewey could have been writing of the hidden curriculum when he observed, "If impetus in this direction is weakened instead of being intensified, something much more than mere lack of preparation takes place. The pupil is actually robbed of native capacities which otherwise would enable him to cope with the circumstances that he meets in the course of his life."[38] Clearly these negative inputs could have bearing on trainees' cultivation of professionalism.

This argumentation was more fully articulated as the hidden curriculum by Benson Snyder in the early 1970s in his book of the same name. In *Hidden Curriculum*, he considered the unstated, inflexible social norms of college campuses and argued that these unwritten rules cause anxiety and impair students' ability to develop critical thinking and reasoning skills. The work was subsequently extended to graduate medical education, where the findings were even more robust, as medical students reported the dehumanizing effects of the hidden curriculum on their nascent professional identities.[39]

This brief conceptual lineage of the hidden curriculum reminds us that we must attend to the sociology and the context of learning if we hope to over-

come the powerful pull of these forces. And that is why we believe that hospitalists, exerting educational influence in the clinic, might be highly effective in countering the hidden curriculum's negative influence on professional formation.

REMAINING CHALLENGES

Our vision for the hospitalist-educator, empowered to bring questions of ethics and professionalism to bedside teaching, is ambitious. Some might even say it is quixotic. Nonetheless, we believe that, with appropriate help, hospitalists are well positioned for this role based on their proximity to patients and their central role in modern medical education. With proper training in clinical ethics, to complement their considerable clinical experience, they will be able to fulfill this vital educational role.[40]

To realize this we must broaden the possibilities of what it means to be a hospitalist as practitioner and as a medical educator. We need to engage leadership in hospital medicine, medical ethics, and undergraduate and graduate medical education to better apprehend how to train hospitalists for this expanded role. A first step is to strengthen the ties between clinical ethics and hospitalist communities and explore opportunities for collaborative efforts in medical education and research. Medical ethicists can (and should) be brought to the wards to initiate teaching collaborations with their hospitalist colleagues.

This connecting role with the wards may allow for earlier detection of ethical conflict, as well as for a sharper realization of the daily ethical challenges in inpatient care. Clinical ethicists have an opportunity to achieve a major educational impact on a wider proportion of medical trainees through their hand-in-hand work with an homogeneous, concentrated, and consistently available population of attending physicians. Similarly, hospitalists should have exposure to medical ethics activities such as service on hospital ethics committees and teaching in the preclinical ethics curriculum.

We also need current practice data. What are the primary ethical issues that inpatient clinicians confront? How often do they arise? How are they resolved? How do hospitalists frame these issues? By quantifying and describing these scenarios, a curriculum may be created to educate hospitalists—to "train the trainers"—so that ethical and professional issues can be woven into daily ward rounds with students and residents.

Given the demands of the job, hospitalists may initially need incentives to engage in additional ethics training. This training can lead to an increase in the quality of care. Engaging in clinical ethics provides numerous benefits for healthcare professionals, not only because of the satisfaction of conducting themselves in a professionally ethical manner, but because they may then cope better with professional burnout.[41]

There is much work to be done to move this agenda forward, and many conversations to be had across disciplines that before now have had minimal engagement. It would be wrong to see this initiative as a threat to clinical ethics; rather, we envision a multiplier effect, in which an increase in ethically conversant physicians and trainees leads to greater awareness of the challenges encountered on the wards. To counter the hidden curriculum and sustain professionalism, it is time to move from these reactive encounters and pursue proactive, collaborative efforts with clinical ethicists to reaffirm the art and science of bedside teaching.

PRIVACY

The patient's details have been changed to protect the patient's anonymity.

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