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Leveraging the Power of Medical Professionalism to Improve Health Care: *A New Platform for Reform*

Summary of a Roundtable on Advancing 21st Century Medical Professionalism: A Multi-Stakeholder Approach

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On January 13-14, 2009, the ABIM Foundation, the American College of Physicians and the Institute on Medicine as a Profession convened a diverse group of more than 50 stakeholders to explore the notion of medical professionalism and to discuss how to advance a 21st Century definition of this concept in order to improve health care. The meeting began to define a shared understanding of professionalism and why it matters and to identify concrete ways to reform physician payment, implement organizational supports and enhance public reporting to foster an environment more conducive to professionalism.

The dialogue focused on an updated definition of professionalism articulated in the *Physician Charter*, which identifies three core principles that need to guide physician behavior in practice:

- **Patient welfare** – Dedication to serving the interest of the patient, including a commitment to improving quality of care;
- **Patient autonomy** – Respect, honesty and transparency with patients and a commitment to fostering a patient-centered approach to care; and
- **Social justice** – Fair and equitable use of health care resources, including a commitment to cost-effective management that advances equity and affordability.

The meeting started from the premise that there are forces in the environment that inhibit – and, in many respects, undermine – physician capacity to fulfill these obligations. The goal of the discussion was to explore how to collectively advance a reformed health care system that supports and nourishes professionalism in order to improve quality and outcomes. The discussion focused on three key areas central to reform: payment policy, organizational strategies and public reporting.

The More We Rely on Pay-for-Performance and Public Reporting, the More We Need Professionalism

Diverse stakeholders strongly suggested that as the health care system places growing emphasis on payment incentives and transparency to improve patient care, the importance of professionalism increases. The group acknowledged that we never will be able to construct a set of quality metrics and performance incentives that perfectly engineer the system to produce high-quality and cost-effective care, and professionalism always will be an essential element to what makes the health care system work. As David Blumenthal, MD, of the Institute for Health Policy at Massachusetts General Hospital, and recently nominated as National Coordinator for Health Information Technology, noted, “Professionalism compensates for the weaknesses of what regulation and markets can achieve on their own.” Carolyn Clancy, MD, of the Agency for Healthcare Research and Quality, urged the group to consider ways to align these forces so that they can become mutually reinforcing and work in concert to achieve societal goals.

Cultivating 21st Century Professionalism

Christine Cassel, MD, of the American Board of Internal Medicine and the ABIM Foundation, offered a definition of professionalism that embraces accountability and responsibility for engaging in quality improvement and acting as stewards of scarce resources. This definition diverges from the more nostalgic view of professionalism, which seeks to preserve and protect physician autonomy. A number of participants noted the current “chasm between professional norms and behaviors,” acknowledging the need to strengthen professionalism in practice to improve system performance.

Several participants agreed with Cassel’s assertion that the challenge is to move the professionalism concept into action – describing more effectively what professionalism looks like in practice and working in partnership with other stakeholders to explore how adherence to these aspirations can be supported.

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Glenn Hackbarth, JD
MedPAC

David Rothman, PhD, of the Institute on Medicine as a Profession, offered a proposal to develop “Professionalism Impact Analysis” (PIA) statements, which are similar to environmental impact analyses. Rothman described the PIA as a tool that could help educate stakeholders about the impact of organizational policy or government-led initiatives on physician professionalism. He noted that the PIA could be a powerful device to educate stakeholders about the value of professionalism and how forces in the environment influence professionalism in practice.

Current Approaches to Payment Conflict with Professionalism

Meeting participants voiced strongly that current payment methodologies undermine physicians’ abilities to adhere to professional values. For instance, depending on payer source, health care services are compensated at dramatically different levels. Physicians, in theory, are expected to provide equitable care to all patients, yet there is a strong financial incentive for physicians to prefer those who are reimbursed more favorably, which can lead to disparities in care. Similarly, there are marked disparities in the level of reimbursement for different types of services relative to their underlying costs, which create incentives to favor those services at the margin. Moreover, these discrepancies send signals to physicians about choice of specialty and where to locate their practices – decisions which affect workforce supply and patient access to care.

Our reliance on fee-for-service further compounds the problem. According to Robert Berenson, MD, of the Urban Institute, fee-for-service is like “pouring gasoline” on the “more is better” orientation that pervades U.S. health care today. Conventional wisdom is that fee-for-service avoids the risk of stinting. But increasing evidence shows that a more conservative approach often is in the best interest of the patient, as well as society more broadly. Fee-for-service payment does not provide any incentive for physicians to promote judicious use of society’s scarce health care resources and inhibits physician attention to the sustainability of the health care system. In addition, fee-for-service fosters a fragmented approach to care delivery, with important services, such as care coordination or cognitive services that help patients understand and interpret options, unfunded or under-provided.

Taken together, these forces can be counter-productive to physicians' efforts to adhere to professional values in practice. Meeting participants noted that it was unrealistic to expect physicians to consistently "throw themselves in front of the train" and act heroically in the face of conflicting incentives. Rather, they argued, we need to adopt new approaches that support physicians in their efforts to balance their professional obligations with the natural pull of self-interest. As Glenn Hackbarth, JD, of MedPAC, suggested, "We need to find a way for physicians to do well by doing right."

Restoring the Trust

Meeting participants were enthusiastic about strengthening professionalism as a frame for health reform, but cautioned that important groundwork would be needed to restore public trust in physicians to make this possible. George Isham, MD, of HealthPartners, reminded the group that there is a "give and a get" in this implicit renegotiation of the social contract. He encouraged physicians to address an emerging "crisis of confidence," as it relates to doctors' financial relationships with pharmaceutical and device manufacturers. "The profession can't be credible unless we address these things upfront," he said.

A number of participants argued that physicians should recuse themselves from decisions related to physician payment because of the inherent conflict of interest. Several participants called for non-physician stakeholders, such as consumers and employers, to drive Medicare's Resource Based Relative Value Scale Use Committee (RUC), given that entity's mandate to assign relative values to physician-provided services. Others suggested that

Professionalism in the United Kingdom

Professor Dame Carol Black, Chair of the Nuffield Trust in London, England, noted that although the United Kingdom does not have the challenges of the American physician payment system, there remains an urgent need to promote professionalism among physicians. She also commented that much like in the United States, medicine in the United Kingdom is being "unmasked," and the public is asking for greater transparency and accountability.

Professor Dame Black described current efforts to promote "a new, strengthened form of medical professionalism, valid for this time, to maintain trust and confidence in doctors and their part in our system of health care." As in the United States, the United Kingdom's medical community has affirmed physicians' commitment to core values, continuous improvement and partnerships with health care professionals, institutions and the public. As a practical expression of the commitment to professionalism, the United Kingdom will begin a new physician recertification process in 2010, known as "revalidation." As part of this process, all physicians will participate in annual appraisals, with peer and patient feedback, engage in continuing professional development and demonstrate that there are no unresolved concerns about their practice.

while physicians should have a say in payment decisions, the public would not respect physicians leading the charge.

At the same time, some physicians participating in the meeting argued that payers need to do their part to regain the trust of physicians. Richard Baron, MD, of Greenhouse Internists and Chair of the American Board of

Internal Medicine, commented that it is hard for physicians to embrace the responsibility to manage societal resources when they are not confident about where the savings will go. To engage physicians in promoting efficiency and cost-effective care, there needs to be greater certainty about how the savings will be reinvested in the system to produce better care for patients, and assurances that these savings will not be captured as corporate profits.

Payment Methodologies to Foster Professionalism

“It is the setting and ecology into which this payment system is deployed that determines whether it is positive, negative or neutral.”

Martin Sepulveda, MD
IBM

for the “more is better” mentality that is damaging the health care system today. Berenson advocated for hybrid approaches to payment that balance the positives and negatives of different payment methodologies, including partial capitation or fee-for-service with per-person payments for certain services.

Hoangmai Pham, MD, of the Center for Studying Health System Change, argued that “we should remove as many services as possible from fee-for-service payment, and re-price the remaining services as accurately as possible relative to the costs of service provision.” She

Getting incentives right is a “fool’s errand,” said Robert Berenson, who also argued that there is no perfect method for paying physicians. He recommended that we start from the perspective that payment incentives are supposed to influence behavior, and focus on creating countervailing pressure

also encouraged physician practices to develop structures that are conducive to per-capita payments.

Many participants expressed enthusiasm for salary with some form of bonuses based on organizational-level performance targets. Martin Sepulveda, MD, of IBM, noted that salary is the foundation for compensation in virtually every high-performing system. But, he also reminded the group that “it is the setting and ecology into which this payment system is deployed that determines whether it is positive, negative or neutral.” Sharon Levine, MD, of Kaiser Permanente, said that the salary model works at Kaiser Permanente, because payment is not the only signal for how physicians should behave.

Strategies to Reform Physician Payment to Advance Professionalism

Many participants advocated for “bold strategies” to address payment policies that impede professionalism. These strategies include:

- Removing as many services as possible from fee-for-service and re-pricing remaining services to eliminate disparities in relative profitability of services;
- Replacing individual physician payment with payment to larger units of accountability that utilize evidence-based guidelines and promote professionalism; and
- Funding a “primary care stimulus package” to quickly re-infuse primary care services into the system, perhaps building on the National Health Service Corps.

Some participants cautioned against linking professionalism too closely to payment policy, arguing

that it might imply that physicians are proposing a *quid pro quo* – “adequate pay” in exchange for professionalism – a notion which might be off-putting. Others clarified that how we currently pay physicians is corrosive to professionalism and results in practice patterns and workforce configurations that threaten the sustainability of the health care system. Re-framing payment reform as a critical strategy to advance professionalism may help to build physician and public support for this undertaking – and may be an important starting point for re-establishing trust among stakeholders that the ultimate goal of reform is to improve patient care and to ensure equity and affordability.

Advancing Stewardship of Finite Resources

Physicians also need to be supported in their role as responsible stewards of finite health care resources. Robert Berenson argued that, despite the negative connotations of the term, physicians can – and in fact already do – engage in “bedside rationing.” He noted that physicians routinely ration their own time and attention, and these decisions significantly affect patient well-being. Centralized mechanisms to guide appropriate service use are important in situations when the physician is not in a position to judge comparative effectiveness of various treatment options (e.g., for the use of new, expensive technology). However, in daily practice, there is virtue in individualizing decisions to the circumstances of patients.

Berenson also argued that medical ethics justify physicians’ roles as “bedside rationers,” and patients expect physicians to draw upon their judgment and expert knowledge to make informed decisions about

their care. Evidence-based practice guidelines provide a step in the right direction to help physicians wisely manage health care resources. But, Berenson noted, the new trend toward “evidence-based individual decision making,” supported by genomics, shared decision making models, an emphasis on patient-centered care, and IT-facilitated decision-support tools, likely will have a greater impact.

Other participants called for greater public engagement to generate broad societal support for the need to collectively manage scarce health care resources. Richard Baron suggested that we learn from the environmental movement and borrow the concept of “sustainability” for health care – inviting physicians and patients to commit to individual actions that might individually not feel like very much, but collectively could support socially responsible stewardship of health care resources. Others similarly called for activating patients and engaging them as partners to help guide the vision for reforms needed to reinvigorate professionalism in practice.

Resetting Organizational Culture

Many participants emphasized the power of organizational culture to support professionalism – suggesting that collective norms and behaviors can trump reimbursement strategies. Stephan Fihn, MD, of the Veterans Health Administration, noted that the much-lauded transformation of the VA occurred with no change to schemes for health care providers (i.e., no monetary incentives). Rather, he described a renewed focus on mission and culture change, in conjunction with an electronic health record and a robust performance measurement system, as key drivers of

that system's successful turn-around. Similarly, Patrick J. Brennan, MD, of the University of Pennsylvania Health System, described the transformation of culture at his institution that emanated from a campaign to strengthen management of conflicts of interest and improve the daily interactions between physicians and nurses.

Larry Casalino, MD, of Weill Cornell Medical College, urged physician practices and delivery systems to embrace an "organized view of quality," which moves beyond the physician taking responsibility for the patient when he/she presents in the office to include considering the needs of those who should show up, but do not. He encouraged physician organizations and delivery systems to provide feedback to physicians on their performance and make explicit investments in improving care for disadvantaged populations. Moreover, he challenged physician organizations to commit to the pursuit of excellence over income maximization – and demonstrate that commitment by reinvesting in organized systems of care rather than distributing all dividends to physicians.

Patricia Sodomka, of the Medical College of Georgia, encouraged organizations to seek out and heed advice from patients and family caregivers to guide the culture change needed to support professionalism. She and others noted the increased clarity of purpose and focus when patients and family members are at the table.

While large, integrated systems can more readily support professionalism, participants were careful to note that these goals are not out of reach for small practices. Richard Baron commented that small practices have the advantage of being more nimble and have greater latitude to make operational changes. He

and others encouraged more exploration of how investments in health information technology and the development of "virtual" groups can help advance accountability in small practices. Lydia Vaias, MD, of the National Physicians Alliance, encouraged small practices to draft mission statements that make explicit the group's expectations about physician behavior, and the consequences for deviating from those expectations.

Medical education was identified as a critical area to advance the culture change needed to support professionalism. Participants called for re-examining the entire continuum of the medical education enterprise – from medical school and training to continuing medical education – to cultivate professional ethics and an organizational culture conducive to professionalism. George Thibault, MD, of the Macy Foundation, encouraged health care stakeholders to recognize the role of educational institutions in shaping the outcomes of the health care system. He encouraged closer attention to who gets into medical school and what gets taught, both via the formal curriculum and what behaviors are modeled in the training environment. He advocated for more explicit teaching of important skills, such as quality improvement, patient safety and teamwork to support professionalism in practice. He and others also encouraged the medical community to explore "our abdication of continuing medical education to industry," and suggested that it was time to reset the norms of what is acceptable.

Engaging and Informing the Public

Accountability and transparency are core tenets of 21st Century professionalism, and although meeting

participants acknowledged that current public reporting efforts are not driving consumer-led change, they encouraged physicians to embrace public reporting as a fundamental act of professionalism that supports continuous quality improvement in practice. One of the difficulties is finding the right balance between what information consumers and physicians want and need to drive improvement. Moreover, there is considerable diversity within each of these groups, and participants encouraged greater attention to tailoring information to acknowledge this heterogeneity.

Carolyn Clancy, MD, of the Agency for Healthcare Research and Quality, noted that “the quality enterprise is so clunky right now...But when physicians collect data themselves to solve a problem they find it very empowering.” Clancy suggested that improvements in HIT that will support availability of more meaningful clinical data, coupled with social networking (for instance, via specialty societies), may help.

“Physicians can get together and say, ‘What’s wrong with this picture?’ and approach the problem from a collegial perspective, rather than one focused on attribution and assigning blame,” she said.

Matthew Wynia, MD, of the American Medical Association, and Jack Lewin, MD, of the American College of Cardiology, added that medical boards and societies have an opportunity to rapidly make more valid, actionable information available to physicians and support real-time quality improvement.

Participants offered an expanded view of what types of information are useful to report, with John Santa, MD, of Consumers Union, encouraging physicians to build public trust by reporting not just on quality metrics, but

on the full spectrum of fiduciary responsibilities to patients. He included physician reporting on who you are (basic credentialing information), who influences you (disclosure of financial relationships) and how the organization where you practice influences your behavior (disclosure of organizational codes of conduct). Santa argued

that this information should be made available to the public via a single, collaborative, “public facing” database – perhaps by building on the current National Practitioner Database or the new systems for disclosure envisioned under the Grassley bill related to conflict of interest.

Clarence Braddock, MD, of the Stanford University School of Medicine, reminded the group of the famous Albert Einstein quote that “things that can be counted don’t always count, and things that count can’t always be counted.” He encouraged the public reporting and measurement arena to consider assessing key behaviors related to professionalism, such as patient-centeredness, teamwork and physician participation in organizational quality improvement efforts. Len Nichols, PhD, of the New America Foundation, advocated adding physician resource use, conflicts of interest and patient satisfaction data to the list of clinical quality metrics that physicians have a professional obligation to report. He acknowledged that there would be many technical issues to sort out, but suggested an aggressive three-year plan, starting with private review by physicians before the data is made public, would get all parties “highly motivated” to make it work. ■

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Carolyn Clancy, MD
Agency for Healthcare Research
and Quality

For more information about this meeting or next steps related to advancing medical professionalism, contact:

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