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# Medical Professionalism in the Changing Health Care Environment: Revitalizing Internal Medicine by Focusing on the Patient Physician Relationship

Position Paper of the

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## I. Executive Summary

The American College of Physicians (ACP), the largest medical specialty society in the United States, represents 115,000 doctors of internal medicine and medical students and is responding to the well-documented decline in internist career satisfaction and medical student interest in internal medicine practice through a comprehensive initiative to revitalize internal medicine. As part of that process, the Ethics and Human Rights Committee examined the specific challenges that the changing health care environment poses to professionalism in general and to the patient–physician relationship in particular. The Committee's goal was to articulate a common vision of professionalism for general internists and subspecialists, to identify environmental barriers to achieving that vision, and to suggest strategies for confronting those barriers.

The College recognizes that professionalism is a fundamental piece of the puzzle that is the future of internal medicine. There are, however, other pieces. As part of the revitalization initiative, appropriate committees and divisions within the College are developing and advocating for policies to address other critical issues, such as medical student debt, physician reimbursement, and the need for universal health care coverage.

### *Recommendations of the American College of Physicians*

1. **General and subspecialist internists should develop and commit to a shared vision of their role as professionals in providing quality patient care. That vision should be based on an examination of what adult patients want and need from the health care delivery system, and an assessment of how internal medicine skills and expertise can best meet those needs.**

2. **That vision should build on the profession's strength as an integrating, cognitive specialty and its knowledge base in preventing, diagnosing, and treating complex conditions. It should be consistent with internal medicine's dedication to providing comprehensive care for the whole person, for investing in strong, sustained, collaborative patient–physician relationships, and for being patient advocates.**

3. **General internists and their subspecialist colleagues should make a joint commitment to replace the trend toward fragmented episodic health care with a coordinated team approach that promotes health, prevents disease, manages complex chronic conditions, and facilitates maximum patient functioning and independence throughout life.**

4. **Physicians and their professional organizations should focus their commitment to professional excellence on the following:**

    - **Advocating for patients and strong patient–physician relationships;**
    - **Enhancing communications with patients and colleagues to foster health care partnerships and improve the coordination of care;**
    - **Expanding and applying the internal medicine knowledge base and developing and implementing improvements in the process and coordination of care and;**
    - **Developing and implementing performance measures linked to quality improvement and accountability in a manner that respects the patient–physician relationship.**

5. **Society must provide the appropriate context for delivering health care. Health plans, purchasers, government, clinicians, and patients should all recognize the importance of and provide consistent support for sustained, intimate patient–physician relationships within which physicians can fulfill their ethical obligations to patients.**

6. **All parties to health care delivery should foster an ethical health care environment, including universal access and a reimbursement mechanism that encourages physicians to take the time required to provide and coordinate appropriate care for adult patients throughout the aging process.**

## II. Introduction

The cornerstone of medical professionalism for internists lies in collaborative, enduring patient–physician relationships. Within these relationships, the virtues of altruism, excellence, advocacy, integrity, and respect are all focused on recognizing and meeting patient needs through comprehensive and coordinated quality care (1-3). The current health care environment creates substantial barriers to the vision of medical practice to which internists aspire. Those barriers contribute to both the well-documented career dissatisfaction among practicing internists and the decline in the number of high caliber medical students choosing careers in internal medicine (4-7). Revitalizing internal medicine will require general internists and subspecialists to commit to a common vision of medical professionalism, to identify barriers to achieving that vision, and to develop strategies for overcoming those barriers while remaining true to the essential values of medical professionalism by focusing on the patient–physician relationship.

Professionalism is a fundamental piece of the complex puzzle that is the future of internal medicine. Commitment to a refined, shared vision of professionalism should provide the patient-centered foundation for ongoing efforts to address the many challenges that the future presents. This article briefly reviews the elements of medical professionalism that are critical both to the relevance of internal medicine in the current health care environment and to physician satisfaction with and interest in internal medicine as a career. It then explores how the changing health care environment has contributed to the "devitalization" of internal medicine by constantly challenging medical professionalism. Finally, it suggests a vision of professionalism for general internists and subspecialists and identifies strategies for confronting environmental barriers to achieving that vision.

## III. Internal Medicine as a Profession

Medical professionalism encompasses all the characteristics of professions in general (i.e., specialized knowledge and training, monopoly over delivery of specific services, service to vulnerable persons and/or protection of vulnerable social values, elevation of others' interests above self- interest, a formal code of ethics, an obligation to serve others, social trust in the form of autonomy and self-regulation [8-11]) with a focus on patient–physician relationships. It involves a primary obligation to advocate for and serve the specific needs of each individual patient, and a secondary obligation to serve societal interests and allocate finite resources to achieve good health for the larger community (3,12). To achieve these aspirations, internists must work in partnership with each patient to address his or her health care needs by examining, inquiring, researching, analyzing, consulting, informing, and discussing, and then planning, coordinating, delivering, evaluating, and revising care. Simultaneously, sustaining competence and achieving excellence in internal medicine practice require keeping up with the rapidly changing and expanding body of medical knowledge.

In the past, these challenging demands drew the best and brightest to internal medicine for many reasons. First and foremost is the desire for long-term, trusting relationships where patients feel comfortable discussing health and psychosocial issues, thus enabling an effective partnership for achieving health and managing disease. Second, the intellectual challenge of maintaining knowledge and competence in the treatment of "the whole patient" and the autonomy to make independent clinical decisions are critical to attracting students to internal medicine and sustaining career satisfaction. Societal and collegial respect and the opportunity to consult freely with specialist colleagues for the benefit of patients are also important to career satisfaction. Finally, internists value the role of advocate, both on behalf of individual patients and on a broader societal level. While earnings potential has importance, studies repeatedly demonstrate that non-monetary elements of professionalism determine career satisfaction (4,5,13).

## IV. Growing Challenges to Medical Professionalism

The changing social, cultural, and economic environment in which health care is delivered has altered the traditional manner in which the contract between medical professionals and their patients is fulfilled. A more highly-educated patient population approaches medical care from a consumerist perspective and does independent research, asserts personal control, and factors cost into health care decision making (14). The increased importance of patient autonomy and self-determination together with the evolution of a significantly more pluralistic society has appropriately diminished paternalistic physician decision making. Media coverage of abuses of power, conflicts of interest, and economic insensitivity, as well as publicity surrounding scientific and medical innovations, institutional errors, and medical mistakes, have replaced blind faith with skepticism (15,16).

While a healthy dose of skepticism and more active patient participation in the health care process are positive changes, their coincidence with ever increasing corporate, insurer, and government control over medical practice is straining the application of traditional concepts of medical professionalism. The pressure of controlled physician reimbursement rates and rising medical practice costs, together with growing administrative demands imposed by private payers and federal regulation is making traditional internal medicine practice more difficult to maintain (17). Confronting these challenges inevitably diverts some physician

energy away from focusing on relationships with patients and understanding patient needs. The increasing difficulty of achieving commonly held expectations of medical professionalism has contributed to dissatisfaction with medical practice, causing established internists to subspecialize or to cut back, retire from, or leave their practices (5,14,18-20). This dissatisfaction is sending a strong message to medical students and residents, causing many to forgo general internal medicine for more clinically-autonomous, less time-pressured, and more highly-compensated, procedure-oriented specialist careers (21-25).

### *The Patient–Physician Relationship*

A sustained long-term patient–physician relationship in which each interaction strengthens the foundation for the next is fundamental to developing the trust and respect required for full, open, and collaborative communication within each clinical encounter. That communication is crucial to providing quality health care. Despite the dramatic changes in the health care environment over the past twenty years, the vast majority of Americans have demonstrated a consistent preference for a sustained relationship with a primary care provider (26). Recent studies suggest that the existence of a continuous patient–physician relationship may reduce emergency department use (27) and total health care costs per patient (28). Furthermore, sustained patient–physician relationships correlate directly with patient compliance, improved health, positive outcomes, and reduced malpractice litigation (26).

Research has repeatedly demonstrated a strong correlation between patient satisfaction and physician satisfaction, both with the clinical interaction and with practice in general. Likewise, the degree of physician satisfaction correlates directly with the extent to which his or her patients are satisfied with their care (6,18). Furthermore, critical medical outcomes such as accurate prescribing practices, patient compliance, and high quality-of-care are all related to physician satisfaction (38). It is clear that the degree to which the complex changes in the health care environment impede the development and maintenance of strong, mutually-satisfying patient–physician relationships has important consequences for health care access, quality, and efficiency.

Trusting, intimate relationships with patients have suffered in the evolving health care environment. The financial and bureaucratic complexities of relationships between physicians and private and public payers are difficult for patients to comprehend, and administrative and coverage issues can cause substantial stress within patient–physician relationships. Despite the ethical implications, some physicians, with their patients' support, feel pressured to mislead insurers to gain coverage for specific services (29). This is primarily because pursuing arduous appeals processes to obtain coverage for non-approved services has adverse consequences for both patients and physicians in that it reduces time available for patient care and leaves physicians vulnerable to being dropped from often crucial provider networks. Their highly publicized role as stewards of limited health care resources creates further stress within patient–physician relationships when physicians must say no to specific care their patients may demand (25,30,31). Finally, while the majority of physicians report being financially neutral when making treatment decisions, nearly one third of those responding to a recent national survey reported not offering patients relevant services because of coverage restrictions; 35 percent of those reported doing so with increasing frequency over the past five years (32).

The cumulative impact of these pressures is that many physicians report being perceived by patients as adversaries rather than advocates (33). One com-

mentator clearly summarized patient concern regarding physician loyalties in the current environment: "In a system in which the sick are stigmatized as costly and physicians are charged with keeping costs down, can I trust my doctor to take good care of me when I'm sick?" (34).

Unfortunately, the changing health care environment has also substantially diminished the continuity of patient–physician relationships. Ties between provider networks and both physicians and patients are tenuous, subject to interruption at any time due to business decisions, contract negotiations, job changes, employee benefit plan changes, etc. As many as one in six patients change insurance coverage each year, often forcing a change in primary care physician (35). Twenty-five to 30 percent of managed care enrollees report experiencing discontinuity with their primary care physicians within a two to three year period (30). The growing ranks of physician employees versus practice owners leave patients more vulnerable to physician turnover due to employer business decisions or physician dissatisfaction.

Generalist physicians are increasingly concerned about health care fragmentation and its impact on quality care and patient–physician relationships. While the delegation of routine care and physical exams to nurse practitioners and physician assistants may be an efficient, effective means of allocating limited resources, it must be done appropriately in order to avoid distancing the generalist physician from his or her patients (4,25). As patients rely increasingly on subspecialty care, coordination and collaboration between primary care physicians and specialists often falls short of preserving continuity of care (18,25). While the growing hospitalist movement is having a positive impact on the cost and quality of inpatient care, it can best serve patient needs and protect physician satisfaction only if effective professional communication fosters the continuing involvement of primary care physicians in their patients' hospital care. And, while spending less time in patient interaction and relying more heavily on scans or lab tests may be more time efficient, the potential imbalance between technology and the art of physical examination and patient interaction raises quality-of-care and ethics concerns (36). The potential impact of these developments on the internist's historic strength in treating the whole patient, across both time and settings, is unclear.

Whether direct from clinic administrators or the indirect result of decreasing reimbursement rates per clinical interaction, perceived pressure to fit more patient visits into shorter time intervals is having a significant negative impact on patient–physician relationships and on career satisfaction (7,18,37-39). While time pressures are a source of dissatisfaction in many fields, the problem is compounded for general internists whose primary role is providing comprehensive, integrated care (34). This issue will become even more troublesome with the aging of the population and the critical role internists play in diagnosing, treating, and managing the complex, chronic conditions affecting older adults (40,41). One study found that, while specialists spent an average of 51 minutes on a new-patient visit to focus on a single organ or system, general internists were able to spend an average of only 39 minutes to build the foundation for a long-term therapeutic relationship with a new patient; conduct a complete history and physical exam; provide routine screenings and preventive care; provide counseling; assess, discuss, and define treatment plans for multiple problems; evaluate relevant psychosocial factors; discuss the risks, benefits, and potential treatment interactions of relevant alternative and complementary medicines and; address any coverage issues related to new and ongoing treatment (4).

In stark contrast to physician perceptions, studies indicate that the average time-per-patient visit has increased over the years, regardless of whether the

practice is fee for service or HMO, the care primary or specialty, the patient new or established (42). The impact of the administrative time-per-patient visit and time outside the clinical encounter for charting, reading x-rays, reviewing lab results, etc. is unclear and merits further study (33). Time pressures most likely stem from a variety of issues including: the growing health demands of a more informed patient population; the complexity of choosing among varied treatment options for each condition; the level of communication required for collaborative decision making; the ever expanding standards for preventive care; the impact of direct-to-consumer advertising of prescription drugs; and media coverage of medical innovations and the proliferation of health information readily available on the internet (14,37). While patients need to be well informed about financial and coverage issues relating to treatment options, the need to advocate for and inform each patient of those issues also contributes to time pressure within clinical encounters (12,37).

Time pressures, whether real or perceived, can manifest themselves in the physician's attitude and behavior within the clinical interaction as:

- Interrupting the patient and controlling the agenda;
- Impatient, rushed manner impeding collaborative exchange;
- Less attention to critical psycho-social issues;
- Less active listening;
- Diminished ability to demonstrate respect, advocacy, and loyalty for the patient;
- Limited opportunity to honor patient autonomy and share decision making;
- Limited ability to adequately prepare patients to give truly informed consent;
- Inadequate discussion of advance care planning and end-of-life issues;
- Diminished ability to treat each patient as a unique and valued individual.

Unfortunately, the cumulative effect is diminished quality of care and a far less satisfying relationship for both patient and physician (37).

### *Exercising Clinical Judgment*

The ability to exercise independent clinical judgment has also been strained significantly by the complex changes in the health care environment. Physicians almost universally report a loss of control over every aspect of practice, including clinical decision-making, access to medically necessary services for patients, freedom to spend adequate time with patients and to maintain ongoing patient relationships, and ability to consult freely with other physicians (4-6,18,20,43-45). Direct-to-consumer advertising that results in patient demands for specific treatments that may not be appropriate has strained both the patient–physician relationship and independent clinical decision-making (14,46). While physicians appreciate the potential cost savings of restricted formularies, the sheer number of different formularies confronting them and the variable complexity of the restrictions strain physician autonomy to choose what is best for each patient and add substantial administrative burden to physician practices.

These complex challenges to traditional concepts of clinical autonomy constitute the single strongest predictor of career dissatisfaction among physicians (5,18,20), accounting in large part for a 50 percent increase between 1996 and 1999 in the number of primary care physicians reporting being somewhat to

very dissatisfied with practice (6). In fact, in one study of physician satisfaction, the negative impact of health care environment changes on physician satisfaction disappeared after controlling for their effect on professional autonomy (20).

### *Knowledge/Competence/Excellence*

Ongoing changes in the health care environment bring multiple challenges to bear on professional obligations to maintain up-to-date medical knowledge and skills and to advance, share, and consistently implement appropriate new knowledge in order to foster excellence in health care delivery (10). These challenges are especially rigorous for internists, whose strength is their ability to evaluate and thoughtfully integrate medical and social histories, directed physical exams, and results of carefully chosen tests and then apply a broad current knowledge base to diagnose and develop tailored therapies for patients with multiple, complex diseases. Maintaining this skill set will be increasingly important as the aging population seeks coordinated care for the chronic conditions affecting older adults. Providing that care requires research, contemplation, comprehensiveness, analysis, and a dedication to developing trusting patient–physician relationships, all of which take time (2).

The time pressures discussed earlier also limit internists' options for engaging in research, teaching activities, and professional interaction with colleagues (10). The trend toward hospitalists providing acute inpatient care can isolate general internists within their offices, further limiting valuable interaction with specialists and other professionals within the hospital setting. In addition, this isolation can contribute to generalist dissatisfaction by exacerbating conflicting perceptions between generalists and their procedure-oriented colleagues regarding relative professional status (4).

### *Advocacy and Social Responsibility*

Today's health care environment makes the physician's role as advocate for each individual patient significantly more challenging. Financial disincentives regarding referrals for specialist consults, diagnostic testing, and procedures, together with limitations on the pool of physicians, hospitals, and services available for referral can restrict the physician's ability to provide each patient with access to the most appropriate diagnostic and treatment options for his or her condition. Cumbersome procedures for obtaining approvals or certifications or appealing coverage denials can be time consuming and divert precious time away from direct patient care.

Fortunately, recent tracking of pro bono care shows little or no decline in the overall level of charity medical care provided (47) and a recent study estimated that ACP-member internists in private, office-based practices provide approximately 2.6 million hours of care (10.2 million patient visits) to the uninsured annually. However, the changing health care environment will continue to pressure physicians to cut back on or discontinue providing charity care (48). Payer-imposed price discipline severely restricts the ability to cross-subsidize charity care, and the risk of exclusion from crucial payer contracts is a strong disincentive to serving a high percentage of uninsured patients. Internists with ownership in solo or small-group practices provide the most charity care, primarily because they have the discretion to accommodate those patients unable to pay (48). Consolidation into larger corporate or hospital-owned practices restricts that discretion (49).

## V. Conclusion: Renewing Medical Professionalism by Focusing on the Patient–Physician Relationship and Committing to Comprehensive, Coordinated Care Across the Aging Continuum

In trying to adapt to the stresses of the current health care environment, internal medicine may be losing some of its historically strong sense of identity and direction (50). As a result, it may no longer be clear to internists, their patients, payers, and colleagues exactly what role internal medicine is uniquely able to fill (51). Revitalizing internal medicine will require defining a shared vision of the role internists should play in providing quality patient care. Developing that vision will require:

- Examining what adult patients want and need from the health care delivery system;
- Assessing the skills and expertise of both general internists and subspecialists;
- Defining a strategy by which internists can direct their talents toward providing the integrated, comprehensive care adults want and need across the aging continuum.

The shared vision of internal medicine should build upon the profession's strength as an integrating, cognitive specialty and its knowledge base in preventing, diagnosing, and treating complex conditions (52). It must be consistent with the profession's traditional dedication to providing comprehensive care for the whole person, investing in strong, sustained, collaborative patient–physician relationships and being patient advocates (3).

While internists possess the diagnostic and preventive skills important to healthier young and middle-aged adults, their skills are especially relevant in caring for older patients with multiple diagnoses, which must be viewed in the aggregate in order to accurately assess and meet health care needs. Between 2000 and 2030, the number of Americans over age 85 will increase from 4.2 to nearly 9 million and the challenge of caring for elderly patients with multiple chronic illnesses will soon be one of the major issues in health care delivery (53). This patient population requires a coordinated, "big picture" approach to complex care, including curative and palliative treatments to stall disease progression and relieve symptoms as well as coordinated specialty care to enable maximum daily functioning and quality of life (54). General internists and their subspecialist colleagues, working in partnership, can provide that care.

Internal medicine has an opportunity to replace the trend toward fragmented, episodic health care with a coordinated team approach to promoting health, preventing disease, managing complex chronic conditions, and facilitating maximum functioning and independence throughout life. General internists and subspecialists can build upon the concept of "Doctors for Adults" by making a joint commitment to improving communication and working in partnership towards maximizing patient health. Enduring, collaborative relationships with patients should provide the context within which the internist's knowledge of medical history, lifestyle, psychosocial factors, and values are crucial to recognizing emerging health problems or worsening symptoms, identifying contributing factors, and adjusting treatment plans to appropriately address both acute problems and progressive deterioration due to chronic illness. Those relationships also foster patient comfort, trust, and compliance when specialist intervention becomes appropriate. This is especially true when the generalist clearly explains the goals of specialist care and when both the

generalist and specialist demonstrate mutual respect and a joint commitment to overall continuity of care.

The trust and respect of patients, colleagues, and the public are also essential to attracting students to internal medicine and to sustaining long-term career satisfaction. Preserving that trust requires consistently strong individual patient–physician relationships as well as repeated public demonstrations of the profession's good faith through consistent displays of competence, caring, and accountability (55). By focusing their professional commitment to excellence on the following four areas, individual internists and their professional organizations can preserve and strengthen patient, collegial, and societal trust and respect.

- A well–articulated, profession-wide commitment to advocating for patients and for the patient–physician relationship.

- A commitment to enhanced communications with patients and colleagues in order to foster health care partnerships and improve coordination of the health care team.

- A renewed commitment to "mastery," both in expanding and applying the internal medicine knowledge base and in developing and implementing improvements in the processes and coordination of care.

- Development and implementation of performance measures linked to quality improvement and accountability in a manner that respects the patient–physician relationship.

For its part, society must provide the appropriate context for delivering health care.

- Health plans, purchasers, government, clinicians, and patients should all recognize the importance of and provide consistent support for sustained, intimate patient–physician relationships within which physicians can fulfill their ethical obligations to patients.

- All parties to health care delivery should foster an ethical health care environment, including universal access (56,57) and a reimbursement mechanism that encourages physicians to take the time required to provide and coordinate appropriate care for adult patients throughout the aging process (12).

Revitalization of internal medicine requires a profession-wide commitment to overcoming environmental barriers to providing comprehensive, coordinated quality care for adults throughout life. Internists, both individually and collectively, must clearly articulate internal medicine's identity to patients, medical students, other health care system stakeholders, and the public. Leadership must support internists in defining, promoting and fulfilling their shared vision and in achieving the prerequisite system reforms. By keeping strong patient–physician relationships and patient needs as its focus throughout the revitalization process, internal medicine can remain true to the essential values of medical professionalism.

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