

The Medical Profession in Today's Health Care System

Several surveys and commentaries in recent years have described physicians' concerns about developments in the health care system. The focus is often on clinicians' frustrations with specific structures and processes of medical management, their misgivings about risk-sharing reimbursement arrangements, and their resentment over the erosion in physicians' autonomy. The broader context, however, has to do with the fundamental attributes of the medical profession.

Three thoughtful articles published in 2000 consider aspects of being a physician in the changing health care environment. Each author addresses the conflicts between traditional models of physician roles and functions and the constraints and demands of the contemporary system. The authors suggest new frameworks and ways of thinking about the profession that they believe will benefit not only physicians but also patients and the health care system as a whole.

1. Mechanic D. Managed care and the imperative for a new professional ethic. *Health Affairs*. September/October 2000;19(5):100-111.

David Mechanic acknowledges that many physicians are unhappy with managed care and its structures and incentives. However, these operational elements emanate from larger external systemic factors: cost issues and resource constraints; patient empowerment and access to information; and growth in knowledge and information about clinical care. "Doctors must weigh treatment decisions more consciously in light of costs. Patients are better educated than before and come to physicians armed with information

from the media and the Internet, expecting more participatory relationships. The complexities resulting from growth in knowledge and technology, the magnitude of information, complex reimbursement incentives, and new expectations and demands require innovative approaches to communication, coordination, and quality assurance."

These trends are irreversible, so physicians need to adapt. Mechanic calls for a new professional ethic and accompanying efforts within medical education to provide socialization consistent with the new environment. He describes the most important elements of the new professionalism as 1) new forms of patient advocacy, 2) responsibility for population health, 3) the forging of new patient partnerships, and 4) participation in an evidence-based culture.

Physicians have traditionally served as advocates for their patients. Mechanic would retain this role despite increased tension resulting from new economic incentives and allocation responsibilities. The challenge is to fairly represent patients' interests while distributing care equitably to a population. To this end, he recommends structures of procedural justice and conditions of fairness, including honesty among parties and appropriate incentives. Regarding population health, he advocates closer relationships and shared interests among public health practitioners, physicians, and health plans.

New patient partnerships are a response to patients' demand for more collaborative relationships. Since, in addition, evidence

shows better health outcomes resulting from these relationships, physicians need to acquire the necessary interpersonal competencies. Finally, evidence-based culture and practice are an antidote to the large amount of unjustified variation that continues to exist. Physicians need to demonstrate clear rationales for their decisions.

Mechanic concludes with an appeal to academic medicine to embrace these principles for the sake of future generations. “The new professionalism will depend most on the perspectives that doctors bring to their work. Thus, professional education and socialization are crucial to its success. While many educators are making efforts to prepare trainees for their likely futures, many of our most accomplished doctors are still fixed on illusory efforts to recapture the past, making it more difficult for student physicians to learn to exercise a new professionalism.”

Health Affairs can be found at <http://www.healthaffairs.org/>. This article is also available at Medscape, <http://managedcare.medscape.com/ProjHope/HA/public/HA-journal.html>

2. Minogue B. The two fundamental duties of the physician. Academic Medicine. May 2000; 75(5): 431-442.

Brendan Minogue, MD, focuses on one of the considerations in Mechanic’s article: patient advocacy. He describes traditional medicine as a single-stewardship model in which it is the single fundamental duty of the physician to secure the individual patient’s best interests and wishes. However, he argues, this model is not sustainable in a resource constrained environment. Also, it creates inevitable conflicts between physicians and payers. Minogue presents and recommends an alternative view: a dual-stewardship model in

which physicians “have two fundamental duties: they must balance the interests and wishes of the patient with the welfare of the health care system in which they practice.”

Physicians must assume a role of rational distributor of scarce resources. The practical implication of the dual-stewardship model is “a shift away from seeking to fulfill the patient’s interests and wishes at any cost toward seeking the best health care value for the patient.” Value is a function of both cost and quality; given different treatment options, the one that is more effective and less expensive has the greater value. Minogue does not equate being a steward of the system with acquiescence to health plan policies and structures; if health plans compromise the commitment to the patient, then physicians should resist the plans in which they practice. He also explains how this model of professionalism will yield beneficial consequences in certain areas, including improved end-of-life care and more scientific knowledge and effective approaches to difficult clinical situations.

Academic Medicine’s website is <http://www.academicmedicine.org>.

3. Fisher B. Physician autonomy in the managed care era: the physician-citizen or subject? *Journal of Medical Practice Management.* March/April 2000;15(5):256-261.

Brent Fisher, MBA, analyzes a different aspect of physician life: the organizational structures within which physicians work. He describes how the evolution of the industry and organizational structures of medicine has impacted physicians and changed their status. In the traditional model, physicians enjoyed autonomy and control over their decisions through owned, self-governed, small, or solo

practice. Fisher characterizes this circumstance as “citizen” status.

The newer model is marked by large organizations, medical groups and networks where physicians are employed or otherwise accountable to managers and leaders outside their own unit. These organizations typically adopt business strategies of consolidation and centralization. The result is diminished physician independence, autonomy and decision-making, which Fisher refers to as “subject” status. This contributes to physicians’ frustrations and disenchantment with their profession.

Fisher contends that there is a way to reconcile the autocratic nature of large organizations with the benefits of traditional citizenship. The key lies with the organizations’ principles of governance. He states that “the implementation of federalist principles of governance in medical structures will permit physicians the same citizen decision rights enjoyed as owners in small and solo practices.” Federalist elements such as participatory decision-making and physician control over local units within a larger organization will help maintain citizenship, physician commitment, and professional satisfaction.

The Journal of Medical Practice Management’s website is www.mpmnetwork.com. Note that selected articles are available online, but Fisher’s article does not appear.