Medical Professionalism in the 21st Century: Perspectives from Employers, Primary Care Physicians and Patients

Therese Zink, MD, MPH and Roberta E Goldman, PhD*

Department of Family Medicine, Warren Alpert Medical School of Brown University, Providence, Rhode Island, USA

Abstract

Purpose: The increasing numbers of employed physicians and the for-profit nature of health care in the United States raise serious concerns about medical professionalism and commitment to patients. We explored the impact of current business pressures on professionalism by interviewing executives, primary care physicians, and patients from health care organizations across the US.

Methods: We purposively sampled health care executives (HCEs), family physicians (PCPs), and patients with chronic illnesses (triads affiliated with the same health care organization, when possible), with attention to: Rural/urban locations; diversity in gender, age, race; and organizational status including for-profit/not-for-profit, majority physician leadership/ non-physician leadership, and academic/ non-academic. Questions were developed for each category, and telephone interviews were conducted between May and July 2019. Data were analyzed using immersion/crystallization qualitative analysis techniques.

Results: Twenty-four interviews were conducted: 7 HCEs, 9 PCPs, 8 patients. Some organizations intentionally support professionalism with continuous quality improvement strategies including routine measuring/monitoring, and involving practicing physicians in business decisions. Physicians without active organizational support design their own coping methods, including decreasing clinical hours. Patients value physicians who listen and act on what they hear, and patients blame insurers rather than organizations or physicians for lapses in care. All view patients as an insufficiently-tapped resource to guide changes for keeping patients at the center of care.

Conclusions: Since a strong moral compass is not enough, organizations must support professionalism and identify meaningful ways to include practicing physician and patient input into decision-making to promote value and quality throughout their health care systems.

Keywords

Medical professionalism, Value in health care, Physician-patient relationship, Patient care, Quality of care, Organization of care, Health care delivery transformation, Physician well-being

Introduction

Today, more practicing US physicians are employed than self-employed [1]. Physician employment status and the increasingly for-profit nature of health care raise serious concerns about the profession of medicine and its duty to patients [2,3]. While the triple aim of primary care emphasized value for cost and patient experience [4], the quadruple aim includes physician satisfaction into the integrated whole [5]. Patient safety, quality of care, and physician burnout were identified as important aspects of professionalism prior to Covid-19 [6,7]. With pandemic onset, challenges to maintaining professionalism have been exacerbated [8]. To better understand impediments to professionalism stemming from the business pressures on health care prior to the pandemic, we interviewed health care executives (HCE), primary care physicians (PCP) and patients.

Materials and Methods

Individual, semi-structured, qualitative interviews were conducted between May and July 2019 with HCEs, PCPs, and patients with chronic illnesses. Interview guides were developed for each participant category. Purposive, stratified cri-

SCHOLARS.DIRECT

teria-based sampling [9] was used to recruit triads of participants affiliated with the same health care organizations, when possible, from across the US with attention to geography; rural and urban locations; diversity in gender, age, race; and varied organization status of for-profit, not-for-profit, majority physician leadership, non-physician leadership, academic and nonacademic. Potential participants were contacted by email, and if willing, a telephone interview was scheduled. After obtaining verbal consent, a 30-60 minute audio-recorded interview was conducted. Only patients received a $50 gift card. The American Association of Family Physicians institutional review board approved the study.

Data analysis

We analyzed the data for content, patterns and themes using the immersion/crystallization technique for qualitative analysis [10]. This entails repeated reading of interview notes, listening to interview recordings and sorting data into topical categories for further analysis and identification of patterns and themes. We discussed our emerging interpretation iteratively as interviews were completed, and through the final presentation of results.

Results

Twenty-four interviews were conducted with 7 HCEs, 9 PCPs and 8 patients. Median years out of medical school was 13, ranging from 9 to 24 years (Table 1). Findings from HCEs and PCPs are grouped together as most of the executives were also physicians, and their responses addressed similar themes. Patient-specific findings follow. Patient advocacy was discussed by all three participant categories and is presented separately.

Health care executive and physician interviews

HCEs and PCPs defined professionalism as "How they and others treat patients, colleagues and staff"; and "It has to do with integrity, ethics, respect, dignity and compassion." Some HCEs linked their definitions to the values and missions of their organizations. Both HCEs and PCPs spoke about "putting the patient first," "keeping the patient at the center of care," and "keep the patient as our North Star." Physician educators discussed helping learners develop self-reflection and manage communication in today's digital world.

HCEs and PCPs reported positive and negative impacts of business pressures on professionalism. They described how

Table 1: Participant demographics for health care executives, primary care physicians and patients interviewed.

	Health Care Executive (HCE) n = 7	Primary Care Physician (PCP) n = 9	Patients n = 8
Gender	F = 2; M = 5	F = 5; M = 4	F = 3; M = 5
Race/ethnicity Caucasian	6	7	7
Hispanic	1	1	
Black	0	1	1
Geographic Location Northeast	1	2	2
Midwest	2	2	2
Plains	1	1	0
Southeast	1	2	1
Southwest	1	1	1
Northwest	1	1	2
Community: Urban/Rural	Urban = 5 Rural = 2	Urban = 7 Rural = 2	Urban = 5 Rural = 3
Age median (range)	45 (38-66)	Not collected	57 (26-87)
Years since medical school graduation median (range)	6 = physicians 28 (18-40)	13 (9-24)	
Health Care Organization type	For Profit- 2 Not For Profit-4 Federally Qualified Health Center-1 Academic-2		
Majority Physician Leadership	Yes-4 No-3		

Note: We interviewed 24 individuals which represent five complete triads-HCE, PCP and patient from the same organization. We were unable to reach the HCE of one PCP. Three PCPs were not willing/unable to provide patient contacts. One HCE worked in the hospital and did not have a panel of PCPs appropriate for the scope of this study. An additional PCP and patient were secured from two different triads.

their organizations assist physicians in maintaining professionalism and/or physicians' independent strategies, and outlined issues to consider going forward. Following are the positive impacts, negative impacts, organizational assistance and independent strategies.

Positive impacts of today's business pressures: HCEs and PCPs described what we term patient focus factors--changes that enhance the patient experience, as well as value-based care efforts that link quality and cost. They viewed the organization's emphasis on teamwork as adding value to their work. The teamwork focus is the result of patient-centered medical home (PCMH) activities and continuous quality improvement efforts. Participants' examples of how focus on the patient improves care quality and helps manage cost include: Same day access, attempting continuity with the PCP or team, online communication portals allowing for timely contact, sharing test results, and proactive patient outreach after emergency department (ED) visits or hospital stays. One HCE explained:

"We work with the doctors and nurses to create a list of at-risk patients leading up to the winter holidays so the case manager can try to preempt ED use by calling patients to ask how they are doing, inform them of holiday clinic hours, make appointments as necessary, and remind them to get flu shots. Medical staff really appreciates it. . . Patients like it too."

Participants explained that this type of patient outreach was encouraged with the introduction of PCMHs and Accountable Care Organizations (ACOs), and accomplishes several goals which were inadequately addressed in the past: Encouraging patient compliance with health prevention recommendations, completing quality indicator activities (e.g. getting a flu shot for high risk patients), and avoiding expensive ED visits by offering timely appointments.

An HCE who was also a chief medical officer (CMO) and continued patient care explained how the focus on value-based care drives new physician behaviors and benefits patients.

"We have to worry about our finances because we have value-based contracts with insurers. This value-based journey aligns us with patients in a more holistic way. We have to make sure we are providing both high quality and affordable care. Historically, medicine has not focused here . . . We order things and don't know the cost. This weekend in the ED, I talked with a patient who could have had a CT scan to further evaluate her problem. I told her: 'We have this concern, the only way to know for sure is a CT-but we also worry about radiation and the cost.' The patient decided to forgo the CT. She was fine, and I knew she'd come back if something changed. We have great continuity and we know our patients. This was a more shared decision than I might have done in the past. The value and cost realignment is providing more opportunities to do this."

Another HCE/CMO who worked in a hospital explained how efforts like the Joint Commission had improved the work environment: "[There is much more] honesty among staff. Unprofessional behavior is no longer tolerated, even among certain specialists. Staff knows they can speak up and that they will be heard." In settings where organizations invested in creating teams, physicians described having scribes and/or well-trained office staff with a customer service approach, which took some burden off physicians. One PCP stated, "It gives me time so I can think and feel less rushed."

Negative impacts of today's business pressures: Most HCEs and PCPs discussed how "physicians are in survival mode" and "burned out." They described negative factors such as volume and productivity pressures, electronic health record burdens, complexities of the current system, and persistent undervaluing of primary care. Several worried that the pressures were affecting the physician's ability to care and deliver high quality patient care.

One HCE asserted, "The volume-driven world doesn't work." Another noted the negative impacts of "managing costs by securing permission with prior authorizations and gathering specific data on what physicians are doing to improve management functions" as making "physicians feel like professional documenters who also give medical advice." One PCP summarized his frustration with the complexity:

"Sometimes I feel like I'm working at an airline and by the time someone comes to me they're already frustrated with other things that have happened. By the time they get to my counter. I can be as nice as possible and they'll still be frustrated and feel screwed. Their insurance won't cover the med. They can't get in touch with the nutritionist I referred them to. Their food budget will only go so far. They've hit all these barriers. Their frustration is obvious. And the whole health care system reflects on me, the individual provider. The bills, the fees, the referrals have become so complex and difficult to navigate, and the patient is fed up."

A HCE commented on how the "current payment model has not kept up with delivery system changes. Procedures are rewarded over thinking, and disrespect for PCPs shows up in subtle ways." One PCP reported two different specialists refusing to do prior authorizations for medications they had prescribed, so the prior authorizations came back to the PCP to complete. "I guess doing prior auths is beneath them," she concluded.

Several HCEs/CMOs stated that physician burnout was limiting "emotional generosity to help each other, and this is not just millennials." Another HCE/CMO reported: "People are worried when the physician seems not to care. This is emotional withdrawal . . . I get complaints about physician behavior, and when I dig in, I find it had nothing to do with the patient, but the physician couldn't separate [a difficult encounter] from affecting this [subsequent] interaction."

Organizational efforts and individual physician strategies to support professionalism: Many participants described proactive steps their organizations are taking to address concerns about burnout and other threats to professionalism. Organizational efforts to support professionalism include maximizing physician time with patients by hiring scribes to limit physician data entry; hiring case managers and well-trained medical assistants and nurses; providing coding sup-

port; and offering patient call centers. Other priorities are: improving EHR efficiency by "making every [computer] click matter," using meeting time well and taking the opportunity to "align purpose and values." Several HCEs/CMOs asserted that non-physician executives must be educated about clinical realities. One explained her efforts at her health system, and as a result, "Admin has softened the productivity talk."

Several HCEs/CMOs were intentional about engaging PCPs in leadership. Another recognized the PCPs as "lonely and isolated" due to their heavy workloads, and created venues for discussion and support. Several CMOs characterized professionalism lapses as predominantly a lack of self-awareness, and stated they approach conversations about lapses as learning opportunities. Others routinely measure and monitor wellbeing. Physicians who reported no organizational efforts to support professionalism described strategies they

Table 2: Themes and Quotations illustrating Organizational Strategies and Individual strategies primary care physicians employ to maintain their professionalism when there are no health care organization efforts.

Organizational Strategies	
Engage PCPs in leadership	"Engaging our PCPs in the leadership process. Instead of finding new ways to tell physicians what to do, [we] engage them, give them a spot at table, help us to navigate out of this mess. . . as a result we've seen improved morale and improved measures of physician burnout and wellness." --HCE/CMO
Unload physicians' administrative duties	"We try to limit their (PCP) administrative work . . . so physicians can do what they do best-care for patients." --HCE
Measure and monitor	"Our organization measures physician burnout quarterly with the Mayo Clinic Well-Being tool[1] and reports results to administration. I have a coaching conversation with physicians who score poorly, and the physician group uses a process improvement approach [with group results]. This has taken burnout from 60% to 18%, just below what a standard worker is in a non-health care setting." --HCE/CMO
Address isolation	". . . to address the loneliness and isolation we sponsor regular gatherings to replicate what happened in the doctor lounge of old, where physicians have the chance to talk and support each other. . . we have other sessions for doctors and nurses together . . . to enhance teamwork. . . " --HCE/CMO
Continuous learning opportunity approach	"I use the Just Culture construct[2], I learned it from this patient safety work. When I approach a physician with a professionalism issue, I talk about it as a *learning event* we discuss: 'What was within your control and what was not? What was your behavioral piece?' The system factors need to be owned by me, the CMO . . . This has done a lot to elevate the level of discourse here. We don't blame, we examine what needs to change. The individual needs to own their behavioral piece, self-reflection is important, but we also need to make system changes to support professionalism. . . What can we learn from learning events, which are not necessarily mistakes? . . . Highly professional individuals have an interest in continuous learning and use self-reflection to learn from these opportunities." --HCE/CMO
Independent Strategies	
Maximize control where possible	"I may be more proactive than some colleagues, but I take it upon myself to interview office staff. I enjoy the administrative component. I rearranged the schedule template so that I maintain the every 15-minute appointment requirement, but it flows in a manner that works for me. I've balanced the needs of administration, my wife and myself." --PCP
Switch from revenue-based to flat salary	"I had revenue-based compensation—a challenge, you think differently and, there are different pressures. The administrators say, you should take as much time as needed with patients, but on the other hand you should see 25 people [a day]. There was a salaried position available at another clinic in the organization, so I moved." --PCP
Decrease clinical time	"I felt defeated at the start of the day and my frustrations were making it hard to be professional. Decisions are made by those above me. The CMO doesn't do much patient care so she doesn't get it. I had to do something. I was burned out. . . I decreased my clinic time to two days, and found an outside administrative job and I do some teaching. . . I recognized what I could control and what I could not." --PCP

[1]Mayo clinic Well-being tool

[https://www.mayo.edu/research/centersprograms/program-physician-well-being/mayos-approach-physician-well-being/mayo-clinic-well-beingindex.]

[2]Just Culture construct [https://www.centerforpatientsafety.org/david-marx/]

established for themselves. These include attempting high levels of control over their schedules and staff, moving to flat salary positions, and cutting back on clinical time. See Table 2 for exemplary quotations.

Patient interviews

Patients focused on what they saw as "good care," their perceptions about how the organization helps or hinders PCPs in providing good care, and their experience with and expectations about specialist referrals.

Patients' descriptions of "good care": The most pervasive comment from patients about what good care means to them was they want "the doctor to listen." They also said they want the physician to: Be personable, knowledgeable, straight-forward, and act on what s/he hears. Patients want their "needs recognized" by physicians, and "to be taken seriously." As an older patient asserted: "I know a lot about my body after all these years." Most patients said they prize continuity with a PCP, but several changed physicians or clinics to find a physician they could trust. In contrast, the youngest patient said she values convenience over continuity and uses express care for her medical needs.

Experiences and expectations with specialists: Many of the same characteristics desired in a PCP were cited as important in specialists. However, a "knowledgeable" specialist is most important for many patients, and some said they are willing to tolerate poor interpersonal skills if they feel they are getting "good care" and the answers or referrals they need. A patient living in a rural area explained, "I was not heard, not taken seriously. But he ordered the tests I needed and referred me to the neuropsychologist . . . I got what I needed."

Pros and cons of care styles today: Patients said they value friendly and helpful front desk staff and nurses. Many, even our oldest interviewed patient (87 years), said they like using the electronic patient portal to communicate with doctors. Several mentioned reading physician reviews and profiles online. However, one cancer patient expressed suspicion of the practice's marketing efforts:

"The organization makes so much money off cancer. They do a lot of advertising to capture the patient. We're supposed to have a team. You get this brochure that lists your team . . . It's a crock . . . Maybe they share some notes, but not how the patient is coping."

Patients uniformly stated they hold insurers responsible for barriers to good care rather than blaming the health care organization, their physicians or clinic staff. This included patients who receive care in clinics where there is no organizational support for maintaining professionalism.

Role for patient advocacy-HCEs, PCPs and patients

Some patients and physicians advocated for an enhanced role for patient self-advocacy and involvement in health care transformation. A 69-year-old patient talked about empowered patients:

"You need to tell [doctors] what you expect of them as

well. 'It's my body. We need a partnership.' A person needs to be proactive . . . know what's going on . . . what the meds are, what the side effects are."

A PCP educator tells her residents: "Dealing with all the uncertainties we do in ambulatory care, we need to encourage patients to call if something isn't right. The patient can act as a whistle blower during these chaotic times." A HCE/CMO discussed the missed opportunities that occur when patients are engaged only as tokens on ACO boards and PCMH committees.

"Unfortunately, our organization doesn't really value patient input. This is a potential resource that isn't adequately tapped. Everyone but the patient is paid for coming to the ACO meetings. The patient is either retired and they're on their own dime, or has to take time off work. That's not fair."

Discussion

Findings from this study raise important challenges that organizations and physicians face in maintaining professionalism in the context of business pressures on care. We engaged a diversity of interviewees to identify perspectives and opportunities for next steps. As others have found, lifelong learning and continuous quality improvement approaches to professionalism are critical [11-14]. The importance of engaging practicing physicians in organizational decision-making and actively supporting physicians to maintain professional behavior is key. Failing to do so may result in physicians choosing to decrease clinical time [15]. Creating forums where real learning occurs, measuring and monitoring physician wellness, and providing opportunities to process concerns is essential [11,12]. Despite individual efforts physicians reported in this study, a strong moral compass appears to be important but not enough [13], and both organizational and individual efforts are essential [11,12].

A limitation is that we were not always able to recruit a HCE, PCP and patient from the same organization. We interviewed five complete triads (HCE, PCP, patient) out of the attempted eight, and thus could not analyze triad members together. With this typical, small qualitative sample size we did reach saturation, hearing similar concepts repeated [16].

While the complex environment of the Covid-19 pandemic has showcased high levels of professionalism in medicine, it has also revealed fissures and challenges which will demand ongoing exploration and discussion. These include: The underfunding of public health, price competition for critical resources such as protective equipment and ventilators [17]; the lack of planning about advanced directives and scarce health care resources [18]; and uneven telemedicine implementation [19]. In addition, the pandemic has exposed the importance of organizations providing adequate support for physicians and staff with protective equipment, reasonable work hours, and making it acceptable not to work when ill [19]. This is a new era in health care where the for-profit challenges to professionalism are further magnified and trust may be eroding for both patients and physicians [20]. In a recent survey, a quarter of clinician respondents said they anticipate the pandemic will result in "a broken sense of trust between

Zink and Goldman. Arch Fam Med Gen Pract 2020, 5(1):109-114

Open Access | Page 113 |

the public and the medical world;" and 60% believe that policies changed to support primary care during the COVID-19 pandemic will be reversed once the pandemic lessens [21].

Moving forward, whatever changes are brought to the health care environment, it is essential in value-based practice to keep patients at the center of care [22]. This includes facilitating engagement of practicing physicians in guiding system transformation and solutions, and engaging patients in meaningful ways to help chart the path forward [12].

Sources of Support

Acknowledgements

References

1. (2019) Employed physicians now exceed those who own their practices. AMA-asn.org.

2. Pellegrino ED (1999) The commodification of medical and health care: The moral consequences of a paradigm shift from a professional to a market ethic. Journal of Medicine and Philosophy 24: 243-266.

3. Kenny NP (2010) The 25th John P. McGovern Award Lecture. 40th Meeting of the American Osler Society.

4. Berwick DM, Nolan TW, Whittington J (2008) The triple aim: Care, health, and cost. Health Aff (Millwood) 27: 759-769.

5. Bodenheimer T, Sinsky C (2014) From triple to quadruple aim: Care of the patient requires care of the provider. Ann Fam Med 12: 573-576.

6. Dyrbye LN, West CP, Hunderfund AL, et al. (2020) Relationship between burnout, professional behaviors, and cost-conscious attitudes among US physicians. J Gen Intern Med 35: 1465-1476.

7. Dyrbye LN, Shanafelt TD, Sinsky CA, et al. (2017) Burnout among health care professionals: A call to explore and address this under-recognized threat to safe, high-quality care. National Academy of Medicine, Washington DC.

8. Tsai C (2020) Personal rish and societal obigatin amidst COVID-19. JAMA 323: 1555-1556.

9. Kuzel AJ (1999) Sampling in qualitative inquiry. In: Crabtree BF, Miller WL, Doing Qualitative Research. Sage Publications, Inc, Thousand Oaks, California.

10. Borkan J (1999) Immersion/Crystallization. In: Crabtree BF, Miller WL, Doing Qualitative Research. Sage Publications, Inc, Thousand Oaks, California.

11. West CP, Dyrbye LN, Shanafelt TD (2018) Physician burnout: Contributors, consequences and solutions. Journal of Internal Medicine 283: 516-529.

12. Rothman DJ, Blumenthal D, Thibault GE (2020) Medical professionalism in an organizational age: Challenges and opportunities. Health Aff (Millwood) 39: 108-114.

13. Lesser CS, Lucey CR, Egener B, et al. (2010) A behavioral and systems view of professionalism. JAMA 304: 2732-2737.

14. Leach D (2014) Transcendent professionalism: Keeping promises and living the questions. Acad Med 89: 699-701.

15. Dewa CS, Jacobs P, Thanh NX, et al. (2014) An estimate of the cost of burnout on early retirement and reduction in clinical hours of practicing physicians in Canada. BMC Health Serv Res 14: 254.

16. Babchuk WA (2019) Fundamentals of qualitative analysis in family medicine. Fam Med Com Health 7: e000040.

17. Adams V (2020) Disasters and capitalism. . . Covid-19. http://somatosphere.net/2020/disaster-capitalism-covid19.html/

18. Powell VD, Silveira MJ (2020) What should palliative care's response be to the COVID-19 pandemic? Journal of Pain and Symptom Management 60: E1-E3.

19. Hollander JE, Carr BG (2020) Virtually perfect? Telemedicine for Covid-19. NEJM 38: 1679-1681.

20. Dewey C, Hingle S, Goelz E, et al. (2020) Supporting clinicians during the COVID-19 pandemic. Ann Intern Med 172: 752-753.

21. (2020) Primary care & COVID-19: Week 7 survey - primary care practices on their response to the COVID-19 crisis. Primary Care Collaborative.

22. Wynia M, Von Kohorn I, Mitchell PH (2012) Challenges at the intersection of team-based and patient-centered health care. JAMA 308: 1327-1328.

SCHOLARS.DIRECT

Zink and Goldman. Arch Fam Med Gen Pract 2020, 5(1):109-114

Open Access | Page 114 |