VIEWPOINT

What Does It Mean to Be a Physician?

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The practice of medicine is founded on a simple transactional relationship between the physician and the patient. The role of the physician has always been one of gathering patient data and treating disease, of caring and curing, and of bringing science and humanism together to benefit patients. This role has defined the profession across time and cultures. The continuity of clinical information was often dependent on the continuity of the relationship, with clinical data documented only to the degree necessary to inform memory.

Physicians were seen as community resources, but they were not responsible for community problems. Physicians focused on medical diseases and the patients who had them, not the larger world that the patients inhabited. They were often "married to their careers,"[1] sometimes to the detriment of their family responsibilities and personal health, but their job was clear. Now the job is not at all clear with the emergence of new themes of population health, health equity, social determinants of health, and work-life balance.

Most physicians have traditionally relied on their own talents and skills to meet their decision-making responsibilities, and are modest about their successes and accountable for their failures. Their work life is characterized by the cumulative effect of thousands of individual patient encounters. Medical students are selected for these traits and talents, which are then enhanced during training.

That simple role is now being challenged. Modern physicians have expectations and responsibilities not experienced by their predecessors. These expectations may seem to be natural extensions of the physician's responsibility and incrementally appropriate, but the cumulative effect is to radically alter the traditional ways that physicians have functioned. The result is a high level of identity confusion, leading to professional dysphoria and dissonance.

These disruptive forces derive from at least 4 sources: (1) a dysfunctional, profit-driven health care system that requires physicians to fulfill nonclinical functions; (2) changes in physician expectations regarding work commitments and income; (3) disruptions in relational and information continuity with patients; and (4) failure of the public health system.

A Dysfunctional Health Care System

The expensive and wasteful US health care system has caused private and government payers to burden physicians with a wide range of regulatory, financial, and productivity pressures that conflict with or are antithetical to fundamental professional responsibilities.[2] Productivity-based reimbursement systems violate the physician's duty to provide any and all necessary care to individual patients. Profit-driven financial pressures increase administrative costs and regulatory burdens on physicians and their practice finances, detracting from core clinical responsibilities.

Physicians are required to support clinical documentation systems that meet business and legal needs but have limited clinical value. Physicians are held responsible for hundreds of quality measures that are often redundant if not in conflict, not to mention expensive to measure and difficult to report.[3] Patient satisfaction measures are sometimes used to influence physician performance and income, but these measures frequently focus on whether physicians respond to patient demands, not objective measures of professional quality.

Physician decisions are sometimes overruled by nonclinical corporate personnel based on financial considerations rather than clinical metrics. Pharmacy formulary and medical device decisions are often influenced more by corporate lobbying than clinical value, constraining physicians in their ability to fulfill fundamental patient obligations.

Changes in Work and Income Expectations

Older physicians made commitments to their patients and practices that often harmed their personal health and family relationships. Many younger physicians now expect strict limits on work commitments and work hours. This is not necessarily inappropriate, and may even be laudable, but it has occurred without any compensatory mechanisms for managing informational and relational continuity to serve patient needs.

The profit-driven health care system has provided opportunities, even incentives, for physicians to develop and promote the use of medical products and treatments that conflict with professional ethical principles. Medical students have responded to medical school debt and income expectations with skewed specialty choices, practice styles, and employment arrangements that may not serve their talents or patient needs.

Disruptions in Continuity

Reimbursement pressures and organizational barriers impair patient-physician continuity during specialty referrals and hospitalizations. Despite the electronic health record, patients have often become their own information managers, relaying information from one physician to the next. Insurance contract negotiations often lead to physician network disruptions, the need for patients to restart complex treatment plans with a new set of physicians, and expensive out-of-network referrals. All of these disruptions are exacerbated in rural areas and smaller communities without a critical mass of services and physicians.

Failure of the Public Health System

An increasing awareness of the role that social, behavioral, demographic, and educational forces have on

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health care outcomes has naturally, but inappropriately, led to making physicians responsible for their solution. The focus on social determinants of health is appropriate but making physicians responsible for their mitigation is not.[4] Physicians are not prepared for this role. Health care systems do not have the requisite resources or expertise. Neither have control over the necessary interventions. Physicians are charged with leading teams of health care professionals who may be better positioned to address these sociodemographic failures for which physicians have no training or basis for leadership.

Physicians are highly educated and bring many cognitive abilities to their role, but leading multidisciplinary teams of diverse health care professionals is not usually one of those talents. This work is not consistent with, and likely detracts from, core clinical decision-making roles and medical skills. Addressing social determinants of health and encouraging health promotion and disease prevention are critical objectives of a high-functioning health care system. The current system is anything but high functioning, and physicians are neither prepared nor supported to compensate for these inadequacies.

Conclusion

Solutions to these assaults on physician identity may seem daunting, not to mention expensive and disruptive, but they simply need to focus on the primacy of the patient-physician relationship. Physician compensation plans should focus on quality, as measured by empirically tested standards, rather than volume or piecework.[5] A single-payer health care system would simplify and reduce administrative burdens. In any payer system, health care decisions need to be based on clinical, not financial, benefit. In a direct observational study of the daily work of 57 physicians in various specialties,[6] well more than half of their time was spent with computers rather than with patients. Little of that screen time enhances patient-physician communication or clinical quality and should be managed by someone else.

Job sharing could support a better balance in work responsibilities and personal health but requires creative approaches to physician-physician communication that are both explicitly and implicitly endorsed by the profession.[7,8] Primary care physicians and hospitalists need to jointly and actively manage transitions in care. Physician network participation should be based on the quality of physician performance, not skewed economic constraints.

Physicians should not be responsible for addressing social determinants of health, rather they should work synergistically with a well-funded public health system in a way that enhances the physician's primary responsibility to individual patients. The physician has an obligation at the personal and professional level to maintain the primacy of the patient-physician relationship to the greatest possible extent, but that is, in fact, what has led to so much frustration and dissatisfaction—the frustration of trying to do the right thing for patients on a daily basis when so many forces work against it.

So this is what it means to be a physician—to uphold long traditions of professional obligation, to maintain focus on the needs of each individual patient, and to protect the sacred covenant between patient and physician that has been disrupted by financial conflicts of interest, corporate employment, loss of continuity, poor communication systems, and a failed public health system. These changes have affected both patients and physicians, who should join forces to restore the primacy of the patient-physician relationship.[9]

ARTICLE INFORMATION

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