

VIEWPOINT

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Physician Professionalism in Employed Practice

The typical physician practice setting in the United States is changing. The model of the small, self-employed practice is giving way to employment of physicians by large medical groups, hospitals, health plans, and new entities such as accountable care organizations.¹ This change has created concern about the ability of physicians in employed settings to engage in self-regulation, an important component of professionalism.²

Raising this concern does not suggest that physician self-regulation, either by individual practitioners or through medical professional organizations, has been without flaws historically. Nor does it imply that hospitals and health plans or public sector payers should not exercise legal, regulatory, contractual, and voluntary accreditation-based requirements for the oversight of clinical care quality. However, it is important to assert that physician self-regulation should continue to play a central role in ensuring the quality of health care services. In addition, physician self-regulation can establish a credible platform to assuage physicians' concerns that employment will compromise the legitimate ability of physicians to guide the care of individual patients based on the patients' needs, not those of the employer.

The trend toward employment of physicians can either advance or detract from these goals, depending on how employment settings evolve. It is even reasonable to believe that new employed-physician-led

practice settings. Other principles will require significant adaptation to be useful.

Experience with the traditional large group practice model suggests 4 key elements to successful physician self-regulation in the employment setting: clinical governance, management capabilities, clinical performance information transparency, and appropriateness of financial incentives.

Clinical Governance

The use of the term *governance* refers not necessarily to the ultimate legal authority for the organization but rather to the site of determination of clinical practice patterns recommended to (or in some clinical situations required of) employed physicians. This determination should rest with the collective body of the physicians, informed by the needs of their patients, as it does in most self-governed multispecialty group practices. In other employed settings, this process will require that the physicians self-organize, ideally with the support of the employer, into some entity—functionally equivalent to a group practice—capable of establishing and improving practice patterns. Such internal physician entities can serve both the interests of the physicians by creating a nexus for collective self-regulation and of the employer by increasing the likelihood that recommended physician practice patterns will be honored as “self-determined” and ultimately followed.

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dynamics could actually produce a more robust environment for physician self-regulation than has previously been possible within small practices or through medical professional organizations.

Much can be learned from the decades of successful physician group self-regulation in such organizations as the Permanente Medical Groups³ and the Mayo Clinic.⁴ In these and other similar organizations, individual professional responsibility has been enhanced by a strong culture of group responsibility that has produced high-quality patient services and generally satisfied physicians. However, in such organizations, the physicians are self-governed, a setting that not only supports self-regulation but also may fundamentally differ from other newer models of physician employment. Thus, some principles derived from large self-governed group practices may be directly applicable to other employed-

Management Capabilities

Physician self-regulation, even within a physician-led arrangement as described, will be ineffectual without management capabilities to establish and effect needed clinical oversight and improvement. These capabilities include, among others, practice guideline development, quality measurement, quality improvement processes, cost-management capabilities, personnel management, practice workflow improvement, data analysis, and communication skills. These capabilities can be delegated to the physician entity—with appropriate resource allocation—or can be jointly overseen by the physicians and the employing organization.

To be effective in this management work, involved physicians usually will require education and training beyond those skills acquired in medical school and residency, especially leadership and management skills.⁵ Provision of resources for this education and training should be the responsibility of the employer. Knowledgeable and capable physician leaders inspire confidence in their peers, thereby, helping to create an environment conducive to the development of a physician group culture capable of self-regulation.

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Clinical Performance Information Transparency

Self-regulation of patient care quality cannot proceed without reliable and trusted clinical performance information. This includes both individual physician and group (or organizational) performance information. In the context of physician practice, such information, at a minimum, should be provided to individual physicians so that they can observe their own otherwise untallied practice patterns and results, in order to improve as clinicians. This information is most valued by physicians if they or their chosen physician leaders have been deeply involved in its creation.

Of even more value, based on large group practice experience, is the provision of this information to physicians benchmarked against peers and ideally accessible to all involved physicians (this often may be specialty specific). To be useful and credible to physicians, this information must have adequate statistical power, be risk-adjusted when appropriate, and be clear and actionable. Such clinical performance transparency, although often resisted by and even initially shocking to many physicians, has proven to be a powerful motivator of both individual and group improvement and has been a key tool for physician self-regulation.

More controversial is the question of transparency of individual-physician clinical performance information beyond the organizational practice-improvement setting. Many advocate for the availability of this information as the right of current and future patients. Others maintain that the complexities created by small sample sizes, imperfect risk adjustment, and the need for appropriate attribution in a team-based environment argue against physician-specific external reporting. There is little question, however, about the need for and legitimacy of external reporting of clinical performance information at the organization, group, or large-facility level.

Appropriateness of Financial Incentives

All forms of physician payment create the possibility of conflict with physician professionalism, especially the principle of the primacy of patient welfare and the responsibility of physicians to maintain patient trust by managing potential conflicts of interest.² Fee-for-service payment could potentially incent the provision of unnecessary services. Prospective payment arrangements such as capita-

tion and newer risk-reward arrangements could potentially incent stinting on necessary services.

Newer physician employment models have raised concerns in this regard. Some are concerned that hospital-employed physicians may be under pressure to admit patients from the emergency department who could be treated in an observation setting or as an outpatient or to discharge Medicare patients who have "overstayed their DRG [diagnosis related group]" earlier than clinically indicated. New "value-based" payment arrangements that include (generally appropriately so) a focus on cost containment, such as shared savings models, and bundled payments could create untoward pressure on employed physicians' patient-by-patient-care decisions.

This is not to say that physician and health care organizations should recoil from such new payment arrangements. However, several lessons from the prepaid large group practice experience can help mitigate potential conflicts of this sort.

First, financial incentives at the individual physician level should focus on quality and patient experience, not on the use of health care services patient by patient. Incentives directed at overall cost and the overall appropriateness of health care services are best handled at the physician-group or organizational level.⁶

Second, even physician-group financial incentives should be modest, targeted at a reasonably small percentage of projected physician income. Nonfinancial, culture-based incentives, such as group recognition for clinical excellence, are actually more powerful incentives for many physicians. In addition, substantial financial incentives (extrinsic motivation) in some circumstances may actually inhibit intrinsic motivators such as a strong personal commitment to professionalism.⁷

Third, financial incentives should be set by or with the agreement of the physicians; moreover, the structure of and general application of any incentive payment system should be transparent to all involved physicians and provided to patients if requested by them.

In summary, the recent expansion of the employed-physician model is creating new challenges regarding the preservation of physician professionalism and physician self-regulation. It is in the interests of the medical profession, employers of physicians, and especially patients that these concerns are resolved appropriately, and they can be.

ARTICLE INFORMATION

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