PRESIDENTIAL ADDRESS

Doctoring 2009

Embracing the challenge

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Doctoring faces many challenges in 2009, all potentially imperiling our professional soul or ethos of life as doctors. The field of medicine in the United States has never been more fulfilling, yet our dreams and those of our patients are clouded by a sense of unfulfilled promise and our practices are mired in policy restraints. I believe it is possible both to restore meaning to our debate with policymakers and optimism to our profession. To do so, we must rescue medical professionalism from what is becoming an entrepreneurial occupation in which we are asked to deliver a commodity. We must return our principal attention to humanity to ensure that ill humans will always be more than integers on an economic chart.

In this review, I discuss economic, medical, and social planning philosophies which contribute to our current dilemmas yet also provide insights and opportunities for their resolution. I discuss medicine's past and present responses to its challenges and outline a new method of dialogue to accomplish our objectives of better quality and more cost-effective education, research, and clinical care for all.

As the escalating cost[e1-e4] of health care in the United States exceeds that of any nation on earth, economic planning is essential. Much present-day health care delivery dysfunction is the consequence of economic manipulation of physician behavior in the absence of consideration of our ethos. I am neither against social planning with economic ends nor economic planning with social ends, but I am against both when doctrinaire, and not part of a larger humanistic whole.

Elements of recent neuroscientific discoveries serve as the foundation of my thoughts and conclusions. Our human capability and drive toward economic and social functioning confirms a biologic basis for the need for concurrent economic and humanistic planning of health care delivery. Both Glimcher[e5] and Platt and Glimcher[e6] have revealed our ability on a preconceptual cellular level to recognize value, utility, and numerosity through lateral intracortical parietal neuron firing frequency and Rizzolatti's[e7] description of the mirror neuron has revealed our ability on a cellular level to recognize intentions, expectations, and motivation. We know that these abilities are influenced by our intrinsic capacity for both selfish and altruistic behavior.[e8-e10] Kandel[e11] described the molecular basis of long-term memory formation by the synthesis of new mRNA and protein. Si, Lindquist, and Kandel[e12] have explained its epigenetic impact on our genome.[e12,e13] Our understanding of epigenesis[e13] itself, reflecting in part the consequences and the causes of our social evolution, confirms our inescapable duty and responsibility to our genetic future, vastly different from eugenics. Therefore our planning of health care delivery must be informed by a broader philosophical outlook than merely serving an immediate economic outcome, if only because the consequences of such planning will be both short- and long-term behavior modification and its impact will extend beyond the field of endeavor for which it is intended.

OUR CHALLENGE In *Death of the Guilds: Professions, States and the Advance of Capitalism, 1930 to the Present*,[e14] Krause writes that in Western capitalistic democracies, when endeavors are sufficiently costly to affect negatively the agendas of business and governing, they are incorporated into business to further the ends of the state. Rather than the medical profession dying, he believes that medical guild power will be replaced gradually by the power of business. Unlike our predecessors, tomorrow's physicians will serve their employers' goals, and become like other technicians whose sense of purpose has been expropriated. Pellegrino[e15] argues that health care, rather than being a commodity, is human activity responding to the needs of ill humans, whose

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overwhelming fear is abandonment to their fate[e15] by their fellow human beings. Further, converting the ends of medicine[e15] to the purposes of economic, political, or professional prerogative transforms medicine into economic, political, or professional preference,[e15] and not the health caring process for which we all became doctors.

I am concerned by our acceptance of the seeming inevitability of these changes, initiated by the theft of our identities as caregivers, in changing our names from doctors to "providers"; in referring to patients as "lives" or "customers"[e16]; and by characterizing the patient–physician relationship as one of numerous "encounters." I refuse to discard the clothing of "The Doctor," which carries with it my unavoidable responsibility to behave and function as the administering high priest of humans, when, as stated by Pellegrino,[e15] our patients are in vulnerable states, and have to be confident enough to reveal to us the most personal and intimate recesses of their lives. Similarly, I refuse to abandon my stewardship of the physician–patient relationship and of our patient's autonomy.

The Austrian–American economist Friedrich Hayek[e17] wrote that economic planning was social planning, whether done by right- or left-wing governments,[e17] and that at its roots, all planning was potentially hazardous to liberty.[e17] He believed the waning of workplace autonomy initiated by economic planning[e17] altered the character of people, who, in becoming accustomed to loss of control in their workplace, become less concerned when their political liberties are infringed.

Both the opportunity for physicians to work in the manner we believe most appropriate and our confidence in our standing in the political forum are threatened. After identifying problems with the directions proposed by health care planners, we work to salvage as much as we can, and thus tacitly consent to the proposed changes. Rather, those of us in organized medicine, such as Universities and Professional Associations, bear the responsibility for arguing for the specific agendas of the medical profession, because we know that health care planning will fail unless it is organized around the ultimate and limiting pathway of health care delivery, namely, the patient–physician relationship.

The time has come to invigorate our purposes, strengthen our commitment, and collectively manage our political challenges, as we work to reclaim the initiative. As our society is complex, it will take more than this one brief article, or one method of dialogue, to compel discussion of these issues; yet this discussion is fundamentally necessary as we physicians start to heal ourselves and our work.

ECONOMIC THEORY AND HAPPINESS ECONOMICS

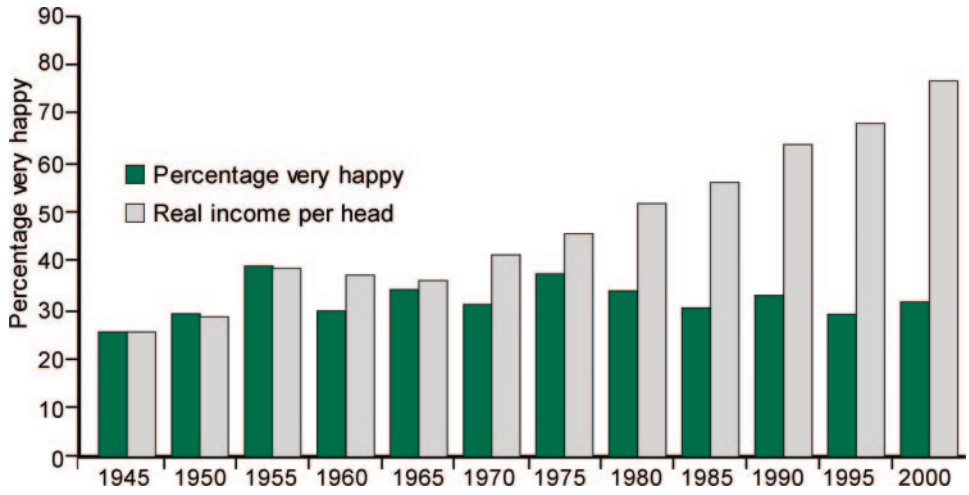
Economics is a fiscal and social science.[e18] The gross national product metric developed in the 1930s to facilitate understanding and management of society's output has been used in our consumer-oriented society to reflect consumer contentment. However, in the late 19th century, English economists[e19] believed that economics was purely about happiness or contentment.

Contentment theory was first described by the ancient Greeks as eudaimonism.[e19-e23] I find this philosophy appealing as it is similar to a physician's way of thinking. "Eu" is Greek for good and "daimon" means internal spirit; collectively, eudaimonism is translated loosely as "happiness or contentment" but is far broader. It is the building block for "human flourishing." Though first discussed by Socrates, Aristotle later defined a hierarchy of human purposes with eudaimonia as the highest—and only—end toward which it is worth striving. This is not constituted by honor, wealth, or power, but by rational activity in a "complete life," which I understand to be a meaningful life, manifested by virtues of character, such as honesty, integrity, personal responsibility, intellect, and rational judgment. Many consider this search for contentment inherently human after satisfying our basic survival drives.[e24] The validity of incorporating the themes of contentment theory in today's economic planning has been confirmed by economists, philosophers, psychologists, and more recently biologists, whose concepts of choice, rational and non-rational economic decision-making have prompted development of the fields of behavioral economics and neuroeconomics.[e25]

For example, Adam Smith,[e26] a philosopher before an economist, though touting the invisible hand of capitalistic progress and the market, championed the need for an "impartial spectator" to provide moral guidance to economic decision-making. More recently, Princeton psychologist Daniel Kahneman[e27] was the 2002 Nobel Economic Laureate for integrating psychological research into economic science; in England, economist Richard Layard,[e19] Director of the Centre for Economic Performance at the London School of Economics, authored an economic book, *Happiness*; and Richard Thaler, Professor of Behavioral Science and Economics at the University of Chicago, is part of President Obama's economic team.

Happiness is considered by many to be an objectively measurable and repeatable[e19] dimension of human experience, demonstrated by single cell recording, functional imaging, and preference assessments, such as life satisfaction surveys. But money has a complex relationship to happiness: contentment rapidly increases across countries with increas-

Figure Happiness as a function of income in the United States



Created with data from reference e29.

ing wealth beyond subsistence, but does not continue to grow with increasing wealth, reaching a peak in many countries with lesser economic standing than ours.[e28] For individuals[e29] (figure), the growth of contentment in the United States since 1965 has not paralleled our increasing wealth, and similar curves have been defined in other countries. Social contentment is also revealed by studies of society's discontent; in the United States[e30] 9 years ago, the percentage of adults who thought that most people could be trusted was half of what it was in the 1950s.

Though contentment studies do not tell the whole story, it is equally clear that financial well-being and its metric, the GDP, have shortcomings when used as the sole arbiters of societal well-being. Wealth alone is insufficient for contentment and both wealth itself and the striving for wealth may in some ways be deleterious to contentment. For these reasons, market metrics such as wages and output are now considered suboptimal when used alone. Metrics of internal contentment reflecting, for example, self-esteem and workplace fulfillment, provide additional understanding of the quality of a society and are used by several countries around the world.

Concurrent economic and humanistic planning requires that we define noneconomic factors based on contentment theory that affect physician and patient flourishing. Commitments to both must be incorporated in our discourse with payors and legislators, to invigorate negotiations for rebuilding the House of Medicine.

CURRENT UNITED STATES AND WESTERN HEALTH CARE MANAGEMENT In the United States, we have developed various medical reimbursement systems before and since enactment of the Medicare legislation in 1965. More recently, these have focused on the supply side by managed competition, and the demand side by cost sharing, such as copays and deductibles. Neither has been sufficiently successful and both have produced significant problems of their own. The pendulum is now swinging back to quality, and planners are attempting to achieve this through pay-for-performance (P4P). Both P4P and evaluation and management (E&M) coding are examples of the vulnerability of medical care quality to isolated economic planning, and both provide opportunities for application of the concepts of physician and patient flourishing.

P4P is now used in many countries including Canada, Germany, and England, where these objectives account for 25% of the pay of primary care practitioners.[e31] P4P incentivizes performance by increasing or decreasing pay to physicians or institutions for patient–physician or patient–hospital encounters that achieve quality objectives, as determined by a third party. For example, the denial of payment to hospitals for prolonged hospitalization caused by hospital-acquired urinary tract infections in catheterized inpatients has been successful in reducing its occurrence.[e32,e33]

While I acknowledge the simple strength of this economic carrot-and-stick incentive on institutions, I am concerned that economic success with P4P for individual physicians may come at the cost of physician internal satisfaction and drive, and may be detrimental rather than additive to quality. Physician motivation by payment alone can never equal the inspiration we derive from a sense of personal responsibility. Physician work motivation includes our focus on patients' needs first; our opportunity for

creativity and workplace autonomy in application of science and our experience; and our drive to achieve our peer group's respect. When we are paid specifically for accomplishing some components of work we assume to be either routine or unimportant, these other more significant drivers of our motivation may fade.[e34] Like so many other workers, we may shed our belief that good work is anticipated. The character values encouraged by our inner drive for growth, competence, and self actualization, so necessary when competing for medical school entry and completion, may be squandered.

E&M's failure to codify quality is a contradiction as we introduce P4P, and as we speak of our need to practice evidence-based medicine (EBM). In the late 1980s, William Hsiao, Professor of Economics at the Harvard School of Public Health, defined the resource-based relative value scale.[e35,e36] E&M coding, developed in response by the American Medical Association (AMA), provides a measurable comparison of the work product during the patient–physician interaction primarily for reimbursement purposes. Most renditions of the electronic health record, soon to be mandated for us, are similarly focused.

Incorporation of E&M into our daily work has required us to shift or add to our focus many details that are relevant for payment but do not speak to the work of doctoring as a whole. The code most commonly used by neurologists for the initial evaluation of a complex patient requires completion of a document with 48 bulleted points, of which 4 relate to the history of the present illness. All physicians, not only those in cognitive fields, recognize that acquiring this history—and especially the manner in which it is obtained—is the major determinant of the quality of the patient–physician relationship and of the value of initial and subsequent care.

The American Board of Psychiatry and Neurology, in attempting to define a method for adjudication of resident competence, has considered applying American Academy of Neurology evidence-based practice parameters[e37] to the history of the main complaint. We need to ask: When finalized, could this fully fleshed-out concept become part of E&M bullets and add value? In conferring heuristic, testing, and some clinical value, the practice parameter is a good start in the effort to restore value to E&M coding, but it is not enough. It lacks differential diagnostic questions and its inclusion risks further dilution of workplace autonomy. Moreover, it poses a barrier, in taking too focused a history, to listening for what is not said and to hearing the innuendo of what is said. It does not address the missing yet essential communication and relationship-building components of the patient–physician encounter.

I have expanded on these from *The Effective Clinical Neurologist* by Caplan and Hollander[e38]: the physician must gain an understanding of the patient's strengths and weaknesses and the confidence, respect, and cooperation of the patient. Armed with this information, the physician can help the patient understand and come to terms with the condition; select, plan, and coordinate investigation and treatment; and thereafter, communicate with the patient and others about the illness, its ramifications, and its management.

As we know, the defining physician–patient relationship is neither explicitly encouraged nor reimbursed. It must be our mission to bring to the attention of policy-makers and payors the absence of attention to this relationship, the sine qua non of our professional interactions.

During the 17 years we have used E&M codes, which are no more likely to ensure appropriate compensation, I have not spoken to a single physician who believes they contribute to clinical quality.[e39-e41] Disingenuous use and teaching of these codes undoubtedly sends the wrong message to medical students and residents. Rather, reintroducing to the debate the idea that we should seek improvement of E&M coding based simply on what is humanly right would reverberate through our ranks.

The consequences of the methods used to define reimbursement by E&M coding raise additional concerns. The AMA appointed the Relative Value Reimbursement Update Commission (RUC) to evaluate and then recommend E&M code reimbursement to the Center for Medicare and Medicaid services (CMS), to enable the government to define how allotted funds, otherwise known as the Medicare sustainable growth rate, are disbursed. RUC/CMS decisions have repeatedly favored procedures, thereby contributing to the altered face and cost of American medicine. Over the past 5 years,[e42] for example, laboratory tests increased 530% and MRIs 94%, while office visits of established patients increased only 12%. Not surprisingly, during this time entry into primary care has fallen significantly[e43-e45] and patients complain that doctors do not listen or talk to them and only seem to want to order tests. This is precisely the change in doctoring one would anticipate given the incentives created by the RUC-recommended decisions by the CMS.

In ethical terms, a moral community[e46] binds its members together and is constituted by the collective will of individuals espousing a set of commonly held moral commitments, other than self interest. We physicians constitute just such a moral community

and some of the RUC/CMS work product appears discordant with these principles.

We face numerous challenges in managing our work because face-to-face physician–patient time is threatened. The complexity of evolving science cries for its expansion yet the crowding of our workplace escalates. It is increasingly inhabited by technologic advances posing deceptively as health care, while in reality they are only the tools of doctoring.[e47] Our patient interactions are overflowing with accumulating obligations such as E&M coding, complicated by current renditions of the electronic health record and e-prescribing, P4P documentation, and the need to satisfy the demands of insurers more often driven by economics than by quality of care. We acknowledge the potential value of EBM[e48-e51] data and perhaps Maintenance of Certification requirements. Our future includes Comparative Effectiveness[e52] studies, and while we accept their potential value we cannot but view with trepidation the role physicians will be called on to play, as quality of life year cost analyses[e53] are applied to them. Each of these concepts has evolved alone yet none exists in isolation. Collectively, they carve out accumulating quantities of patient-focused time.

Humanistic medical care[e54] requires the combination of a cognitive component for diagnosis and management, and an affective component, in which experience and the context of the patient's life, personality, and illness variables are considered. David Leach,[e55] former executive director of the Accrediting College for Graduate Medical Education, states that context-based (physician) behavior demands the application of practical wisdom and prudence, and the need, at times, to break rules to accommodate life's realities. Humanism[e54] is lacking, ethically and practically, if either aspect of care is ignored. These requirements risk converting some or, over time, most, of the patient–physician interaction to a cookbook process; yet they cannot quite so simply (to borrow from William Osler) manage doctoring's fusion of humanity, diagnostic uncertainty, and scientific probability. In short, we have developed and are applying methods of care before studying their intended and unintended consequences. We need to ask: by conforming, are we hastening the death of our guild, and, if so, what can we do differently?

THE CHARTER ON MEDICAL PROFESSIONALISM So, what have we done about this? Our Charter on Medical Professionalism[e56] was published in 2002, by a consortium led by the American Board of Internal Medicine Foundation, American College of Physicians–American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine, and has been endorsed by more than 100 professional associations. This Charter characterizes professionalism as the basis of medicine's contract with society, defined by 3 fundamental principles: patient welfare, patient autonomy, and social justice. Physician commitments include professional competence, patient respect, definition of education and standard setting processes, improved access to care, working collaboratively, and engagement in and collaboration with scrutiny.

The Charter speaks meaningfully about physician conduct but does not speak to our souls, embedded with our medical ethos, the principal influence on our behavior. This single most important component of our professionalism resides at Medicine's junction with society and is influenced, intentionally or not, by socioeconomic planning.

THE ETHOS OF DOCTORING AND THE WAY FORWARD The physician's ethos needs tending now more than ever, given that we in medicine, like no other enterprise that hopes to survive in a capitalistic democracy, have been asked and have consented to produce a mis-incentivized and suboptimal health care delivery product. We have done so to satisfy our country's economic planning, despite the fact that these same economists ignore the cost side of our equation: US physicians, accounting for 20% of the health care dollar,[e57] are called upon to squander about half our earnings on administrative costs, more than double[e58] spent in other countries.

History reveals that we have often stumbled in the application of our ethos. A century before Hippocrates, Hammurabi's medical code[e59] defined differing payment and punishment for doctors in caring for the wealthy and the poor. Recent examples are the yielding of the ethos of doctoring in the 1900s in Germany during National Socialism, and during my life in South Africa under Apartheid.

I propose we begin by convening a global summit of physician stakeholders and thought leaders to develop and define an understanding of the ethos of the physician, based in part on contentment theory, culminating in a Charter on Professional Flourishing, as a parallel document to The Physicians Charter on Professionalism. Though the ethos of doctoring is universal, crossing all times and cultural divides, its application is not, changing from country to country, responding to local circumstances. Two documents are therefore necessary.

First: We must define our ethos: It is not an abstraction, but a set of behavioral principles, which determine how we respond to the sick.[e60] It is our character, behavioral characteristics, internal motivators, physician–patient relationship requirements,

the ethics of our professionalism, and our guardianship of appropriate autonomy for ourselves and our patients. Our ethos has not been, nor will it be, forever impenetrable, and therefore our definition must incorporate integrity to counter human weaknesses such as envy, greed, and power; and it must incorporate, preeminently, personal responsibility, because if we do not accept responsibility, we will surrender our responsibility to others.

Second: We must identify the dynamics necessary for application of our ethos, specific to each society and country. The physician workplace should be built to encourage those values, necessary for physician and patient flourishing, while discouraging distractions. For example, we may consider the misconceived incentives, defensiveness, and irrelevancies in our workplace, while for others, workforce issues may dominate.

Once fully characterized, the philosophical backdrop to doctoring should be defined and taught. Premedical and medical school requirements should include medical and behavioral ethics courses to foster the spirit of altruism in young students. We must develop methods of assessing how students and physicians integrate this behavior and monitor its use in the political forum.

CONCLUSION Our philosophy and our personal responsibility are the ultimate sources of our motivation. They are more steadfast than those traits encouraged for employees working principally for financial advancement, as exemplified by unthinking and non-nuanced application of E&M and P4P, and will outlast regulations. Both must be used to inform our intersection with our medical environment for the present and foreseeable future and strengthen our involvement in the debate on the best methods to encourage professionalism, and our adherence to the external behaviors of the Physicians Charter. Our stance will confirm our commitment to our history, to the nature of doctoring and of suffering, and to the future of doctoring.

Guided by our Charter on Physician Professional Flourishing, and based on the Charter on Medical Professionalism, Medicine must fulfill its obligation to society by taking its seat at the health planning table, not as another shepherd of policy or bean counter, and not primarily to advance social, political, or fiscal policy, but to call for conformity with the philosophy of medical care delivery. We must draw attention to the merits and demerits of isolated economic behavioral management on all aspects of doctoring, and affirm our belief in our calling: that personal responsibility and the values defining our ethos, more effectively than any others, can lead to better quality research, education, and health care delivery, and in all likelihood, in the most cost-effective manner.

By embracing our challenges, exercising our judgment, and entering the health care debate armed with these data, we can return to the authentic nature of doctoring and restore our sense of purpose and confidence in Medicine's future.

DISCLOSURE

Dr. Sergay is Immediate Past President of the American Academy of Neurology; served on an advisory board for Merck Serono; serves on an External Review Group for the NIH; holds stock options in Amarin Corporation; has provided expert opinion in non-malpractice-related proceedings; and is a partner in Axiom Clinical Research of Florida, for whom the following have sponsored clinical trials: Genzyme Corporation, Genentech, Inc., Myriad Genetics, Inc., Neurochem Inc., GlaxoSmithKline, Memory Pharmaceuticals Corp., XenoPort, Inc., Bayer Schering Pharma (Berlex), Merck Serono, Novartis, Pfizer Inc., Elan Corporation, Sanofi-Aventis, Teva Pharmaceutical Industries Ltd., Takeda Pharmaceutical Company Ltd., Vernalis Plc, Boehringer Ingelheim, Endo Pharmaceuticals, Hamilton Pharmaceuticals, Inc., Biogen Idec, AstraZeneca, Ono Pharmaceutical Co. Ltd., Eisai Inc., Genomics Collaborative, Inc., and Eli Lilly and Company.

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