Charter on Physician Professional Flourishing

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ABSTRACT

Medical care delivery has adapted to scientific and societal change in the past. However, today's advancing scientific accomplishments and care capabilities, in the context of current societal and economic developments and our emerging digital age, are challenging physician resilience and endurance and trust in the medical profession. Why has this happened and can these characteristics and perceptions of physicians be reversed? The Charter on Physician Professional Flourishing is a method designed to restore the promise of the medical profession and trust in it. It describes a process to reinvigorate patient-centered care from the caregiving physician's perspective. It integrates discipline ethics, behavioral character ethics, and optimized physician-patient dialogue, while considering past, current, and predicted future context and professional sustainability. Its primary outcomes are enhanced quality of care and cost containment and the ability to reassert the voice of the patient in health care planning negotiations. *Neurology*® 2016;87:2259-2265

GLOSSARY

ACGME = Accreditation Council for Graduate Medical Education; **CMP** = Charter on Medical Professionalism; **CPPF** = Charter on Physician Professional Flourishing; **IOM** = Institute of Medicine.

Let us meet the time, as it seeks us.

—Shakespeare, *Cymbeline*¹

I have discussed US health care's social, economic, and political challenges and those posed by scientific and technologic advances and the need for greater efficiency and effectiveness.² I called on organized medicine to argue for the centrality of patient-centered care to health care planning and for the presence of the voice of the physician, as the doctor embodying the needs of the patient.

This article introduces the premises of a process to define patient-centered care from the perspective of the caregiving physician. I have named this the Charter on Physician Professional Flourishing (CPPF). Rather than a toolbox for individuals, it defines the infrastructure of this method. It requires consolidation of the Charter on Medical Professionalism (CMP),³ epitomized methods of the patient-physician dialogue, and the optimal behavioral characteristics of the doctor. Its product is built on consideration of context and professional sustainability. The components of the CPPF are outlined below, each of which requires vigorous debate.

BACKGROUND Medicine resides at the conjunction of scientific advances and social transformations. Though it has always adapted to and incorporated change, the human need for caring does not change. I am concerned that this human side of illness is considered routine and therefore not emphasized as we grapple with the current products of the scientific revolution, the machine and digital ages and their effects on society.

Medical care delivery has become the subject of unprecedented and extensive thinking by every sector of US life. This is exemplified by *The Innovators Prescription: A Disruptive Solution for Health Care*,⁴ the Institute

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Author's note: I have had published in *Neurology*® my article titled "Doctoring 2009: Embracing the challenge."² In that review and in anticipation of our emerging human and health care challenges, I called for development of the charter I describe.

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of Medicine's (IOM) *To Err is Human*⁵ and *Crossing the Quality Chasm: A New Health System for the 21st Century*,⁶ the Institute for Healthcare Improvement's "The triple aim: care, health and cost,"⁷ "Redefining health care: Creating value-based competition on results,"⁸ the Affordable/Accountable Care Act, and initiatives of the Accreditation Council for Graduate Medical Education (ACGME),⁹ including their definition of core competencies. Valuable advances have been made, including systems to reduce error by omission and commission, to ensure data-driven quality by an enlarging percentage of physicians, and to foster evolution of our workplace. All advance methods of patient care delivery efficiency, effectiveness, and safety, patient and population cost containment, and the importance of patient centeredness.

"Patient-centered," however, is interpreted distinctively by health plans, insurance companies, and administrators. To caregiving doctors it is quite simply our core and our compass, the prelude to patient dignity and the well-spring of healing. Its multilevel implications and all-embracing bearing on patients^{10(p xv)} and caregivers are not fully considered.

I assert that invigoration of the patient–physician relationship would enhance the quality of patient care and benefit patients and physicians and reduce cost.

This entry point to the health care enterprise is fundamental in health care delivery by generalists and specialists, those delivering cognitive and procedural care, and in both "precision" and "intuitive"⁴ medicine. The cognitive fields, and in particular those requiring a narrative history, are more heavily reliant on dialogue. These fields, therefore, should define this methodology, with adjustments by others driven by their unique needs. Neurologic care is dependent on the quality of the patient history. This has been confirmed in the American Academy of Neurology's code of professional conduct (2009), which defines the neurologist–patient relationship as the foundation of neurologic care. Deliberation by neurologists therefore could become an embarkation point in this endeavor.

Charter on Medical Professionalism. The CMP is the product of a trans-Atlantic consortium led by the American Board of Internal Medicine Foundation, American College of Physicians, American Society of Internal Medicine Foundation, and European Federation of Internal Medicine. It has been endorsed by more than 130 professional associations across the world, including the American Academy of Neurology, and has been translated into 12 languages.

The 4 pillars of medical ethics¹¹—beneficence, non-maleficence, autonomy (of the care recipient), and justice (just distribution)—articulated by the ancient Romans and Greeks are collapsed into 3 in the CMP: patient welfare, patient autonomy, and social justice.

Physician commitments include professional competence, respect for the patient, definition of education and standard setting processes, improved access to care, working collaboratively, and engagement in and collaboration with scrutiny. These rules and standards fall mainly under the rubric of principle ethics.

While speaking meaningfully about physician obligations (for example, the requirement to maintain competencies), this Charter speaks insufficiently to physician internal motivation, without which this and other unwritten commitments (e.g., expenditure of "sufficient time" with a patient newly diagnosed with an incurable condition) may not be fulfilled.

Dr. Ingelfinger¹² commented that if the medical professional does not have the requisite virtues to internalize objective rules and standards, these would not be incorporated. My experiences of practice patterns both before and during current health care delivery changes confirm Ingelfinger's concerns and are my basis for advancing the combined application of principle ethics exemplified by the CMP and behavioral-virtue ethics.

Interestingly, the CMP considers physician professionalism to be the basis of medicine's contract with society, while Pellegrino and Thomasma,¹³ eloquent proponents of virtue ethics in medicine, defined molding of character and the teaching of virtue as the unwritten responsibilities of the medical profession.^{13(p178)} As both strengthen and temper each other, it is likely that their combined product would be most effective.

Integrating these 2 schools of philosophical thought is not unique to our time or to medicine. For example, Sol,¹⁴ while reviewing accounting practices over centuries, concluded that successful States were those that blended their commercial culture with a sound moral and cultural framework. Those that did not were always short-lived. The need to reaffirm this dual need in medical care delivery in current context is affirmed by recent US and world economic experiences in financial management and in the shortcomings of "teaching to the test" in education. I maintain that it is our responsibility as physicians to define the joint application of discipline and character ethics in health care delivery and to ensure their inclusion in health care teaching, delivery, monitoring, and planning.

Dialogue. Interpersonal capability, one of the 6 core skills in the competency requirements defined by the ACGME, have been the focus of the IOM and others for many years. Despite this, the most common complaint I hear from patients is simply: "My doctor does not listen to me."

Many argue that this competency is threatened by expanding care technicality and complexity; the

increasing conflicts of doctor accountability beyond the patient: to the population at large, the Health Insurance Plan, the patient's and the physician's employer; the distracting requirements of data recording and the methods used to identify and reimburse care delivery efficiency and effectiveness; and the quest for income generation, by major medical institutions¹⁵ and individuals.

That the electronic health record can enhance health care quality is accepted both for the individual patient (e.g., medication interactions, availability of patient data, treatment alerts, point of care evidence-based guidelines) and in aggregate (e.g., requirement for flu shots, recognition of patterns of care delivery, reduction of redundant testing).¹⁶ However, using an electronic record siphons physician time and focus from patient care, threatening this dialogue and productivity. This technology can enable production of documents that may appear complete and consequential, yet on closer inspection they may be formulaic compilations, sufficient to suggest effort has been expended or to qualify for reimbursement, while lacking true caregiver involvement. This can lead to the shortcut of unnecessary testing and delayed and misguided diagnosis and treatment.¹⁷

The patient–physician dialogue, the scaffolding upon which the optimal behavioral characteristics of the doctor (described below) are deployed, is a defining component^{10(p4,6,116)} of medical care delivery dating back to Hippocrates^{10(p110)} and has been studied deeply. It is the entry point to care delivery and the health care enterprise. Optimizing this dialogue necessitates efficiency, effectiveness, and structural and economic planning on an individual and system level, affirming its role as an essential element of health care planning.

Care for humans by humans is more than a simple transaction. It is a technical and a social process consisting of verbal and nonverbal language.^{10,18} It has both cognitive (knowledge) and affective (relationship)^{10,18} components and suffers if either is lacking. It relies on honest and mutually respectful interaction of 2 experts: the physician, expert on diagnosis and management, and his or her personality and life experiences; and the patient, expert on his or her pain, suffering, fear, and his or her personality and life experiences.^{10,18} This dialogue requires the more abstract skills of doctoring, such as nonstructured discourse, perception of nonverbal^{10(p17)} cues, and caregiver consideration of risk taking and the development of mutual trust.

This is dependent on time spent face-to-face. If insufficient time is allotted to patients at entry,¹⁹ clinical diagnosis, initiation of appropriate investigation, management planning, and in particular healing,^{10(p6)} our ultimate goal may be jeopardized.

Efforts to increase productivity while reducing this time cannot but result in reduced opportunity for psychosocial discussion and individualization of care.^{10(p112)} As both illness and the end of life are unavoidable, the need for comfort and healing are inevitable passengers along life's journey. The physician–patient relationship is invaluable both to the patient and the doctor, for many of whom the essence of being a caregiver is caring. It is likely that diminishing the significance of caring would adversely influence patient perception of care and physician behavior, motivation, and the joy of doctoring. If so, detrimental consequences would be anticipated on the self-belief and self-respect of caregivers, threatening physician wellness and predicting physician burnout. Declining trust and respect for physicians would likely follow.^{10,18}

PHYSICIAN BEHAVIORAL CHARACTERISTICS

Pellegrino and Thomasma¹³ postulated the character of the physician as the guarantor of the well-being of the patient.^{13(p180)}

Socrates, Plato, and Aristotle's *Eudaimonia*²⁰ describes a virtuous or good life as the ingredients for human flourishing, also described as a full and contented life. Derivatives of human flourishing are the idealized behavioral characteristics¹³ of the physician during encounters with patients, which when present, enable physician flourishing and fulfillment,^{13(p165)} both personally and professionally. These behavioral characteristics are necessary in the special relationship engendered by sickness, between patient and physician, and by the response to illness.^{13(p xii)} Pellegrino and Thomasma¹³ described these as the medical behavioral virtues.

The medical behavioral virtues include trust,^{13(p65)} compassion,^{13(p79)} prudence (practical wisdom),^{13(p84)} justice (just distribution),^{13(p92)} fortitude (courage),^{13(p109)} temperance (avoidance of self-interest),^{13(p117)} integrity (predictable behavior),^{13(p127)} and self-effacement.^{13(p144)} Virtue theory, however, links cognition of the good with motivation to do good.^{13(p xiii)} It does not define an act but rather the habitual disposition to act well,^{13(p5)} under the guidance of reason.^{13(p5)} The medical virtues are actualized^{13(p26)} only when they consistently characterize physician and medical institutional behavior and dialogue.

The impact on medical teaching of the virtues could be substantial and may require entry-level changes. For example, to prepare for informed discussions at the bedside, it may be considered necessary to require pre-medical school ethics^{13(p178)} and philosophy courses and to re-evaluate medical school admission criteria.^{13(p180)} Development of teaching methods and metrics of its value will become necessary.

I am keenly aware of the formidable challenge to embracing behavioral rectitude in our current culture of skepticism,^{13(p195)} in which ideals are considered

secondary. This has contributed to the declining level of trust we have in each other, from 66% in 1972 to 33% in 2013.²¹ Full awareness of inherent human strengths, weaknesses, and proclivities and our context strengthens my commitment.

Context. Health care context is a combination of life's experiences and the societal and scientific realities we collectively acknowledge as guides to our thinking and actions.²² Context affects health care expectations of its recipients and the thinking of its practitioners, critics, and planners. For example, physicians supported by a foundation perceive health care planning differently than those who are not. Recognizing societal context, including human frailty, is elemental in planning, not to excuse current practices but to enhance current and future planning and its monitoring, and to ensure missteps are not repeated.

We are embroiled in part in path-dependent planning²³; i.e., planning that considers the outcomes of prior practice patterns without clarifying their bases. I am concerned that recent and current US medical practice patterns are poor conceptual foundations for future health care planning. For instance, recent fee-for-service; usual, customary, and reasonable charging²⁴; evaluation and management coding²⁵; many current requirements; legal exuberance; and others have motivated physician behavior, both positively (e.g., greater caution, increased efforts at cost effectiveness) and negatively (e.g., working to Current Procedural Terminology codes, defensiveness, focus on earning).

Planning based on the assumption that some or all of these behavioral characteristics are inherent in all physicians may be erroneous for some physicians and may lead to methods to correct these behavior patterns rather than their causes.

While behavior conjured by planning may be appropriate in abstract, the reasoning behind human behavioral responses is typically complex and often leads to deviations from anticipated patterns. In practice, these incentives may appear perverse²⁶ and conflicted by moral hazard.²⁷ Socioeconomic planning can never escape these abysses of human behavior, yet their avoidance by physicians delivering patient care is a necessity.

Therefore, recognizing and managing reactions to planning must be a *sine qua non* consideration of health care planning and a monitoring component of its outcomes. The combined use of discipline and character ethics is a tool, which could enable anticipation of these occurrences and their outcomes and definition of solutions.

Current and future care context must include consideration of our second machine age,²⁸ characterized by the beneficial products of digital development and automation,²⁹ which include speed,^{29(p17)}

efficiency,^{29(p17,219)} effectiveness,^{29(p18)} cost control,^{29(p18)} and profit.^{29(p17)}

While we welcome the manner in which automation complements physician cognition, we recognize that current renditions cannot supplant it.^{29(p67)} Beyond being distracting, today's automation imperils the uniqueness and needs of the individual humans we serve.^{29(p100,103)} For example, algorithms cannot plumb the depths of care dialogue nor can they be created for feelings, moral choice,^{29(p186)} curiosity,^{29(p124)} or dispensing hope. Automation risks deflating intangible components of the patient physician exchange, such as effort,^{29(p17)} motivation,^{29(p72,91)} engagement,^{29(p17)} resourcefulness,^{29(p199)} and perseverance,^{29(p182)} and as a consequence unavoidably impacts perception of self-worth,^{29(p161)} of both the patient and the practitioner. The voice of the caregiving physician is necessary for automation's enhancement.

Physician, patient, societal, and other variables will always interface with the CPPF. Its formulation and its deployment is built on past, present, and predicted future context. Therefore, though its deployment will always be affected by context, the CPPF must supersede context.

Why then is it necessary to define CPPF, if its components are a product of constantly mutating and compounding influences? It is precisely because of this contextual unpredictability that definition is necessary, so that universal goals can be identified, deviations can be recognized, and course corrections, which always will be necessary, can be guided; and because ascending to its expectations will encourage the best possible human care in any circumstance. For example, some or all of its goals may be challenged or unattainable, where physician worker or workforce is wanting, where technology and drugs are unavailable, or when overriding economic concerns and sociopolitical mores dominate care decisions.

Sustainability. Physician contentment is built upon our perception of our self-worth. Derogation of this self-concept fosters a sense of existential impoverishment,^{29(p220)} adversely affecting the meaningfulness of our lives.

Physician resilience, or the ability to cope with adversity and stress,³⁰ is now impugned. This is manifested by waning drive and determination. In the recent past, when a career in medicine was considered a calling, physician resilience was seldom questioned. It was a necessary attribute, worn with pride, fomented by the ultimate internal motivation: the well-being and life of a patient.

Challenges to both the physical and emotional well-being of medical students and medical practitioners^{31–33} are becoming increasingly evident. The consequences of physician burnout socially and professionally, including early career termination, have

reached unprecedented levels and are accelerating.³⁴ Sustainability of the medical profession and its practitioners in the United States is challenged.

This was exemplified for me during a focus group³⁵ of young employed practicing physicians and care extenders, when I asked what they most looked forward to when coming to work in the morning. Their unhesitating and almost unanimous response, “A patient not showing up,” is the response I had anticipated from supply-line workers and not those caring for humanity’s most precious possessions: our psyche and our soma.

In the recent past, physicians, who dedicated their youth to becoming doctors, demonstrated remarkable commitment, endurance, and resilience in their teens, 20s, and 30s, without which they could not have gained access from high school, to college, then medical school and then their choice of medical field. They withstood the challenges of long hours of studying and working and increasing debt, while shouldering the burden at an early age of understanding life and death. Why have so many of us, so suddenly, deliberately or inadvertently, reversed our normal behavior patterns? Are we, our context, or advancing scientific complexity the culprit, individually or collectively?

Surely the major precedents of professional sustainability are work with a purpose, work affording both internal and professional contentment, work that encourages selflessness, work that can be practiced mindfully with awareness and focus, and work that allows respite time. While living a balanced life has long been a challenge to physicians and most driven people, efforts to rebalance the lives of physicians, though laudatory, will never be effective alone and could be counterproductive.

Identification and management of specific causes requires analysis of the assembled thoughts of doctor-clinicians and others.

In the nonmedical workplace, employee engagement and contentment are recognized as workplace necessities and a basis of product quality³⁶ and can generate savings.³⁷ Attention to worker contentment is a health system quality indicator in dedicated programs in every Canadian Province³⁸ and in the United Kingdom, by the National Clinical Assessment Service,³⁸ and is not uniformly present in the United States. Ensuring US medical workforce wellness has the power to increase productivity, work quality, and efficiency at the individual and organizational level and to reduce physician turnover and its costs, in keeping with goals of the Accountable Care Act.

CPPF monitoring and policy. The CPPF outcomes must be pragmatic, efficient, and effective patient-centered care, objectively measurable by care quality and economic metrics and physician contentment. Teaching and practicing methods must be developed. When the quality and value of these care competencies

are defined, they should inform policymaking, reallocate face-to-face time, and adjust reimbursement.

Physicians, like all people, may be motivated by virtue, self-interest, and circumstance. Therefore, beyond education, personal, professional, medical institutional, and societal monitoring practices must be built, to ensure consistent application of these behaviors.

DISCUSSION The CPPF aspires to reinforce physician, profession, and patient thriving, to reinvigorate the medical establishment, to restore the promise of the profession of medicine and trust in its practitioners, and to strengthen health care planning. Its products are intended to be enduring and self-renewing guides and yardsticks, for individuals, training programs, medical institutions, health care systems, quality measurement organizations, insurers, and policy developers in the United States and globally. The significance and complexity of the CPPF surpasses the 3 Aims of the Institute for Health Improvement, justifying its consideration as a 4th Aim.

Medical care as a service is too important to fail, but its infrastructure is becoming dispensable, physicians being part of that construct and its victims. More than any other, we know the needs of our patients, the nature of health care, our virtues and our vices. We acknowledge description of our marketplace as asymmetric (i.e., a more informed “seller” than “purchaser”) and that we, like all others, have individual and organizational vested interests, and legitimate self-interest. We understand that the nature of our product, human health care, requires more from us than from others. We recognize, too, that we are part of a greater social upheaval, in which the polyglot and enlarging US population, increasing longevity, accumulating prominence of noncommunicable diseases, incremental scientific advances and health care capabilities, and our behavior, all affect not only the patient-physician relationship but also patient and societal well-being and economic stability. And yes, we do welcome the thoughtful input of all interested parties in health care delivery and the debate they encourage.

In 1959, C.P. Snow,³⁹ in his Rede Lecture at Cambridge (“The Two Cultures”), argued for equal respect for scientists. Now, less than 60 years later, the products of the scientific method, industrialization, and technologic and digital advances threaten the humanities and their importance within society. For medical care and society to flourish, a present-day amalgam of both cultures is necessary. There is no better crucible for this for society than health care delivery, the scientific sphere in which the “personal” is paramount.

We doctors, who have been nourished by our patients, now bear the responsibility for ensuring their future well-being. There is nothing wrong with medical thinking that everything that is right with medical

thinking cannot correct.⁴⁰ Think tanks, focus groups, and summit meetings are an urgent necessity. This is the time: both the opportunity and the responsibility are ours as caregivers, and ours alone. Our voices must be raised for the good of our patients, our profession, and society at large.

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