

Medical Professionalism: A contract with society

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Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is caring for the patient.

-Dr. Francis W. Peabody (AQA, Harvard Medical School, 1906)¹

The modern era of medicine has brought about incredible advances in science and technology to improve the care of patients and population health. Additionally, major social changes are occurring that impact society, patients, physicians, medicine, health care, and medical education. Medical professionals are governed by ethical codes, and make a commitment to competence, integrity, morality, altruism, and support of the public good. This is a social contract, a covenant of trust with patients and society, that determines medicine's values and responsibilities in the care of the patient.

Medical professionalism is a core value and responsibility of physicians. Sir William Osler said, "The good physician treats the disease; the great physician treats the patient who has the disease."² For physicians and medical professionals committed to caring for patients, meeting professionalism responsibilities requires the identification, understanding, development, and implementation of best practices.

Medical professionalism stands on the foundation of trust to create an interlocking structure among health professionals, patients, and society that determines medicine's values and responsibilities in patient care and public health. Medical professionalism is a core value of AQA.

Medical professionalism must be recognized as an active, ongoing, and iterative process that involves debate, advocacy, leadership, education, study, enforcement, and continuous transformation. There should be no

capitulation to efforts or circumstances that undermine ethics, values, or medical professionalism.

Drs. Richard and Sylvia Cruess have noted that the social contract between a profession and society grants the profession the right to considerable autonomy and self-regulation.³ This is paramount to medical professionalism.

The profound and rapid advances in medical knowledge, technology, specialized skills, and expertise are occurring expeditiously for medical schools and practitioners. In addition, the corporatization and businessification of medicine, has created differing values between health system leadership and health professionals.

These changes make it even more important that medicine be practiced based on core professional beliefs and values paramount to the doctor-patient relationship and the care of the patient. Physicians must understand their obligations and commitments. They must put patients first and subordinate their own interests to those of others. They must adhere to the highest ethical and moral standards. These dogma of medical professionalism continue to be the profession's most important commitments, and signify the trustworthiness, accountability, and commitment patients expect and deserve.

There has been dramatic transformation in medicine over the last several decades, from the private independent practitioner to the organization of a common group of physicians, to a corporate group of physicians, often employed by hospitals and systems. Medicine has also seen the introduction of entrepreneurs, investors, and corporate executives. Little or no evaluation of care of the patient, patient outcomes, the doctor-patient relationship, medical professionalism, physician satisfaction and accomplishments are considered in the "business of medicine." Physician success is often related only to high volumes of work and relative value units (RVUs) produced. It is estimated that for every one hour spent with patients, nearly two hours are spent on the electronic health record (EHR), with another hour or two during personal time entering information into the EHR.

Professionalism is also threatened by issues of self-interest, power, prestige, profit, pride, privilege, and lifestyle. Venality, character deficiencies, irresponsibility, and greed can be underlying factors for unprofessional behavior. No matter where or how they are employed, health professionals are obligated to adhere to an ethical ideal and professional values that focus on providing care in the best interest of patients—it's medicine's social contract with patients.

Health professionals must respect and uphold a code of professional values and behaviors. They must:

- Adhere to high ethical and moral standards—do right, avoid wrong, and do no harm;
- Subordinate personal interests to those of the patient;
- Avoid business, financial, and organizational conflicts of interest;
- Honor the social contract with patients and communities;
- Understand the non-biologic determinants of poor health, and the economic, psychological, social, and cultural factors that contribute to health and illness—the social determinants of health;
- Care for all patients regardless of their ability to pay, and advocate for the medically underserved;
- Be accountable, both ethically and financially;
- Be thoughtful, compassionate, and collegial;
- Continue to learn, and strive for excellence;
- Work to advance the field of medicine, and share knowledge for the benefit of others; and
- Reflect dispassionately on one's actions, behaviors, and decisions to improve knowledge, skills, judgment, decision-making, accountability, and professionalism.

More than a decade ago, AΩA realized that medical professionalism as a core value is being challenged by the transformations in medicine and medical practice. AΩA works diligently to promote the core tenets of medical professionalism, and recognizes those dedicated to the advancement of professionalism within the profession through its Professionalism Award. AΩA also studies and emphasizes best practices in medical professionalism by hosting a biennial conference bringing together experts in professionalism to present and discuss issues, barriers, and new practices. As a result of these conferences, AΩA has published monographs (<http://alphaomegaalpha.org/medprof2015.html>), and the most recent conference held in early 2019, will produce a third monograph, *Medical Professionalism Best Practices: Addressing Burnout and Resilience in Our Profession* will be published early in 2020.

During the 2019 AΩA conference on medical professionalism, concerns were raised over the perceptions that changes in medical school grading, training work hour restrictions, and competency examinations will further lead to a loss of the right to considerable autonomy in medical practice and the privilege of professional self-regulation. The question asked was, if we are not willing to effectively assess medical competency as a profession, who will take

over that responsibility from us and further change our social contract with society and our patients?

The following report from The Center for Professionalism and Value in Health Care, by Dr. Robert L. Phillips and colleagues, is in response to the perceptions and data that medicine's professionalism, especially the social contract, has been undermined with the adverse consequence of a possible loss of public trust, a loss of professional autonomy and accountability, and the corresponding consequence of professional burnout. This new organization proposes to address institutional understanding of the value of professionalism and how best to support it within the constructs of today's medical environment. The Center also focuses on The Foundation for Medical Excellence's Physician Charter for Medical Professionalism, which is "intended to articulate a set of principles and behaviors for healthcare organizations that aspire to nurture professionalism, to encourage the pursuit of excellence by all employees, and to achieve outstanding healthcare with the broader community, and sets expectations as to how model healthcare organizations should be led and managed."⁴

Trust and relationships are central to caring for patients. The new Center is reaching out to invite a wide array of health professions and patients to participate. AΩA and *The Pharos* are proud to be a partner in the advancement of medical professionalism today, tomorrow, and well into the future.

The Center for Professionalism and Value in Health Care

Medicine was one of the first professions to define its ethical code and design a social contract with the public specifying its obligations in return for the privileges afforded it by society. According to Cruess and Cruess, a profession is:

...an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.³

Professionalism is not unique to medicine and its tenets have been defined at various times by Supreme Court Justices, Congress, and in federal regulations.^{5,6} The notion that professions and the public share a social contract is most clearly articulated in medicine. Over the years, that social contract has been fraying resulting in a loss of public trust, a loss of professional autonomy, and physician burn out.^{7,8} It is compounded by the commoditization of medicine.⁹

Harvard Business School Professor Clayton Christensen called for the commoditization of physician expertise in 2006.⁶ For Christensen, commoditization means that the work done by the professional work force is a service that can be moved around or replaced without respect to patient relationships. This runs counter to the significant evidence that therapeutic relationships and continuity of those relationships, has significant value.^{11,12} Commoditization is compounded by a rapid shift to value-based payment in which value is rarely aligned with professional intentions or behavior.^{13,14}

Clinicians experience commoditization as a loss of clinical autonomy as they are often asked to increase the number of patients they see, or to move clinic sites without respect for their patient relationships. They are also asked to increase referrals or services when they aren't warranted. These challenges to professionalism increase the rate of physician frustration.

A shared aspiration

Professionalism is a shared aspiration across health care professionals. The American Board of Family Medicine (ABFM) saw an opportunity in this shared intention for creating space for the professions to develop practical policy and practice solutions to repair medicine's social contract. The Center for Professionalism and Value in Health Care is designed to create this space: a neutral territory for the professions to work collaboratively on solutions.

In July 2018, the ABFM created The Center within the ABFM Foundation, structuring it in a way that invites other professional organizations to collaborate while maintaining autonomy and control of resources. The Center has six initial aims related to the care of patients and medical professionalism.

The ABFM recognizes that professionalism issues can be a source of burnout, specifically the dissonance between relatedness/purpose and the expectations and work environment. Many health professionals are being commoditized. Work is measured in volume or RVUs rather than relationships and healing—and professionalism is leveraged against professionals. Being asked to care for too

Initial aims and efforts of The Center for Professionalism & Value in Health Care

Aims	Hypotheses
Test the state of the social contract between health professionals and the public	Patients, health professionals, and employers are unlikely to understand what the social contract means, what related obligations and privileges are, or how fragile it is
Identify relationships between burnout, shame and professionalism	The inability to do what patients need or for work to be heroic rather than measured, valued, and supported is psychically harmful and leads to poor care
Assess growing commoditization of health professionals and the impact on professionalism	Employers of clinicians who value and support patient and professional relationships reap the benefits of improved outcomes and lower costs
Understand alignment between value measures and professionalism	Measures that are faithful to high-value functions in health care, rather than disease and process measures, are less likely to lead to burnout and more likely to improve the patient and clinician experience
Call out expectations of health professionals to routinely sacrifice well-being or financial solvency	The time, attention, and patient services needed to deliver good care are often supported at the expense of clinician personal or financial well-being, and not by current measures or payments
Explore interprofessional understandings of professionalism	Health professionals face similar frustrations and have common cause to explore and promote support for professional intentions and needs

many patients without sufficient time, support, or team members means that doing the right thing for patients is compounded with existing work.

This reality was poignantly captured in the June 8, 2019, *New York Times* opinion essay *The Business of Health Care Depends on Exploiting Doctors and Nurses, One resource seems infinite and free: the professionalism of caregivers* by Dr. Danielle Ofri. More than 1,000 people responded to the essay echoing the toll of being professional as a commoditized service provider, and lamenting the training of the next generation of clinicians in a “toxic” environment.

The misalignment of professional and corporate values is fraying the social contract. Realigning value and professionalism is possible and can support both professional and corporate interests.

A supportive environment

Creating a clinical environment that is structured to support professional behavior, efficiency, and outcomes is possible. The research team led by Drs. Christine Sinsky (AQA, University of Wisconsin School of Medicine and Public Health, 1981) and Tom Bodenheimer studied 23 high-performing practices. They found that these practices had higher than normal professional satisfaction and embraced the joy of caring.¹⁵ These practices had restructured the teams, the work, and enhanced communication in the current payment environment, thereby improving efficiency, quality, and satisfaction.

These findings led them to create the Quadruple Aim—adding provider satisfaction to the Triple Aim of enhancing the patient experience, improving population health, and reducing costs.^{16,17}

Some health systems are addressing the social contract directly and others are working to support professional behavior and well-being. Geisinger Health created a social compact measure for physician reimbursement that, “ties physician performance expectations to core tenets of care rather than incentive goals.”¹⁸ The Mayo Clinic led development of a Charter on Physician Well-being that emphasizes organizational commitments to build supportive systems, develop engaged leadership, and optimize highly functioning interprofessional teams.¹⁵

The Primary Care Redesign team-based model tested by Smith and colleagues increased the medical assistant to provider ratio from 1:1 to 2.5:1 while expanding the role of medical assistants with facilitation by practice coaches.²⁰ Under this model, provider burnout was reduced by half with simultaneous improvements in quality, patient access, and clinician panel size—all while maintaining staffing costs.

Until health care aligns and designs the clinical space to support professionalism, care of the patient, and the doctor-patient relationship the social contract is at risk. This dissonance results in professions rejecting the accountability mechanisms of professionalism. This is reflected in the anti-maintenance of certification (MOC) movement.²¹ In asking states to remove MOC as a standard for hospital privileges and payment credentialing, hospitals and payers are invited to establish their own standards. This example is not a defense of MOC, but rather recognition that attacking a key tenet of self-regulation risks dismantling the accountability-authority axis of professionalism that is core to the social contract. Surrendering authority in an act of protest compounds the problem.

Attacking medicine’s systems of self-regulation is a symptom of unhealthy alignment. Residency training work

hour restrictions were a similar response to an unprofessional, and unsafe, environment, but that policy also created a threat to professionalism by training physicians to expect their work to be defined by shifts.

In the late 1990s, many academic health systems had commoditized trainees, emphasizing service over learning and safety, and one response was to globally restrict work hours.²² David Leach, CEO of the Accreditation Council for Graduate Medical Education (ACGME) at the time, said:

Whenever we act in a manner inconsistent with our values the profession is weakened. The ACGME released the data on the frequency of work-hour citations, and those data indicate that we indeed are acting at odds with our values. If we abuse our trainees and compromise patient care our status as a profession is jeopardized.²²

It was a blunt policy response that sought to fix a dire case of unprofessionalism, but with unintended consequences of injuring professionalism in other ways.

Today, federal regulators appear open to addressing physician burden and burnout, but medicine must take care with policy responses to ensure support of professional behavior.²⁰ The Quality Outcome Framework in the United Kingdom has demonstrated that financial stakes drive behavior, and if that behavior is counter to or crowds out professional values or the actual value delivered, it produces profound burnout, even despair.¹³ However, the United States has gone down the same path with value-based payments, such as the Quality Payment Program.

The measures used to assess value and determine payment drive behavior so selection is key to determining, improving, delivering, and rewarding value.

The status of the social contract

The Center is working with patients and professionals on the meaningfulness and status of the social contract. The contract is frayed, and faces the fate of certified financial planners and clergy in whom public faith has been shaken because presumed professionalism was violated.

Blame for the opioid epidemic has largely landed on pharmaceutical companies, but there is also blame being assigned to clinicians.²⁴ Media articles point to physicians purposefully killing patients, illicitly fathering children in fertilization clinics, and sexually abusing patients.²⁵⁻²⁷ *The Washington Post* weekly *Medical Mysteries* column is often focused on serial misdiagnoses, but is also laced with patient complaints of being treated unprofessionally.²⁸ Many newspapers and periodicals carry similar stories,

which may not only be an important window on patients' experiences but which may also contribute to conditioning public opinion about health professionals.

The social contract may be sufficiently frayed that professionalism in health care is in jeopardy. Will there come a day when health professionals are asked to sign a contract which binds them legally to be the patient's fiduciary agent as financial planners now do?²⁹ The evaporation of trust in financial planners happened quickly and is a lesson to health professions about how fast the social contract can unravel. Trust and relationships are important elements of healing, so the risk is not just to health professionals' status and privilege, but to their capacity to be effective.

The certified financial planner and clergy scandals are also about the failure of institutions to protect the public from unprofessional agents. In the case of certified financial planners, institutions incentivized and systematized the bad behavior.³⁰ Public trust can evaporate, resulting in a painful, long repair process.

In high-trust relationships, such as those with clergy and clinicians, the stakes of loss-of-faith are even higher. In both cases, the agent is a critical part of the therapeutic intervention. Health professionals need to address institutional understanding of the value of professionalism, and how to support and promote it.

As clinicians are increasingly employed, health systems can support professionalism and have a role in identifying and protecting patients from unprofessional behavior. Michigan State University and other organizations learned this the hard way with blame for not protecting members of the U.S. Women's Gymnastics team from an abusive physician.³¹

Some have called for a new compact that better supports physician leadership.³² The Geisinger social compact that is "aligning our culture around caring" also builds on this intention.¹⁸ The social compact compensation model is described in the context of burnout, and many organizations are making changes to address this, but it is unclear which of those efforts will address the more fundamental problem of being able to practice professionally.

The Foundation for Medical Excellence has built on the Physician Charter for Medical Professionalism to develop a Charter on Professionalism for Healthcare Organizations to identify a set of competencies and behaviors that define professionalism for organizations as has been done for individuals.⁴ The Charter has not found wide acceptance, but is an important, early stake.

The Center will be focusing on further exploring organizational roles in supporting professionalism, including the business case, and potentially supporting the Foundation

specifically. The Center aims to understand the value of relationships. The first set of relationships are about policy solutions that might better align intrinsic and extrinsic values and practical policy solutions. Behavioral economics and the concept of "nudge," which was described by Richard Thaler and Cass Sunstein as "any aspect of the choice architecture that alters people's behavior in a predictable way without forbidding any options or significantly changing their economic incentives," is an important strategy for policy and practice design.^{33, 34} How do professional and market values align to make related behaviors the easy choice in caring for patients and populations?³⁴

Relationships are also within the team. Health professionals need to explore the value of professionalism as it relates to interprofessional relationships and collaborations. Trust and relationships are central to caring for patients, to supporting collaboration and team functions. Having shared understanding of professionalism is important to trust. All health professions must join this journey to build trust.

There is great concern about the value of relationships between clinicians and patients.^{11,12} Commoditization of the health care workforce threatens the value of therapeutic relationships. A recent effort to define the future role of family physicians that focused on the evidence behind their valuable functions offered a contrasting "foil" definition based on how most are currently employed.³⁵ The contrasts of these definitions garnered great reaction.

The Center deliberately does not have medicine in its name in order to invite a wide array of health professions and patients to the table. The Center will need institutional partners to collaboratively discover solutions, improve outcomes and enhance the patient experience. The Center is also exploring patients' understanding and expectations of the social contract. The Center welcomes partners in this endeavor as all health professionals must work together to ensure that medicine maintains its professionalism.

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