Published in final edited form as:

Healthc (Amst). 2014 September ; 2(3): 168–169. doi:10.1016/j.hjdsi.2013.09.005.

Becoming a physician in the age of payment reform

Zirui Song

Massachusetts General Hospital, Boston, MA, USA; Harvard Medical School, Boston, MA, USA;
National Bureau of Economic Research, Cambridge, MA, USA

The good physician knows his patients through and through, and his knowledge is bought dearly. 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.

Dr. Francis Weld Peabody, 1926

When my classmates and I entered medical school, we received a copy of Dr. Peabody's famous lecture, "The Care of the Patient," in our white coat pockets. Those words, first delivered to medical students in 1926, offered a moral compass for our training. They established the ethos of medicine, upon which caring for the patient was both our purpose and fulfillment.¹

In Dr. Peabody's day, medical care was only a narrow sliver of the nation's economy, no more a threat to our fiscal future than a pebble to the ocean. Knowledge was limited. Technology was sparse. Specialization was in infancy. For most physicians, medicine was an art practiced on an open canvas, unencumbered by insurers or regulators.

Today, my classmates and I are preparing for a different reality. Health care spending is the predominant driver of our national debt. Pressure to slow its growth has created a landscape far more conscious, and critical, of what physicians do than ever before. As trainees on the wards, we see and hear of an uncertain future, with payment changes altering our profession in profound ways. From some, we hear the rationale and necessity of payment reform—moving away from an unsustainable fee-for-service system to one centered on value and quality of care, in which joint accountability and care coordination enable physicians to become better stewards of society's resources. From others, we hear the pitfalls and frustrations of payment reform—an assault on physician income and autonomy, battles for control in a constrained pool of resources, and difficult conversations with patients over what they do and do not need.

I have often wondered what Dr. Peabody would think of today's world. How would he advise us to approach it? What would be his guiding principles? Undoubtedly, his core message would remain: that interest in humanity is essential to the clinician, that our care of the patient is founded on caring *for* the patient. Yet he would likely also say something more, something about our obligations to each other in an often divided medical profession, about our opportunity to change the culture of medicine in this age of health care reform.

1. Our obligations to each other

Payment reform changes the relationships between physicians. Whereas in a fee-for-service system one physician's decision has little effect on others, in an Accountable Care Organization under a global budget every decision has implications for colleagues. When one physician orders an expensive test, it affects the physician down the hall, even if they never take care of the same patient. In this highly specialized profession, accountability for spending and quality at the organizational level renders teamwork across specialties a basic physician skill. Listening to each other, co-managing complex patients, and helping each other find efficiencies become core competencies that should be nurtured and sustained.

I belong to a generation of trainees who will enter practice in well over 100 specialties and subspecialties, which were not necessarily designed nor incentivized to practice with each other in mind. Naturally, for a century the evolution of specialization in medicine followed a similar pattern as in many other industries. Practitioners at the horizons of knowledge offered services that few others could perform, met a demand that few others could satisfy, and secured a niche in which few others could compete.² Fee-for-service encouraged this trend, which saw the human body divided into turfs with expertise confined to the organ or the etiology. Though struggles over authority were not uncommon, specialties largely faced few tradeoffs with each other. Each could prosper within its bounds, so long as highways for referrals remained busy. But over time, in exchange for the expertise of depth, our health care system began to relinquish the expertise of breadth. In recent decades, consequences of fragmentation have only risen, as the patient's journey has taken on increasingly disjointed stops from turf to turf.

Despite its drawbacks, payment reform pushes us to stitch these turfs together towards a seamless whole. For the typical patient with diabetes who has 3 primary care physicians and 6 specialists, this may not be a bad thing. For the typical patient with coronary artery disease who sees 10 physicians across 6 practices,³ this can be beneficial. Where old incentives meet new obligations to increase the value of care and keep populations healthy, payment reform pushes us to find common ground. It pushes us to ask "How can I help my colleague do his or her work easier, so that we improve the overall care for our patients?" "How can I better understand his or her constraints and motivations, so that he or she may better understand mine?"

It pushes us to innovate, whether in electronic medical records that facilitate safer care and timely communication or in delivery system reforms that smooth the transitions of care from hospital to rehabilitation to home. It pushes us to be practical, adding social workers, dietitians, pharmacists, and behavioral health specialists into our primary care clinics. It pushes us to better use our words in a world where we increasingly rely on our tools, making sure that our choices for patients, whether aggressive or conservative, truly reflect their preferences. Payment reform makes us think about when less is more, not only in our own decisions but also in our use of each other. It makes us reconsider that referral which merely punts away a problem, as any inefficient spending that follows is borne collectively. It makes us double check our discharge instructions to the next provider, for the costs of a preventable readmission are similarly borne together.

For Dr. Peabody, that personal bond which forms our greatest satisfaction may be as important with each other as it is with our patients.

2. Changing the culture of medicine

Payment reform is not a panacea. To physicians, it can be unwelcoming, uncomfortable, and downright disruptive. However, it does provide the impetus for change. In the long run, slowing the growth of health care spending will require a culture change within medicine—one that resonates with societal needs and comes from physicians themselves.

Culture is amorphous. Clinical practice varies from hospital to hospital and city to city, owing to the history, hierarchy, and the peculiarities of institutions.⁴ As students on the wards, we often know culture when we see it. Culture is the way people interact with each other; it is habits and norms; it is vision and values shared across levels of power. At times, it is simply that unspoken feel of a place, reinforced daily by routine.

For our profession more broadly, culture is who we are to the rest of society. It is the way we handle the public's trust, and the credibility our actions lend to our mission. When health care spending deters businesses from hiring, slows the nation's economic recovery, and crowds out education, infrastructure, and other investments, culture is revealed through how we respond. Today, over 50% of physicians believe that trial lawyers, insurers, hospitals, patients, or drug and device manufacturers have the major responsibility for cost control, compared to 36% who believe that physicians do.⁵ While these other forces—most notably patient demand and risk of litigation—undoubtedly influence clinical decisions, resource utilization remains largely in the hands of physicians.⁶ Until a larger proportion of physicians believe that cost control is within the profession's purview, it will be difficult to truly confront the issue.

Culture change has no blueprint. Yet it often has a spark—a tipping point that changes some prevailing wisdom or the prospect of catastrophe that forces our hand. For medicine, it will likely be the latter.⁷ Federal health spending, left on its historical trend, would require substantial tax increases (greater than 160% increases for all tax brackets by 2050), reductions in Medicare or Medicaid generosity, or provider fee cuts to fund.⁸ None of these are particularly desirable.

Culture change may thus be inevitable. If it is, it will need physician leaders to motivate a vision of shared responsibility and reward. It will require innovative physician organizations to set forth models for delivering high quality, patient-centered care at lower cost. It will also take each of us doing our own small part. No matter our specialty, we can help our patients to practice prevention. We can cultivate provider teams comfortable with learning to manage population health. And as interns and residents, we can further the debate about high and low value services and encourage discussion about the broader implications of our clinical decisions. When a better way should replace an old routine, we can aid in the diffusion of innovations into practice.⁹

Little by little, a new generation of physicians may nudge medicine towards a more efficient and understanding place, away from a tragedy of the commons.¹⁰ In a profession where

financial incentives determine so much, it behooves us to recall the timeless words of Peabody or Hippocrates, which add humility to our craft and humanity to our capitalism.

Acknowledgments

Song received support from a National Institute on Aging Pre- doctoral MD/Ph.D. National Research Service Award (F30 AG039175) and a Fellowship in Aging and Health Economics from the National Bureau of Economic Research (T32 AG000186). The funding organization had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

References

1. Peabody FW. The care of the patient. *Journal of American Medical Association*. 1927; 88:877–882.
2. Weisz, G. *Divide and Conquer: A Comparative History of Medical Specialization*. USA: Oxford University Press; 2005.
3. Pham HH, Schrag D, O'Malley AS, Wu B, Bach PB. Care patterns in medicare and their implications for pay for performance. *New England Journal of Medicine*. 2007; 356(11):1130–1139. [PubMed: 17360991]
4. Starr, P. *The Social Transformation of American Medicine*. USA: Basic Books; 1982.
5. Tilburt JC, Wynia MK, Sheeler RD, et al. Views of US physicians about controlling health care costs. *Journal of American Medical Association*. 2013; 310(4):380–388.
6. Chandra, A.; Cutler, D.; Song, Z. Who Ordered That? The Economics of Treatment Choices in Medical Care. In: Pauly, MV.; McGuire, TG.; Barros, PP., editors. *Handbook of Health Economics*. Vol. 2. North Holland: Elsevier Science; 2012. p. 397-432.
7. Chernew ME, Baicker K, Hsu J. The specter of financial armageddon—health care and federal debt in the United States. *New England Journal of Medicine*. 2010; 362(13):1166–1168. [PubMed: 20237338]
8. Newhouse JP. Assessing health reform's impact on four key groups of Americans. *Health Affairs (Millwood)*. 2010; 29(9):1714–1724.
9. Rogers, EM. *Diffusion of Innovations*. 5th. New York: Free Press; 2003.
10. Ostrom, E. *Governing the Commons: the Evolution of Institutions for Collection Action*. New York: Cambridge University Press; 1990.