Physician Autonomy and Health Care Reform

Ezekiel J. Emanuel, MD, PhD
Steven D. Pearson, MD, MSc

MANY PHYSICIANS ARE DISTRESSED AS THEY LOOK TOward the future. A recent survey of physicians reported that 65% thought the quality of health care will deteriorate in the future.[1] Part of this malaise is driven by concerns that reforms contained in the Affordable Care Act (ACA) will further erode physicians' autonomy.

On the contrary, the ACA has provisions that will mitigate the long-standing concern that payers determine what physicians can and cannot do and will instead enhance the role and authority of the medical profession. However, this possibility can only occur if physicians leverage the opportunities to shape and ensure effective implementation of new payment models proposed in the ACA.

What Is Physician Autonomy?

While physician autonomy is frequently invoked as an important value, there have been few attempts to specify its meaning. To many, physician autonomy means that physicians should have complete freedom to provide treatments for patients according to their best judgment.

However, this characterization is inadequate.[2,3] First, it is too limited in scope. Part of physician autonomy extends beyond specific treatment decisions to include broader control of the terms, conditions, and content of work, in particular how to organize the way care will be provided. More importantly, this characterization conflates autonomy with liberty.[4,5] Liberty from controlling interference is necessary but not sufficient for autonomy. For example, in addition to liberty, the conditions necessary for patient autonomy include mental competence, adequate information, and understanding of that information.[6] Similarly, physician autonomy requires conditions beyond liberty.

Perhaps the defining element of physician autonomy is that it arises in the context of the patient-physician relationship. Illness renders patients vulnerable and physicians have specialized knowledge and skills that give them the power to take advantage of that vulnerability. Consequently the ethical justification for physician autonomy requires that they exercise liberty to promote their patient's best interests not their own interests. Therefore, physician autonomy is the freedom to determine both the conditions of practice and the care delivered with the principal goal that care decisions are aimed at promoting the patient's well-being. Requirements include that the physician is technically competent to assess the patient's illness and concerns and to recommend or perform appropriate care; care decisions are guided by the best available medical evidence and professional standards; and—when the patient is mentally competent—are made through a process of shared decision making.

See also p 369.

Physician Autonomy and the ACA

Will health care reform restrict or enhance physician autonomy? The ACA contains many provisions that will both expand coverage for patients and reduce their financial barriers to adherence with physicians' clinical recommendations, such as removing co-payments from preventive services and subsidizing individual purchase of health insurance.[7] More relevant to physicians' autonomy, the ACA initiates payment reforms that will give physicians greater financial flexibility to redesign care delivery, and to provide services that may not have been reimbursed before. For example, traditional fee-for-service payment mechanisms do not reimburse for efforts to enhance medication compliance or to oversee the results of wireless physiological monitoring in patients' homes.

In contrast, an ACA pilot program featured bundled or lumpsum payments to physicians for the care of individual patients over time, allowing physicians to develop and deliver new approaches to care without being concerned about whether Medicare will pay for a specific service. For example, if congestive heart failure is selected for bundled payment, physicians will have the financial power to redesign the structure of posthospital care to improve patient adherence with medications and other tertiary prevention measure. Physicians could decide whether to introduce new wireless technologies for monitoring weight and blood pressure, or whether to make a house call instead of directing the patient to seek emergency department care.

Another provision of the ACA that offers physicians more liberty to pursue patients' best interests is the move toward accountable care organizations (ACOs), which are combinations of physician groups, hospitals, and other providers that will coordinate care for patients.[6] The proposed ACO regulations require physician leadership and empower physicians to determine the information systems and infrastructure necessary for coordinating care. The freedom to redesign care occurs along a spectrum depending on how the ACO is paid. Global or partial capitation that provides physicians with a pool of resources to manage a population of patients provides the maximal flexibility and liberty, although it also has the greatest financial risk.

Author Affiliations: Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia (Dr Emanuel); and Institute for Clinical and Economic Review, Massachusetts General Hospital Institute for Technology Assessment, Boston (Dr Pearson).
Corresponding Author: Ezekiel J. Emanuel, MD, PhD, University of Pennsylvania, 122 College Hall, Philadelphia, PA 19104 (zemanuel@upenn.edu).

Conversely, retaining fee-for-service payment with shared savings provides some, but less flexibility. Nevertheless, compared with traditional fee-for-service plans, the new ACO program offers physicians more liberty to pursue patients' best interests in a more effective manner.

The ACA will also enhance physicians' knowledge to care for patients through the Patient-Centered Outcomes Research Institute (PCORI). When fully funded, the PCORI will devote $600 million per year to comparative effectiveness research and dissemination of its findings. The ACA requires that the PCORI design its work to generate results that help physicians with decision making for individual patients not just for the average patient. Knowing whether surgery, catheter ablation, or pharmacological treatments for atrial fibrillation is most effective—or equally effective and less expensive—and for which subgroup of patients, will enhance decision making for individual patients. Such information will be absolutely essential for physicians as they assume the role of deciding what services they want to provide as part of a bundled payment or how to deliver services within an ACO model. Together, more information through the PCORI and new payment models should facilitate the redesign of care and care decisions in a way that significantly enhances physician autonomy.[8]

Some physicians may be concerned if the PCORI's findings show that a procedure or treatment from which they receive substantial income is comparatively less effective. For instance, publication of studies showing that vertebroplasty was no more effective than a placebo procedure for spinal fractures may mean that interventional radiologists perform fewer vertebroplasties.[9] Such consequences should not be confused with a decrease in physician autonomy.

Autonomy for Individual Physicians and for Groups of Physicians

The ACA reforms will not only enhance the autonomy of physicians practicing in large groups. Small groups of physicians have been able to develop new models for delivering care.[10] Furthermore, solo practitioners will be able to decide whether to join an ACO, with which other physicians they want to collaborate with on a bundled payment, and how to work together to define the care the group of physicians should deliver. Most importantly, coordination of care is a primary requirement for high-quality care. Because physician autonomy should be directed toward patients' best interests, physicians must seek better ways to coordinate care. The ACA helps to support physicians financially in achieving better coordination of care and therefore offers physicians greater opportunities for leadership in cementing a vision of physician autonomy as physicians working together. Working together with other physicians is not antithetical to exercising individual autonomy.

What Should Physicians Do?

The expansion of physician autonomy catalyzed by the ACA will not happen on its own. Physicians need to be proactive. First, physicians need to invest resources in redesigning their care delivery systems. Physicians should not wait for Medicare, private payers, or hospitals to develop bundled payment models. They need to devise and propose their own models with cost and quality indicators that they are willing to be accountable for. Similarly, physicians will have to work to develop ACOs and delineate how to deliver care better. As part of this effort, they will need to leverage the explosion of information by installing electronic health records with decision supports, integrating the added information into their practice design and clinical decisions.

Enhancing physician autonomy will not be easy or risk-free. Indeed, greater physician autonomy in the future is linked to accepting more financial risk. Under fee-for-service payment mechanisms, payers define the limits of physician autonomy. Assuming more financial risk is the price physicians will have to pay for more professional autonomy.

Conclusions

Physician autonomy is not equivalent to the liberty to treat patients however physicians want but fundamentally rooted in the effort to promote patients' best interests. By moving away from the constraints of fee-for-service reimbursement that pays only for specific interventions but not for new ways of delivering care, and by providing new information on what interventions work and for which types of patients, the ACA provides a framework for enhanced physician autonomy. This does not mean that all physicians will benefit equally, or that it will not require physicians to change the way they have been practicing. Indeed, the enhancement of physician autonomy will require more collaboration. But such changes are all in the service of better realizing the chief goal of physician autonomy: the best interests of all patients.

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

REFERENCES

1. Thomson-Reuters. The 2011 National Physicians Survey: frustration and dismay in a time of change. http://mikemeikle.files.wordpress.com/2011/01/2011-thomson-reuters-hcplexus-national-physicians-survey.pdf. Accessed December 12, 2011.
2. Reinertsen JL. Zen and the art of physician autonomy maintenance. *Ann Intern Med*. 2003;138(12):992-995.
3. ABIM Foundation; American Board of Internal Medicine; ACP-ASIM Foundation; American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136(3):243-246.
4. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 6th ed. New York, NY: Oxford University Press; 2009:chap 3.
5. Dworkin G. *The Theory and Practice of Autonomy*. New York, NY: Cambridge University Press; 1988:chap 1, 7.
6. Berwick DM. Making good on ACOs promise—the final rule for Medicare shared savings program. *N Engl J Med*. 2011;365(19):1753-1756.
7. Patient Protection and Affordable Care Act, §3022, Pub L No. 111-148, 124 Stat 119 (2010).
8. Brook RH. Can the Patient-Centered Outcomes Research Institute become relevant to controlling medical costs and improving value? *JAMA*. 2011;306(18):2020-2021.
9. Buchbinder R, Osborne RH, Ebeling PR, et al. A randomized trial of vertebroplasty for painful osteoporotic vertebral fractures. *N Engl J Med*. 2009;361(6):557-568.
10. Milstein A, Gilbertson E. American medical home runs. *Health Aff (Millwood)*. 2009;28(5):1317-1326.