Medical Professionalism in the United States

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MGH and HMS

- Research was funded by grants from the Institute on Medicine as a Profession at Columbia University
- I have never had any relationship of any kind with any company whose products or services are in anyway related to medical education, research or patient care.

- Catherine DesRoches
- Lisa Iezzoni
- David Blumenthal
- Christine Vogeli
- Sowmya Rao
- Janice Ballou
- Jack Fowler
- Tim Ferris
- Elliot Fischer
- Jon Skinner
- Dragana Bolcic-Jankovic
- Mary Beth Landrum
- Paola Miralles
- Lenny Lopez
- John Fromson
- Robert Birnbaum

The Plan

- Background
- Methodology
- Results
- Implications
- Discussion

- Professionalism is defined as **attitudes and behaviors that reflect widely accepted standards of professional conduct**.

- Standards of professional conduct are set forth in the **Charter on Medical Professionalism** formulated by the American Board of Internal Medicine Foundation.

Charter on Medical Professionalism

THREE PRINCIPLES

- Primacy of welfare
- Patient autonomy
- Social justice

TEN COMMITMENTS

- Professional competence
- Honesty with patients
- Patient confidentiality
- Maintaining appropriate relations with patients
- Improving quality of care
- Improving access of care
- Just distribution of finite sources
- Scientific knowledge
- Managing conflicts of interest
- Professional responsibilities

- Explore physician attitudes and behaviors related to the various domains of physician professionalism.
- Understand what factors may explain physician attitudes, behaviors, and associations.
- Examine how these have changed since our 2004 survey.

Methods

- Mixed Mode Study Consisting of:
  - Focus Groups: 4 total (*2 specialists and 2 primary care)*
  - Participants: 8-10 physicians / group
  - Length: 1.5 hours
  - Format: Semi-structured
  - Focus: Professionalism domains not well measured in the 2004 survey
  - Results: Analyzed by 3 members of the study team for new question development

Methods

- Convened an expert measurement advisory group (EMAG).
- Purpose of EMAG:
  - To generate new ideas for development of survey items
  - To evaluate current questions for clearness and appropriateness
  - And in doing so increase the face validity of the survey and its credibility with key audiences
- EMAG was comprised of experts on professionalism drawn from within and outside selected specialties and survey measurement experts.
- EMAG recommendations guided all survey revisions.

Methods

- Survey measured attitudes and behaviors related to each domain
- Limited pre-testing as most items used previously
- 30 person mailed pretest for new items
- Final survey approved by the Institutional Review Board of the investigators’ institution.

- **Analyses**
  - Weighted to account for differential rates of sampling within speciaty as well as for non-response.
  - Bivariate
    - 2-sided t-tests (continuous variables) or x2 tests (categorical variables)
  - Multi-variate
    - Based on our bivariate analyses and previous research
    - Dropped several variables with high correlations:
      - Gender and income due to high correlations with specialty
    - Logistic regression models to evaluate the association of the outcomes with the independent variable

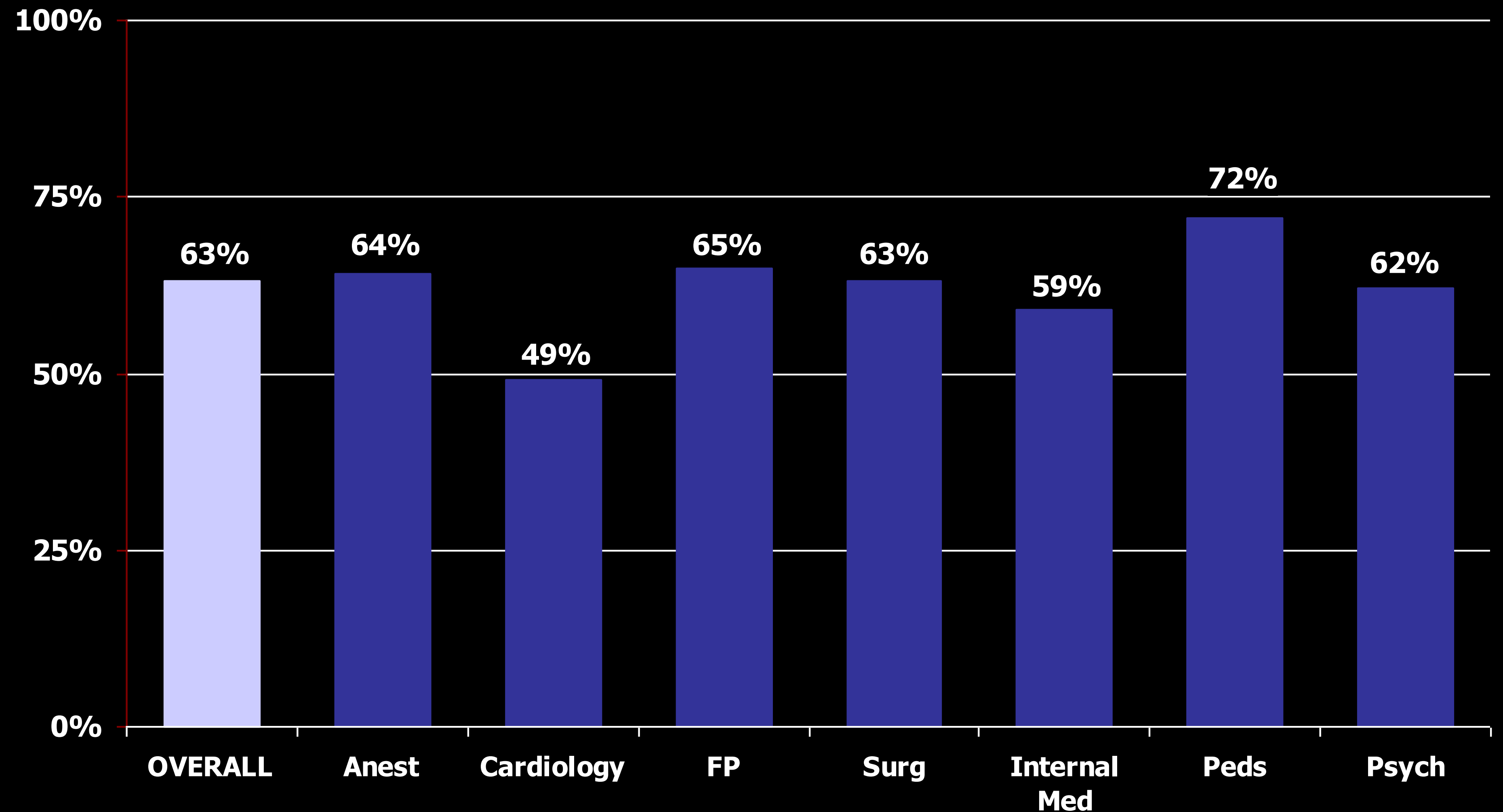
Methods

- **Survey Sample**
  - Using the American Medical Association Masterfile we randomly selected:
    - 500 General Internal Medicine
    - 500 Pediatrics
    - 500 Family Practice
    - 500 Anesthesiology
    - 500 General Surgery
    - 500 Cardiology
    - 500 Psychiatry
    - **Total = 3,500**

Methods

- Survey Administration
  - Survey Firm: CSR (University of Massachusetts)
  - Field Period: Summer and fall, 2009
  - Mailing: 1st round sent Priority Mail
  - Incentive: $20 cash
  - Follow Up: Intensive telephone calls, postcard reminders, and a final mailing to all non-respondents

Response Rates



Characteristics of Respondents

Characteristic:	N	Weighted %
Gender:		
Female	539	32.8
Male	1284	67.2
Race/Ethnicity:		
Non-underrepresented	1648	89.6
Underrepresented	168	10.4
Number of years in practice:		
<10 years	210	12.4
10 - 19 years	464	27.6
20 - 29 years	569	29.0
>=30 years	579	29.4

Characteristics of Respondents

Characteristic	N	Weighted %
Specialty:		
Anesthesiology	259	10.6
Cardiology	218	6.4
Family practice	269	21.8
General surgery	263	7.2
Internal medicine	249	28.7
Pediatrics	297	15.3
Psychiatry	255	10.1
FMG Status:		
USMG	1331	72.2
Foreign medical graduate	494	27.8
Income:		
Lt $100,000	324	20.3
$100,000 - $150,000	378	25.7
$150,001 - $200,000	314	19.3
$200,001 - $250,000	224	12.0
$250,001 - $300,000	178	8.2
More than $300,000	354	14.6

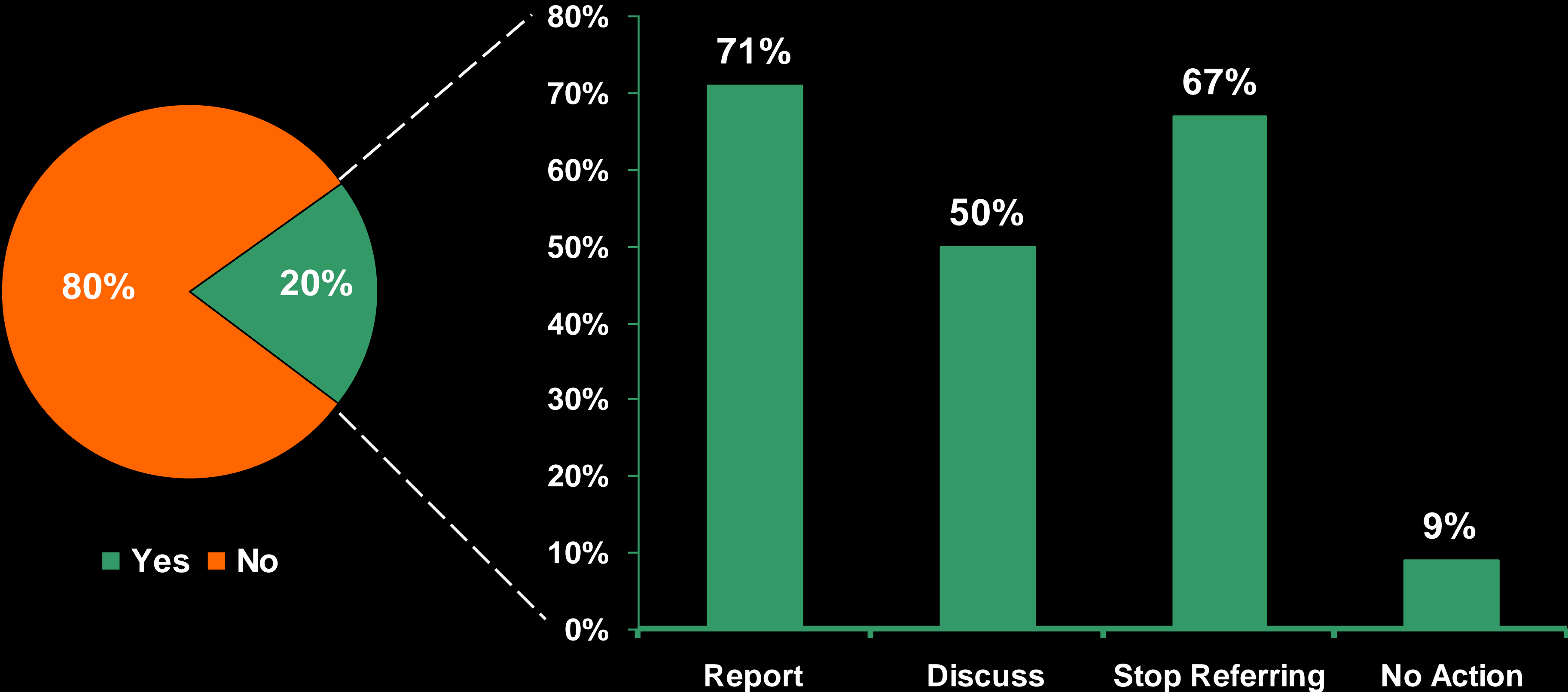
Characteristics of Respondents

Characteristic	N	Weighted %
Practice organization:		
Hospital or clinic	343	18.8
University or medical school	117	5.5
Staff-model HMO	65	3.7
Group practice	744	40.4
Solo or two-person practice	401	22.0
Other	158	9.6
HRRs in Tertiles of Spending:		
Low	355	20.9
Medium	1016	54.9
High	459	24.2
Primary payment mechanism:		
Fee for service	908	48.8
Partial Capitation	63	3.4
Full Capitation	39	2.3
Salary	704	39.9
Other	99	5.7

Selected Findings

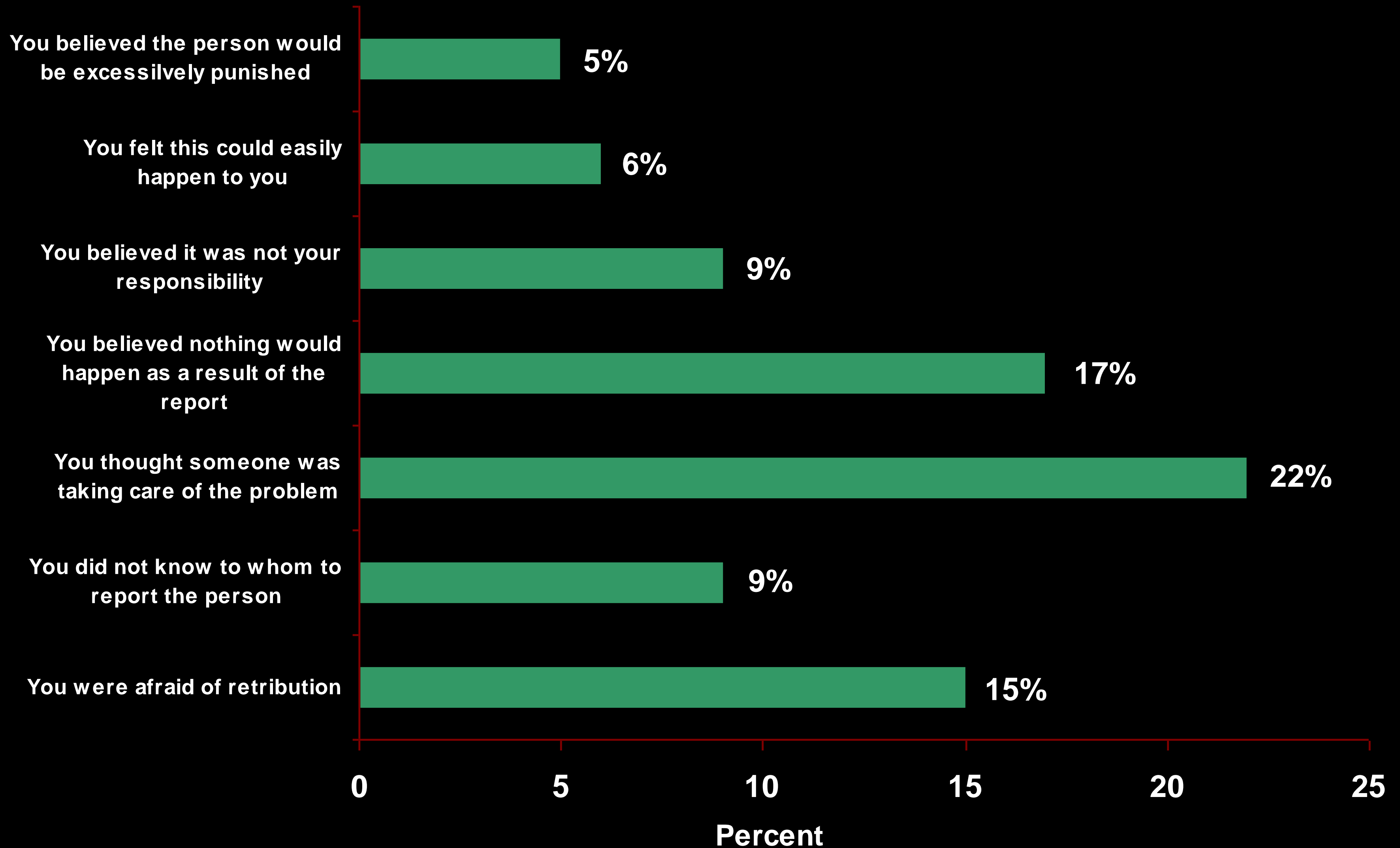
- Reporting impaired or incompetent colleagues
- Physician industry relationships

In the last 3 years, have you had direct personal knowledge of a physician who was impaired or incompetent to practice medicine in your hospital, group, or practice?

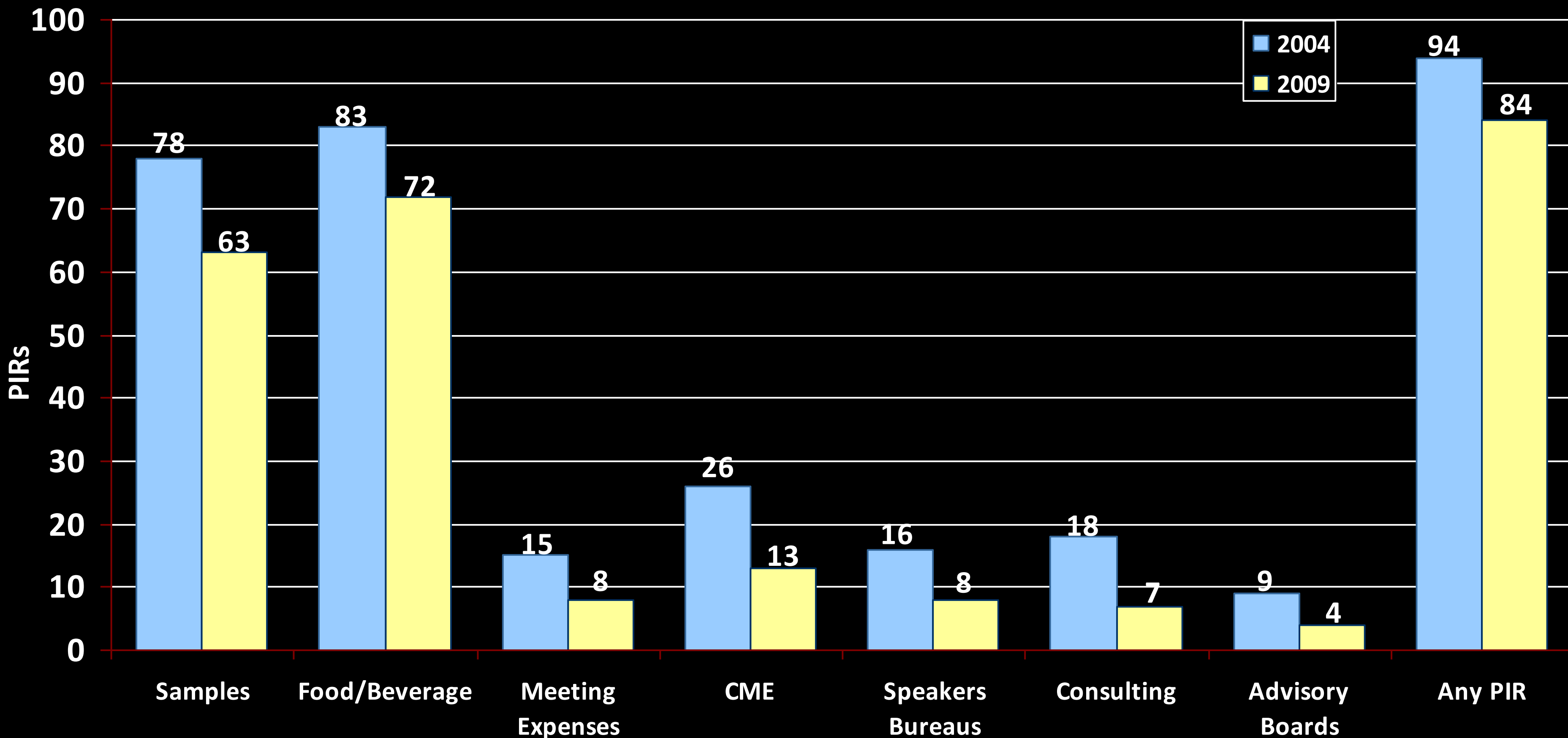


In the most recent case did you…

Reasons given for not reporting incompetent / impaired physician

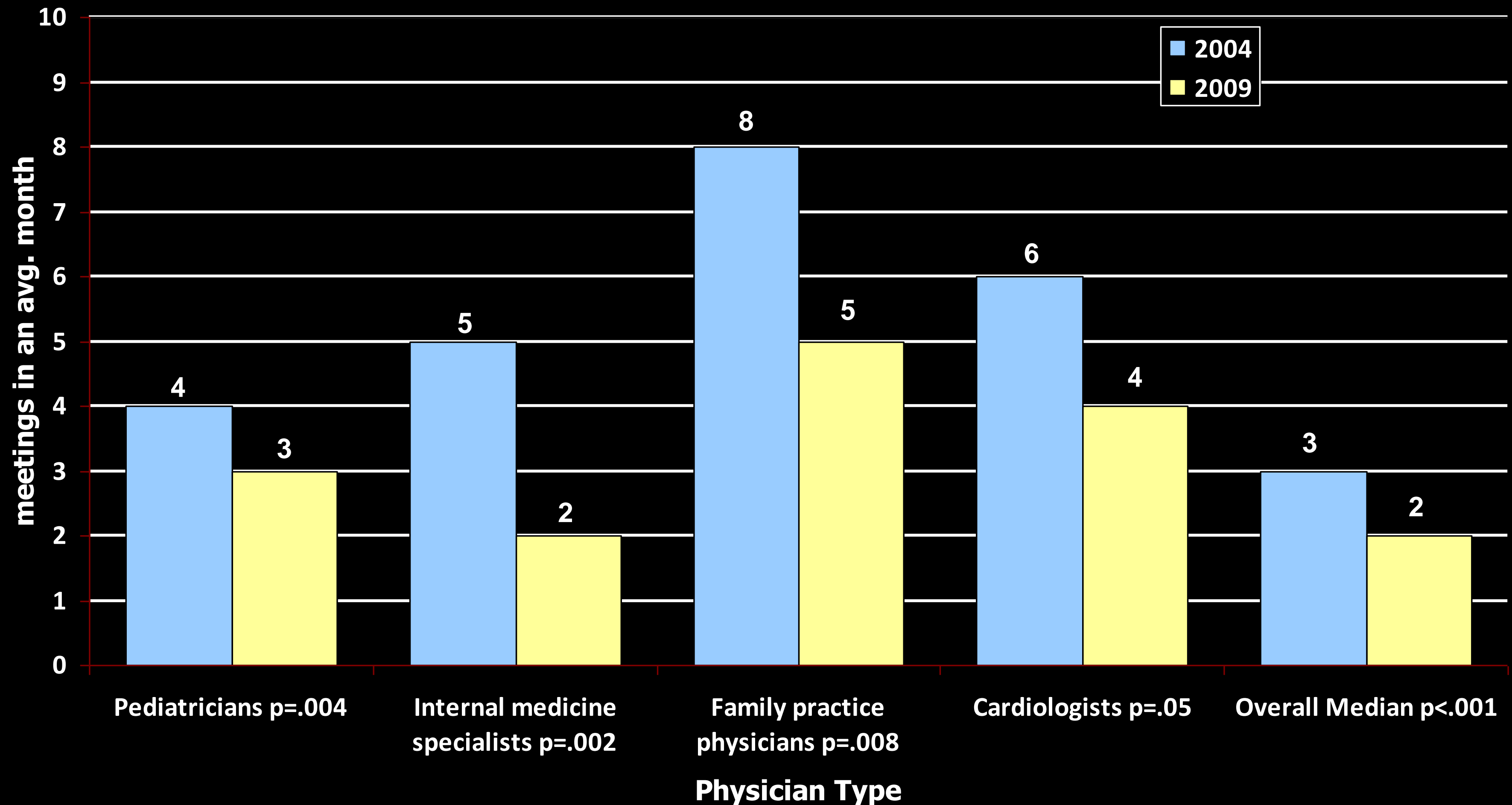


Changes in PIRs 2004-2009

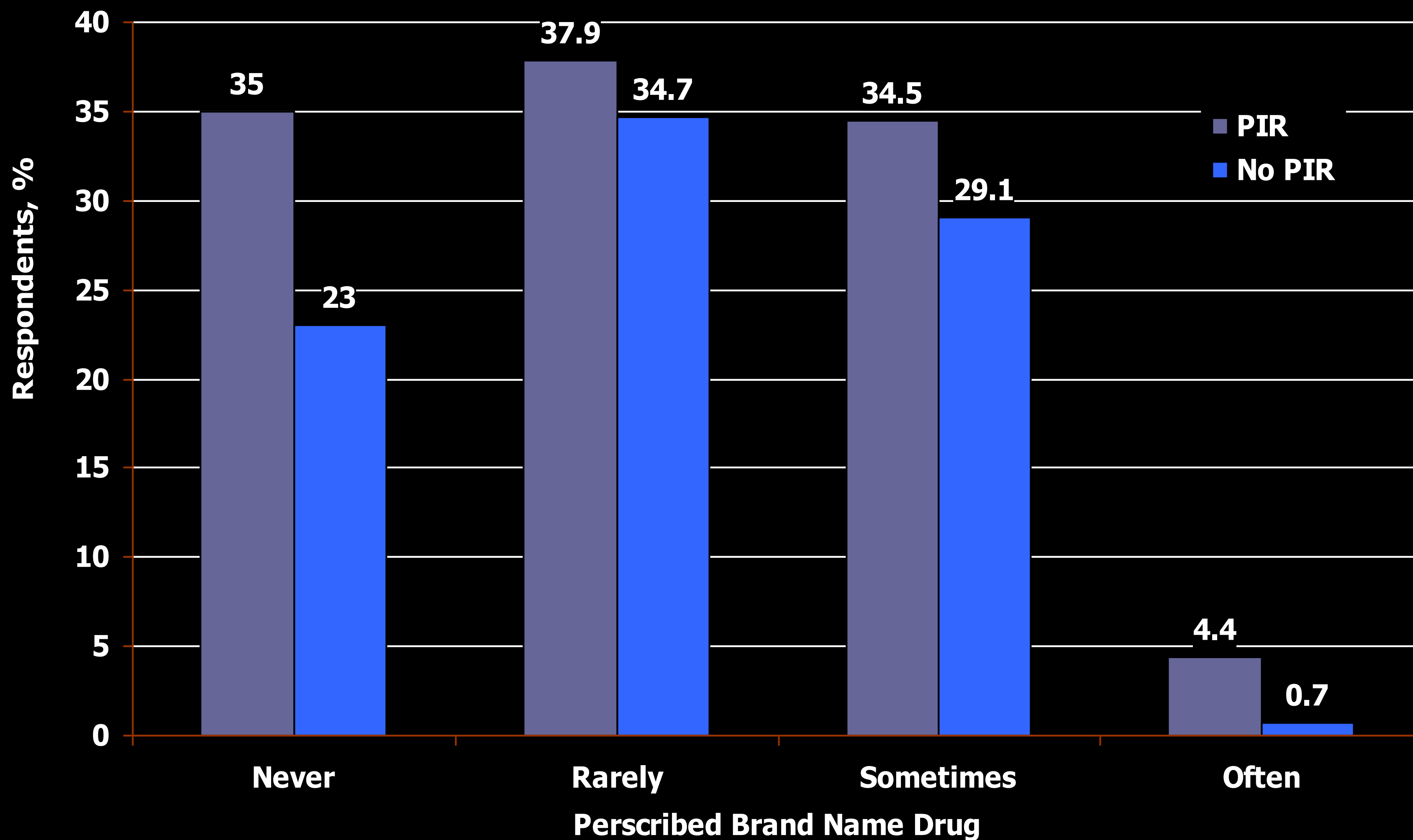


± p-value <.001 comparing weighted 2004 data to weighted 2009 data

Number of meetings between drug reps and physicians



PIRS and Self Reported Prescribing Behavior



- At least three additional papers on quality, physician-patient communication and care for the poor and underserved
- Working with collaborators in England on a US vs. England comparison
- Exploring options for expansion of this survey as part of licensure.