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Pay for Performance and Medical Professionalism

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Health care delivery systems are widely studying and implementing physician pay for performance (P4P) initiatives to improve quality and control costs. However, the increasing focus on quality-driven financial incentives has some troubling implications for medical professionalism. This article examines the P4P concept in light of a notion of medical fiduciary professionalism that dates back to the 18th-century Scottish physician John Gregory. Gregory's principles serve as a framework to assess the appropriateness of P4P initiatives in disseminating the principles of high-quality care without damage to professionalism, the patient-physician relationship, and access to care for all patients.

Key words: *physician incentive plans, professionalism*

It has been widely documented that physicians often fail to implement even well-established and accepted recommendations for patient care[1,2]; this failure in quality has the potential for real harm to patients.[3] It is an ongoing challenge to the profession to continue to accurately define "quality" as it pertains to different patient populations and care settings and to determine novel mechanisms to educate and encourage individual physicians to provide effective, high-quality care. Physician pay for performance (P4P) initiatives are being widely introduced and studied in this context; by linking physician pay to some definition of high-quality care, they aim to improve health care quality while lowering costs.[4] P4P concepts are being implemented with the collaboration of a wide variety of health care organizations, including the US Centers for Medicare and Medicaid Services, the Joint Commission, the National Quality Forum, the Agency for Health Care Research and Quality, and the American Medical Association (AMA),[5] as well as a large number of corporate and insurance interests.[6] It is clear that at least for the near future, P4P will be expanding and broadening its reach, touching the practices of more and more physicians.[4] Certainly few would dispute the validity and importance of the twin goals of improving the quality and cost-effectiveness of care provided to all patients. However, the notion of using financial incentives to support and improve quality of care

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in the context of a professional endeavor such as medicine is not without moral and practical risk, particularly in light of some of the specific challenges of implementing effective P4P programs in the current environment.

This article will examine the P4P concept in light of a notion of medical fiduciary professionalism that dates back to the 18th-century Scottish physician John Gregory. Gregory's principles serve as a framework to assess the appropriateness of P4P initiatives in disseminating the principles of high-quality care without damage to professionalism, the patient-physician relationship, and access to care for all patients.

MEDICAL PROFESSIONALISM

It is well known that physicians begin their professional lives by swearing an oath. In truth, the details of the original text of the Hippocratic Oath would surprise many observers, given the inclusion of reference to swearing by the ancient gods and goddesses, a promise that physicians will financially support their medical teachers and impart medical wisdom to their children without fee, and blanket prohibitions on surgery and abortion. Although the degree of attention paid to the oath by practicing physicians must vary considerably, most would still agree that the oath can be considered in its symbolic form to link modern physicians to an ancient tradition of healing and self-sacrifice.[7] There is a widespread sense that physicians, as members of a noble profession, have rights as well as responsibilities to their patients and to the society that go beyond those of members of other trades. The patient-physician relationship is necessarily a fiduciary one, in which the imbalance of power between the 2 individuals requires a high level of trust on the part of the patient and a duty on the part of the physician to be worthy of that trust. Physicians' efforts to merit that trust and to live up to the principles of their oath are supported by a concept of medical professionalism that has developed as the profession has grown. Although many, if not all, physicians fall short of the rigorous standards central to the notion of professionalism, it is still instructive to consider physician conduct in light of these historical ideals.

The development of the modern notion of fiduciary professionalism has been traced to 18th-century Scottish physician John Gregory. He laid out a framework for intellectual and moral excellence in medicine that can be summarized by 3 main elements. First, physicians must accept the intellectual discipline of science so their practice will be free of bias. Second, their primary consideration should be the protection and promotion of the patient's health-related interests. Third, physicians should keep all forms of self-interest, economic and otherwise, systematically secondary. These principles are to be supported and put into practice through the embodiment of 4 key virtues: integrity, compassion, self-effacement, and self-sacrifice.[8] If all physicians were perfectly attentive to the principles of professionalism and their attendant virtues, they would naturally be drawn to provide high-quality care, irrespective of outside incentives, financial and otherwise. However, given that self-interest is a natural and powerful force, one way to understand P4P initiatives is that they represent efforts to align physicians' self-interest with the intellectual discipline of science. This is a reasonable goal. Even so, in considering such a fundamental change to the financial framework of medical practice, one must assess its potential effect on all aspects of medical professionalism and the professional virtues.

Gregory's first principle of professionalism, scientific discipline, is well served by the goals of P4P programs. The notion of optimizing quality of care is ubiquitous in the language of P4P mission statements; if program developers are to be taken at their words, optimally designed P4P programs would support the ideals of medical professionalism. There is, however, an associated professional requirement to scientifically evaluate the effects of the programs themselves. The second principle of professionalism is only somewhat more problematic for the development of P4P programs. If the primary professional goal is to be the protection and advancement of patients' health-related interests, well-designed P4P arrangements can facilitate this through their direction

of providers' attention to the most pressing of those interests. However, a poorly designed or imperfect P4P plan can counter this principle by interposing a layer of distraction between the medical assessment of the patients' needs and the implementation of a plan to address those needs, leading to inappropriate over- or underuse of tests, treatments, or procedures. Simply put, if a P4P program promotes and measures one action but the patient's condition requires another, P4P may make physicians reluctant to provide for the patient's real needs.

The third principle of professionalism, requiring that physicians put all forms of self-interest "systematically secondary" to patient well-being, is the most problematic in the implementation of P4P. One of the intentions of P4P is to address concerns of misaligned self-interest inherent in the traditional fee-for-service environment, where rewards based on *quantity* of care can lead to financial disincentive for provision of optimal care, because physicians and hospitals receive no compensation when they appropriately withhold a test or procedure.[9] This leads to a tension between the need of physicians to make a living and their professional responsibility to put patients' interests first. If all physicians were perfectly self-sacrificing, payment schemes would have no effect on practice. However, given that financial realities do at times have an effect on physicians' behavior, the P4P movement seeks to turn this weakness into a strength, exploiting physicians' desire for financial gain in service to patients. This can be seen as an attempt to render the third principle of professionalism obsolete, by aligning physicians' financial interests with the health needs of their patients. It carries a risk, however, of further weakening the notion of the virtue of self-sacrifice, leading physicians over time to devalue their professional responsibility to put their own rewards second. This scenario has the potential to degenerate further into one in which physicians would learn to neglect those substantial aspects of good practice that are not being specifically measured.[10] As anyone who has ever seen a student raise a hand and say "Is this on the test?" can attest, overt measurement can focus attention tightly on those items that are measured, to the detriment of other areas. Even as P4P measures are refined, the needs of patients and the dictates of P4P payers cannot always be perfectly aligned. Physicians will then need to rely on their professionalism and their virtues of integrity, compassion, self-effacement, and self-sacrifice to make the right choices. Vigorous attempts to teach physicians that maximal reward should always follow from maximum quality may leave them ill-prepared to make the right decision when that assumption does not hold.

Is health care a business like any other?

The idea of using financial incentives to alter physician behavior has its roots in the business world and in the study of human behavior, applying established principles of performance measurement and compensation to health care providers.[11] Given the principles of medical professionalism, though, is P4P an appropriate application of business thinking? At some level, health care is a business; patients are billed so that physicians, other practitioners, hospitals, and pharmacies can be paid for their work. However, the work of physicians and their relationships with those they serve are in many ways fundamentally different from those in other fields of business; this divergence should give us pause in too freely applying business principles to medicine. A few examples illustrate this difference.

One such example is the expectation that in times of natural disaster physicians will stay with their patients rather than evacuating with their families, as demonstrated by the many heroic actions by health care providers following hurricane Katrina.[12] Another is the tradition of physicians caring for patients with infectious diseases despite the risks to themselves. This has not always been considered a requirement of the profession, but the notion that physicians should remain to offer their services when "pestilence prevails" was included in the AMA's first code of ethics in 1846.[13] Although that statement has been removed as the AMA's code has been shortened, the notion that professional virtue and the implicit contract between physicians and society at times requires physicians to voluntarily expose themselves to contagious disease has remained in the modern era.[13,14]

This historical duty of the profession is an extension of Gregory's expectation that physicians should at all times put the patients' needs first; it represents a strong distinction between the role of the physician and those in other types of businesses.

The notion of a contract between physicians and society is a powerful one. This contract can be understood to require physicians to provide a level of dedication beyond that expected of workers in other fields in exchange for the support the society gives their training and their practice. Some authors argue that the very possession of the medical skill set confers a responsibility to use it when it is called for, although there is debate as to whether this is different from the expectations the society has of persons with *any* skill set that could be useful in an emergency.[15] It has even been said that physicians have a responsibility to offer unsolicited opinions to strangers in nonmedical settings, if they believe the benefit to the patient is sufficient to justify the violation of privacy.[16] This could be said of those in other fields as well, but the responsibilities of physicians are unusual in the very personal nature of the information in which they trade. Most people would be more bothered by a doctor who did not stop to help at an accident than by a librarian who refused to help with a research emergency. This view of medical professionalism requires that physicians follow Gregory's edict to place the needs of patients ahead of their own even when the person in question is not formally their patient at all.

In addition, the practice of medicine is further set apart from other businesses by the expectation that physicians are committed to the notion of beneficence. It has been said that in this physicians are no different from pilots or shopkeepers, as all work is done with the intention of providing some benefit to a customer.[15] However, physicians ideally take the notion of *benefit* one step further, by considering it a professional responsibility to determine whether a service requested by a patient is truly in his or her best interest before providing it. Although it is a pilot's job to transport all passengers safely, the pilot does not concern himself with whether the trip will benefit the passenger. Likewise, shopkeepers can freely sell their customers articles that they do not need, while prescribing unnecessary medications or procedures for personal profit is unacceptable for physicians.[17] This is a telling example of Gregory's third principle of fiduciary professionalism, requiring physicians to place their own financial needs systematically secondary to the needs of their patients. In general, the principles of professionalism lead to a contrast between physicians and workers in other businesses in which there is no fiduciary duty. In considering the business motivation behind newly developed P4P programs and the effects the programs may have on medical practice, it is important to remember that medical professionalism and the social contract make the "business" of medicine hardly a business at all.

Corporate forces driving P4P implementation

Although P4P counts among its advocates such professional organizations as the Institute of Medicine[18] and the AMA,[19] the P4P plans cited in reviews of the topic have generally been initiated and driven by insurance companies or corporate purchasers of health plans. In Epstein and colleagues' 2004 review, they outline 3 "prototypical systems." Of these, one (Bridges to Excellence) is described as spearheaded by General Electric in collaboration with a number of health plans and "other employers"; the other two are directly led by a health plan and a group of health plans.[20] The listing of board members on the Bridges to Excellence web site lists 5 physicians among the board's 14 members, but the listed affiliations indicate that each of the five represents a health plan or a corporation.[21] The P4P scheme assessed in detail in the 2005 study by Rosenthal and colleagues was implemented by a health plan, PacifiCare.[22] This is not to imply that P4P initiatives spearheaded by business interests or insurance companies do not have the potential to be of substantial benefit to patients. After all, if payment is being used as the motivator, it would be impossible to implement substantive changes without involving payers. However, it is worth considering the potential motivations of the various players in light of the expectations of professionalism. Many health plans are publicly traded, for-profit companies. Their

stated missions may be to improve the health of their clients, but in a publicly traded company shareholder value and profitability are always present as background considerations. Likewise, the large corporations that lend their might to P4P initiatives in their roles as purchasers of health insurance are ultimately beholden to shareholders to produce a profit. Although they likely value the health of their employees both from basic human decency and from their desire to avoid lost workdays and retraining costs, it cannot be forgotten that employee health care is a significant, complex, and growing expense for large corporations.[23,24] Cutting these expenses must be part of their motivation for endorsing P4P programs. The Leapfrog Group, a consortium of employers with the mission of "trigger[ing] giant leaps forward in the safety, quality, and affordability of health care. . .," acknowledges as much by including affordability in its top 3 goals.[25] Also, although the focus on cost-cutting as a goal has been described as "highly controversial," it is often mentioned as one of the intended benefits of the programs.[20] Even the Institute of Medicine includes *efficient* as 1 of 6 key attributes of an improved health care system, along with safe, effective, patient-centered, timely, and equitable.[18]

While business interests address profitability and researchers consider efficiency, what is the message for physicians in view of the components of medical professionalism? As mentioned above, the principles of professionalism promote physicians' duty to protect and advance the interests of their patients and to keep their own interests secondary. Given that the duty of insurance companies and corporations differs, it is appropriate and important for physicians to be wary of the motives and influence of these agents on the forms that P4P programs take. Even in this context, though, it remains reasonable for physicians to take an active interest in cost containment. This is an area in which expectations of professionalism allow common ground between physicians and payers. The elimination of wasteful spending in health care has the potential to benefit all of society, including the patients themselves. In fact, the ethical principle of justice indicates that medical decisions should include consideration of the benefits to society as a whole, seeking to maximize the health care value provided for all patients given limited resources. However, professional responsibility also makes it critical that any cost-cutting be done without harm to patients. Although one can hope that the interests of patients and the interests of the large payers who drive the P4P process can be aligned, it falls to individual physicians to remember to assess the impact each new program will have on their patients and to advocate for them if the incentives are misallocated. This idea is supported by the AMA guidelines for P4P programs, which state that "The primary goal of any PFP (sic) program must be to promote quality patient care that is safe and effective . . . rather than to achieve monetary savings."[26(p1)] One of the recommendations proposed for ensuring this is that "Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program."[26(p1)] Although most P4P programs presumably do seek substantial physician input, the professional obligation of physicians toward patients makes the integral involvement of *independent* physicians in the design process a key principle. Practicing physicians should endeavor to make themselves available to participate in program development whenever possible to ensure that new programs support rather than hinder their ability to carry out their responsibilities to their patients.

Will P4P have the desired effect?

Concerns about the effectiveness of rewards

As we affirm that physicians' role as guardians of their patients' health needs separates them from the more financially motivated interests participating in the P4P debate, it is worth noting that even in the business literature the idea of driving substantive change via financial incentives is controversial. In one critique of monetary incentives from a business perspective, Kohn points out that "Research suggests that . . . rewards succeed at securing one thing only: temporary compliance . . . Once the rewards run out, people revert to their old behaviors . . . Incentives . . . do not alter the attitudes that

underlie our behaviors. They do not create an enduring *commitment* to any value or action" (emphasis original).[27(p55)] Perhaps more ominously, Kohn refers to behavioral research demonstrating that "the more cognitive sophistication and open-ended thinking that was required, the worse people performed when working for a reward."[27(p55)] In addition, he raises the concern that rewards create an environment emphasizing control rather than exploration, learning, and progress, which leads to less innovation, efforts to avoid challenge, and decreased intrinsic interest and personal engagement in the task.[27] Gregory's focus on scientific discipline as a means to promote intellectual excellence in the practice of medicine foreshadows this concern. In the context of medical practice, "intrinsic interest" in the task and "cognitive sophistication" are critical to physicians' continued ability to meet the standards set by the tradition of professionalism.

Limitation of care for sicker patients

In contrast to concerns that incentive programs do not permanently change behavior are warnings that too *much* compliance with poorly designed guidelines may lead to undesirable consequences. In the business literature, it has been said that "A danger of incentive schemes is not that they do not work, but that they work too well."[28(p101)] This statement echoes Kohn's assertion that incentives at times do change behavior, but in unintended and undesirable ways. One of the most commonly cited such concerns in reviews of the topic is the possibility that participating physicians will act to improve their P4P outcomes by refusing to provide care for poorer or sicker patients.[4,20,29,30] This concern has been studied in the context of public reporting of mortality statistics. In a survey of interventional cardiologists in New York State, 83% agreed or strongly agreed that patients who might benefit from angioplasty may not receive the procedure as a result of public reporting of physician-specific mortality rates.[31] Although this represents the practitioners' opinion that access might be adversely affected by public reporting as opposed to clear data that access *was* affected, it remains a troubling report. Given that many P4P initiatives include public reporting as well as financial incentives, it is reasonable to extrapolate that similar concerns might apply to sicker patients in P4P programs. Theoretically, high-quality risk adjustment of the measures should solve this problem, giving physicians who care for sicker patients allowances for the associated poor outcomes. However, this, too, was found to be problematic in the New York example. In the same survey, more than 80% of respondents did not believe the risk stratification in the system was sufficient, and similar numbers also believed physicians might report higher-risk conditions to improve their risk-adjusted statistics.[31] The professional expectation that physicians put their patients' needs first and their own needs second should act to counter the impulse to avoid sicker patients or to inflate risk-adjustment statistics. Nonetheless, a limitation of access to care for the sickest patients remains an unintended but plausible adverse outcome for P4P programs.

Problems with imperfectly designed measurements

Another set of risks involved in the implementation of P4P programs is those related to the details of measurement and program design. Even if financial incentives are felt to be appropriate as a primary means to guide physician behavior, there remains the critical question of exactly which measures should be tracked and how bonuses should be designed and distributed. A number of concerns have been raised in this regard; one example is the inability of an insufficiently detailed assessment to capture the presence of subtle or uncommon contraindications to established therapies in particular cases. An extreme but plausible instance of this is a physician's failure to comply with the American Diabetes Association best practice recommendation that all patients with type 2 diabetes have regular retinal screenings because the patient in question is blind. Likewise, some physicians intentionally omit the recommended microalbuminuria screen for patients with diabetes who are already taking angiotensin-converting enzyme inhibitors.[32] Thorough chart review would capture these

distinctions, but the commonly used technique of gathering statistics from claims data might miss them, resulting in an unfair penalty to the physician for failing to provide "high-quality" care. In general, the overreliance on claims data as a source for program rankings is another concern that has been raised in discussions of P4P measure design.[33] The use of claims data as a source for P4P calculations has been criticized as not reflecting the complexity of the patient's situation[4] and as having a high potential for inaccuracy, including due to possible intentional falsification by providers "gaming" an inappropriately designed compensation system.[34] Despite these concerns, claims data are often recommended as the basis for P4P measures because they are "the least burdensome to physicians."[35(p6)] Selecting the least burdensome measure is a worthy goal, but if the measure is also oversimplified, unreliable, or inaccurate, it may instead burden physicians with unfair compensation,[33] distracting them from their professional responsibility to provide scientifically appropriate care to all patients' and to place patients' needs foremost.

Rewarding attainment of a quality "threshold" versus rewarding improvement

A focus on attaining specific goals as an indicator of quality rather than on improvements in the absolute or relative level of health care quality also has the potential to lead to unexpected consequences. The effects of this approach, for example, have already been seen in an ambitious performance incentive plan outside the health care arena: the United States No Child Left Behind law. In describing the effect of measuring teachers on the proportion of their students who reach a threshold score on a high-stakes test, Booher-Jennings notes that "In a system that's based on thresholds rather than growth, there's no reason to move someone from a 60 to a 95, or from a 20 to a 70.... It's focused on moving a 69 to a 71."[36(pNJ8)] Observers fret that this emphasis tends to cause districts to cut subjects that were previously considered important to a well-rounded education. At times, this pits the educators' professional judgment about what would be in the best interests of their students against the mandates of the law, leaving them in the unenviable position of being required to implement what they see as negative changes to their practice.[36] Although the widespread reports of poor quality in health care and the frequency of outright medical errors[18,37] demonstrate that individual physicians' judgments of what is most in their patients' interests are often flawed, the professional responsibility to advocate for those interests requires that physicians insist that any changes they are asked to make in their practice be ones that work in favor of all aspects of patient care. The rapid extension of the reach of P4P programs, like the rapid implementation of No Child Left Behind, requires an equally rapid assessment of both intended and unintended consequences.

Difficulty of participating in multiple plans

An additional risk posed by the expansion of P4P programs that is exacerbated by the leadership role being taken by insurance companies and third party payers is the possibility that a physician or group may be become beholden to multiple P4P programs, each with its own measures and reporting requirements. Many of the current programs apply to only a small fraction of a given physician group's patient panel, leaving dollar amounts at stake that may be too small to justify the administrative costs of participating.[20] The proliferation of competing plans may also limit their potential value in imparting to participants a thorough and permanent understanding of the guidelines being used. If the hope of P4P is to improve the ability of practicing physicians to follow the professional tradition of providing care according to the dictates of an objective, disciplined science by focusing their attention on important aspects of high-quality care that they would otherwise neglect, it is counterproductive to "focus" on too many measures at once. Concentrating on dozens of new measures at a time is not concentrating at all, and seems unlikely to have a meaningful effect on the behavior of already busy practicing physicians. In addition, unless the process by which measures are updated or retired is extremely nimble, the focus of P4P programs on single specific measures could have the

effect of institutionalizing outdated care. As Epstein and colleagues have proposed, perhaps a rotating panel of new measures would be more likely to disseminate the concepts of high-quality practice that P4P is intended to encourage.[20] This would give participating physicians time to become familiar with and internalize a small number of new recommendations at a time. However, in the current multipayer environment, this would require a degree of coordination between the various players that may be difficult to attain.[20]

Adverse effects on access to care

A final consideration in assessing the efficacy of the P4P concept is the effect it may have on uninsured or underinsured patients. The second principle of professionalism, requiring that physicians protect and advance their patients' health-related interests, can be extrapolated to address the responsibility to consider the health-related interests of society as a whole. It has been noted that improvements in the quality of care do nothing to improve the health of those who do not or cannot access the health care system.[38] Serious efforts to improve health care delivery in this country must also address the plight of those who lack affordable, accessible health care. Although improving the efficiency of health care delivery could theoretically allow the redirection of funds to cover the uninsured, there is no particular evidence that that is the intended use of any savings from P4P. By the same token, one must also consider the effects that P4P initiatives have on those individuals who are effectively dependent on the lowest-performing medical groups, whether due to proximity, insurance coverage, poor information, or other factors. It may be that P4P will provide the incentive needed for these low-performing practices to begin providing higher-quality care, but it may also be that the reason they are low performing to begin with is that they have limited resources and care for highly challenging patients. The poor health outcomes in disadvantaged neighborhoods are often linked to community factors beyond the physician's control.[38] Although P4P proponents insist that programs should be based on bonuses only, not penalties,[26] withholding a bonus *is* a penalty. This is particularly clear in the case of the Medicare demonstration project that is explicitly required to be "budget neutral."[35(p3)] Removing resources from the poorest practices by denying P4P bonuses will have the potential to further broaden the disparities in health care between the richest Americans and the poorest Americans. The professional obligation that physicians consider their patients' health-related interests also requires that they consider the effects of collective actions on everyone's patients, and on those who are no one's patients but who should be.

Further considerations

In considering all aspects of professionalism and how they relate to the P4P movement, one key point emerges. Although no physician perfectly lives up to the classical ideals of professionalism, most do want to put their patients first and provide high-quality care. The critical factor in reconfiguring measurement and payment schemes is that systems not be designed in a way that forces well-meaning physicians to work against ill-conceived incentives, or that require they sacrifice their livelihoods to stay true to their professional responsibilities. The P4P movement has a lot of momentum; it may be a useful tool to extend the delivery of the highest-quality care, particularly in those areas where there is strong evidence to support clear, nearly universally applicable care guidelines. However, experience with P4P in medical practice is only beginning to build. The principles of professionalism require that the medical profession continue to view the promises of P4P with critical eyes, insisting on detailed assessment of plans' effectiveness in improving quality of care without compromise to the trust required to maintain the patient-physician relationship and without diminishment of access to care for uninsured and underconnected patients. If adequately controlled trials of P4P cannot demonstrate it to be more effective than alternative means to improve overall quality in the areas measured, *without risk of decrement to quality in other areas,* it would be unscientific and thus inconsistent with the dictates of professionalism to continue to support it.

It is crucial to continually reassess whether P4P is truly the best way to support the delivery of high-quality care. Part of physicians' dedication to patients should include dedication to developing systems to support and disseminate high-quality practice. Lending time and talents as active participants in the development of successful P4P programs may be one way to do this. However, even if P4P ultimately proves to be an effective tool in the struggle to do what is best for patients, it may not be the only tool or the best one. There may be a better way to create and nurture a culture of quality than targeting poor practice patterns one specific measure at a time. In particular, it may be that what low-performing practices need is not financial incentive but resources. In the future, well-designed, real-time decision support tools with appropriate prompts and warnings may do more than any measurement scheme to encourage high-quality care, without draining resources from the poorest practices. The profession should not be so blinded by the promise of P4P that it neglects to seek other means to support physicians in doing their very best work.

CONCLUSION

Internist and family practitioner George W. Shannon has said that there are 3 compensation models: "Last year's, which everybody hated. This year's, which nobody likes. And next year's, which is the perfect answer."[39(p9)] There are well-documented and substantial flaws in medical care that predate the current enthusiasm for P4P.[1,9,18,37] These are partially attributable to misplaced financial incentives in previous compensation models and to the inadequacy of professionalism alone as a safeguard for quality assurance.[20] Thoughtful professionals rightly continue to strive for new systematic approaches to extend the availability of the highest-quality care. P4P represents one such novel system, and it may prove to have merit in some situations. However, respect for the traditions of intellectual rigor and subordination of self-interest are also integral features of the practice of "high quality" medicine; without them, physicians run the risk of losing the singular relationship they as a profession have with those they serve. As the examples discussed in this article illustrate, there are areas of tension between the culture of professionalism and the implementation of P4P programs. As forces originating outside the medical profession continue to develop and implement the P4P concept, physicians must be on their guard for structural changes that have an undue negative influence on their ability to practice in a manner befitting their traditions. In some cases, this may require that practicing physicians volunteer their time to ensure that new P4P programs are appropriately designed to reflect the realities of their practices. In other situations, this may require that physicians advocate for substantial changes in or discontinuation of a P4P program that does not support their professional goals. In any case, physicians must remember that the profession they chose is one with a profound historical duty. Payers should not be the strongest leaders in the struggle to advance medical quality; the profession must recapture for itself the critical functions of determining what constitutes excellent care and ensuring that everyone receives it. Physicians must retain within the profession a sense of responsibility for critically evaluating new initiatives such as P4P, and for constantly seeking the best ways to support each other in providing the highest-quality care to their patients and their communities.

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