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MINIREVIEWS

Professionalism and patient education in urologic surgery

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Abstract

Medical professionalism provides the guidelines that govern the patient-physician relationship. This implicit contract requires that patients be informed before making decisions regarding their medical care. Educating patients about diagnostic and treatment decisions is critical to an informed decision-making process. Shared decision-making is a recent paradigm shift in patient education that allows patients to make decisions based both on the counsel of their physicians and according to their own preferences and values. This approach moves away from previous models that focused on physicians or third-party payers as the arbiters of diagnostic and treatment choices. Urologic surgeons have been at the forefront of shared decision-making research and continue to promote this concept in the most recent American Urological Association Guideline on Detection of Prostate Cancer. Unfortunately, the fee-for-service financial structure that predominates in the United States' health care system provides a disincentive for shared decision-making. By promoting patient volume rather than time spent with patients, this system rewards physicians who spend less time educating patients about diagnostic and treatment options. Therefore, to promote adherence to the educational responsibility inherent in medical professionalism, we recommend physician payment reform that rewards physicians for time spent with patients rather than the volume of patients seen.

Key words: Urology; Health care reform; Professionalism; Patient education; Decision making; Informed consent

Core tip: Medical professionalism provides the guidelines that govern the patient-physician relationship. This implicit contract requires that patients be educated regarding their diagnostic and treatment decisions. Shared decision-making is a recent paradigm shift in patient education that allows patients to make decisions based both on the counsel of their physicians and according to their own preferences and values. To promote adherence to the educational responsibility inherent in medical professionalism, we recommend physician payment reform that rewards physicians for time spent with patients rather than the volume of patients seen.

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Health care is a dynamic environment. Beyond advances in diagnostic tests and treatments, there is a perpetual shift in the both the landscape of pathology and in the landscape of the health system itself[1-4]. This is particularly true in the United States where the Patient Care and Affordable Care Act will bring significant change to the health care system[5-14]. In the midst of this dynamic space, however, there is a constant and immutable center: medical professionalism. What this term means and its role in the physician-patient relationship will be explored in this piece, as will the interplay between professionalism

and the growing movement behind patient education. Finally, we will explore the potential role for public policy in promoting professionalism and patient education in urologic surgery.

Although medical professionalism is difficult to define, the literature is certainly not bereft of efforts to do so[15-28]. The most notable and durable effort was the publication of Medical Professionalism in the New Millenium: A Physician Charter. A collaborative work by the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine, the Charter was published simultaneously in the Annals of Internal Medicine and The Lancet in 2002[29,30]. The Charter defines professionalism as "the basis of medicine's contract with society", asserting that an implicit contract exists between patients and their physicians. Understood in these terms, it is the implied contract of medical professionalism that legitimizes the intimate and often invasive role of physicians in the lives of their patients. In other words, medical professionalism defines the set of standards that physicians must adhere to in exchange for the privilege of diagnosing and treating patients.

The Charter identifies three fundamental principles that define medical professional standards and expounds on these principles with ten specific professional responsibilities. The fundamental principles include the primacy of patient welfare, patient autonomy, and social justice. These principles require physicians to place patient interests above their own, empower patients to make informed decisions, and promote the equitable distribution of health care resources across society. The professional responsibilities most apropos to the current discussion of patient education in urologic surgery include commitments to professional competence, honesty with patients, and maintenance of trust by managing conflicts of interest. Together these responsibilities demand that urologic surgeons commit themselves and their peers to maintaining the knowledge and skills necessary to deliver high quality care and ensure that patients are making medical decisions based on complete information without consideration of physician gain or personal advantage.

The professional obligation to ensure patient autonomy and informed decision-making has led to a new emphasis on patient-centered care[31-42]. Unlike previous eras when decision-making was driven first by physicians and then later by payers, contemporary health reforms now focus on putting patients at the center of care decisions. Nowhere is this more evident than in the sections of the Patient Care and Affordable Care Act that provide grants to promote patient-centered care[43]. Specifically, the Act promotes "shared decision-making" and "patient decision aids" as a means of promoting patient-centered care in those clinical settings where the literature supports multiple diagnostic and/or treatment options. Shared decision-making is defined as a decision-making process that allows patients to consider medical care choices based on clinical evidence and personal preferences, and patient decision aids are the educational tools provided to patients to support this shared decision-making process[44-47]. To illustrate this concept consider a patient diagnosed with clinically localized, intermediate risk prostate cancer. Current evidence supports radiation and surgery as equivalent treatment options for cancer control and survival, although each has a distinct risk profile, while active surveillance is appropriate in certain populations[48]. In the shared decision-making paradigm the patient and his urologic surgeon would discuss the risks and benefits for each option and account for the patient's values and preferences when considering the different approaches. In this example, a patient with bothersome lower urinary tract symptoms might choose surgery over radiation because of a desire to avoid potential radiation injury to the bladder, while a patient with similar disease may choose radiation to avoid the risks of anesthesia. In both instances the urologic surgeon uses shared decision-making to educate patients and ensure that treatment decisions reflect the patients' values and preferences.

Notably, there is a longstanding history between urologic surgery, patient education and shared decision-making. The early research on shared decision-making centered on urologic surgery patients choosing between surgical and non-surgical management of benign prostatic hypertrophy[49,50]. These studies demonstrated that patient preferences had a significant impact on treatment decisions, and that patient preferences flowed from the education that patients were receiving about the treatment options. More recently, the revised 2013 AUA guideline for the early detection of prostate cancer prominently features shared decision-making. For men ages 55 to 69 who are considering prostate cancer screening with a serum prostate specific antigen, the guideline explicitly recommends "shared decision-making" and consideration of each patient's "values and preferences"[51].

To advance physicians' professional obligation to engage patients in shared decision-making will require innovative health care reform. Specifically, physicians should no longer be incentivized to maximize clinical throughput, but should instead be rewarded for spending time with patients to counsel them about their diagnoses and treatment options. One potential mechanism would be to compensate physicians based on the amount of time spent with patients rather than according to fee schedules for particular diagnoses or types of visits. A payment system based on the time spent rather than patients seen would discourage physicians from rushing through clinic visits and elevate the value of the patient-physician relationship. Furthermore, patients could exercise more control over health care spending by comparing the costs and benefits associated with lengthy versus abbreviated clinic visits.

Medical professionalism defines the obligations that urologic surgeons owe to their patients, including ensuring patient autonomy by allowing patients to serve as the primary arbiters of their medical decisions. Towards this end, there has been renewed interest in delivering patient-centered care through patient education. Serving as the nexus between medical professionalism and patient

education, shared decision-making defines the formal process of patients arriving at medical decisions based on the counsel of their urologic surgeon and an evaluation of their own preferences and values. This approach is in sharp contrast to the historically paternalistic medical decision-making process and provides an opportunity to minimize the health care system's disincentives to deliver on medical professionalism's promise of patient autonomy.

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