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The Changing Nature of Medical Practice: As the Health System Evolves So Does Doctoring

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Many hospital board members grew up watching *Marcus Welby, M.D.*, and he was the representative portrait of the wise and caring doctor. This iconic image of the 20th century physician was predicated on an understanding that the doctor was an accessible reservoir of essential medical knowledge, familiar with those he cared for and a ready source of continuity care. He was usually the sole custodian of the personal health information of his patients, and capable of treating most conditions without the assistance of a cohort of consultants and technicians or the use of complex medical institutions.

Of course, media portrayals of physicians can be fickle and today's television purveyors of medical care range from the unprofessional, drug-addicted misconduct of Dr. House, to the endless romantic escapades on *Grey's Anatomy*, and the scathing parody of medical professionals seen in *Scrubs*.

While these recent TV characterizations of physicians do not reflect the common practitioner, there is no question that doctoring in the 21st century is evolving rapidly and we have left Dr. Welby far behind. The drivers of this change are easy to spot and include:

- The continuing subspecialization of medicine, which causes individual practitioners to provide care for an ever more narrow range of medical issues
- The necessity of delivering complex medical care in teams comprised of medical specialists, technicians, non-physician practitioners, nurses, and other support personnel
- The progress in digital information management that has made medical knowledge and data instantly retrievable
- The advances in medical technology that have reduced the need for human touch in medical encounters
- The growing sophistication of computers and artificial intelligence that can inform clinical decision making in real time
- The decline of the hospital as a "medical home" for physicians since more and more of their time is spent in outpatient settings where the bulk of medical care can now be provided
- Accelerating demand for physicians to attend to population health needs and balance group interests against the needs of any *individual* patient under the doctor's care
- The shift from a 20th century focus on *acute* care medical needs to a 21st century environment in which the dominant need is for doctors to manage the care of *chronic* medical conditions
- The rise of retail medicine, a scaled-down version of primary care delivered in shopping locations like Walmart and Walgreens, which highlights the access inadequacies of the traditional doctor's office
- The advancement of telemedicine that allows for medical care to be accessed virtually through the Internet from a physician who may be hundreds or thousands of miles away

Doctoring in the 21st Century

As if the list above doesn't represent enough change, in coming decades the nature of doctoring will be additionally buffeted by the advancements in robotics (imagine a doctor who needs no sleep!), nanotechnology, and the manipulation of patient genetic material. Doctors will be sought out to not only address the ailments of individuals, but also to modify, customize, or enhance the physical capabilities of the human body to meet personal preferences or adapt individuals to achieve specialized goals. A host of new ethical concerns will accompany the ability of doctors to facilely transform the human body.

As the nature of doctoring changes, so too do the players who wish to provide the traditional services rendered by physicians. The growing numbers of nurse practitioners and physician assistants have been accompanied by an equally expanding scope of practice for these non-physician clinicians. This is a trend unlikely to diminish in the years ahead. In Missouri, a recent change in the laws governing medical licensing will allow medical school graduates to begin practice in rural areas even before completing traditional post-graduate medical training or taking (and passing) the clinical practice portion of the standard U.S. medical licensing exam. The rationale for this reduction in training requirements is to address a severe shortage of physicians in rural areas. There is a clear perception in many quarters that medicine can be practiced without the traditional and extensive preparation undertaken by physicians since the medical education reforms of the early 20th century. The traditional visit to the "doctor" will increasingly mean evaluation and treatment from someone other than a residency-trained physician. Expected shortages of physicians into the next decade will provide added impetus to this trend. As more routine care is provided by non-physicians, doctors will be more likely to specialize further or to serve solely as consultants to those providing care without "M.D." behind their name.

It's hard not to notice the advances in telemedicine that are transforming medical practice dramatically. Doctors can now care for even the sickest hospital patients remotely (e.g., through Electronic Intensive Care Units). Video consultations with specialists in underserved areas are becoming more common. Mayo Clinic now has a subscription-based smartphone app that provides real-time video chats with Mayo Clinic nurses.[1] The app also offers a personal medical concierge who can provide health information and schedule patients' doctor appointments. The market for smartphone-based concierge medicine is already quite crowded and the use of doctors to provide telemedicine care is evolving quickly. Ongoing efforts by a large group of states to create a multi-state licensing mechanism for doctors will facilitate these telemedicine trends. Known as the Interstate Medical Licensure Compact, it would greatly reduce the barriers to gaining licensure in a multiplicity of states. In this second decade of the 21st century, when we hear the words "the doctor will see you now" it no longer implies an in-person face-to-face encounter. The smiling face of Dr. Welby who listens to our medical concerns may likely be an electronic avatar on a smartphone or an iPad.

[1] Neal Ungerleider, "The Mayo Clinic's New Doctor-in-an-iPhone," *Fast Company*, April 18, 2014.

A Changing Medical Staff

As physician practice evolves, how will hospital medical staffs be affected? One impact will be an increasing diversity of practitioners joining the medical staff. In the years ahead, we will likely see more and more hospitals adding nurse anesthetists, midwives, nurse practitioners, and physician assistants to the ranks of the medical staff. Recent changes in Medicare's Conditions of Participation for hospitals make clear that such expansion of medical staff membership is permissible. Medical staffs will not only become a more varied assortment of clinicians, but also expand to encompass outpatient practitioners across ever-larger geographic regions. Medical staff citizenship will cease to be defined largely by clinical activity provided within the walls of a hospital. Those doctors who spend lengthy periods in the hospital—the "ists" such as hospital*ists*, intensiv*ists*, labor*ists*, surgical*ists*, and procedural*ists*—will be greatly outnumbered on medical staffs that are numerically dominated by ambulatory primary care and specialty practitioners. Across the country, medical staffs are already undergoing redesign in various ways, such as simplifying burdensome bureaucracy by downsizing committees and departments or merging staffs across hospitals in a health system.

Alternatively, medical staffs may disappear entirely. As hospitals and medical practice evolve, the historic medical staff model has become increasingly outdated. The employment of most doctors will mean that an organized medical staff is no longer needed to communicate the interests of private practitioners nor to serve as a means to protect their business interests. While physicians are important players in advancing quality in hospitals, medical staff organizations do not have a strong track record of improving safety and performance. Large companies manage quality and safety effectively without outsourcing these matters to semi-independent organizations of workers. Similarly, integrated health systems will develop strong internal quality assurance and performance improvement capabilities and may come to rely less and less on the historically weak peer review activities of the organized medical staff.

Physician interest in medical staffs has been waning for decades since these organizations do little to meet the business needs of physicians. In the years ahead, we can expect doctors to identify increasingly with the accountable care organization

(ACO) or clinically integrated network (CIN) to which they belong rather than the anachronistic medical staff organization. These new formulations of healthcare providers will be more closely in sync with the changing nature of medical practice.

The new world of healthcare is less hospital-centric, but we will still need these facilities to deliver complex care to seriously ill patients. Housed in buildings from the last century, many hospitals will need to alter their physical space as doctoring evolves. For example, space that can accommodate multi-disciplinary "team huddles" will need to be present in all patient service areas. Many hospitals have recently upgraded doctor lounges and dining rooms to foster better communication and camaraderie between medical staff members who otherwise don't see one another and spend most of their clinical time in off-campus sites. Many hospitals, noting the rapid changes in medical skills necessary to keep up with changing techniques and technologies, are building or expanding on-site simulation training facilities. The sophistication of clinical simulation technology and its use in medical education has become quite impressive. Having such training technology readily at hand allows a hospital to undertake prompt remediation of deficient medical staff members. It also provides a means to safely and quickly expand the clinical repertoires of existing medical staff practitioners without having to recruit doctors with these new skills.

Doctors and their activities have always been the beating heart of the hospital. Board members, who are fiduciaries for the hospital enterprise, will want to keep a close eye on the evolution of this profession and the impact on the future of our hospitals and healthcare institutions.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director, Sagin Healthcare Consulting, LLC, and Governance Institute Advisor, for contributing this article. He can be reached at TSagin@saginhealthcare.com.