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FROM THE EDITOR
Rewarding Ethical Medicine

Physicians are motivated by many things, including the desire to improve the health and well-being of others and an insatiable curiosity about how the human body works in health and illness. But as much as it may pain us to admit it, more pragmatic considerations often factor into the equation—namely, money. It is human nature to be motivated by rewards—financial and otherwise—and health care reform raises myriad questions about which rewards and incentives motivate physicians effectively. Even more difficult to answer is exactly which behaviors and practices should be rewarded. What constitutes "value" in medical care? What are the constituents of quality in patient care? The July issue of *Virtual Mentor* examines the ethics of physician incentives and the struggle to reform health care delivery in the U.S. in a way that aligns incentives with the goals of medicine.

Ideally, we want to deploy incentives that motivate physicians to practice medicine that serves patients best. As Alexander H. Sommer explains in his health law piece, one of the provisions of the Affordable Care Act requires states to pay 100 percent of the federal Medicaid reimbursement rate for primary care visits—as much as a 35 percent increase for some states—to make sure that low payment rates do not discourage doctors from seeing patients on Medicaid. This policy incentive seems to align with patient care goals.

Too often in our current system, Anita Arora, MD, and Alicia L. True explain, the amount and intensity of care delivered correlates more closely with the number of beds or doctors available than with the degree of care needed or preferred by patients. So how can reimbursement systems best guide doctors to provide necessary and beneficial, but not excessive, care? That question is explored by Shivan J. Mehta, MD, MBA, and David A. Asch, MD, MBA in response to a clinical case scenario. Greg F. Burke, MD, gives one possible answer in his reflection on the success of Geisinger Health System, known for its tight-knit culture, performance-based compensation system, and such innovations as "warrantees" on outcomes affected by preventable complications. Laura A. Peterson, MD, adds that a key component of an effective performance measurement is not only the service or outcome measured, but the method of measurement.

One example of a reimbursement model that has not produced desired results is the Resource-Based Relative-Value Scale, or RBRVS, which provides incentives for performing procedures but not for face-to-face time with patients. As Allan H. Goroll, MD, writes, the consequences of implementing the RBRVS range from skyrocketing cost of health care to a shortage of primary care physicians. Why blame

RBRVS for a shortage of primary care doctors? Most doctors enter practice with more than $100,000 in loan debt from medical school. Albert Hsu, MD, and Kelly Caverzagie, MD, tell us that this debt factors into a young physician's choice of specialty, and even a young person's desire to opt for or against a career in health care, as Daniel B. Shulkin, Mark W. Shulkin, MD, and David J. Shulkin, MD, reflect.

Even the codification of diagnoses and procedures, as in the ICD-9 and ICD-10 coding systems, encourages and rewards certain behaviors. When such systems are used for reimbursement, they create incentives that interfere with the longstanding primary use of clinical records—namely, patient care—and can come at great financial cost, says Christopher G. Chute, MD, DrPH. The so-called "red tape" that increasing paperwork and documentation (including coding) brings can drive a physician into concierge medicine in an effort to get back to simply caring for patients. William Martinez, MD, MS, and Thomas H. Gallagher, MD, discuss this temptation in their commentary on a case scenario.

The journal discussion piece by Ali Irshad, MD, Matthew Janko, and Jacob M. Koshy takes us through one retrospective study of 6 million patients that found that key outcomes were similar in hospitals where financial incentives were offered and hospitals where they were not, suggesting that financial incentives alone may not be the answer to ensuring benefit to patients.

That is the good news and the bad news—rewarding quality and value in health care is not a simple matter of dangling a financial carrot in front of physicians. It will require investigation into what boosts physician professional satisfaction and facilitates optimal patient care, and then implementing the fruits of that research to establish an environment in which both can thrive.

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