and the patient's belief that the physician will not allow him or her to be harmed.

Truth telling. Trust begins with truth telling and not necessarily with the provision of all services the patient might prefer. Patients increasingly know that their physicians do not control access to all treatments, but it is important for them that their doctors make their interests primary and are not swayed by a personal stake in the direct economic consequences of their treatment decisions. Our interviews with patients indicate that they only have vague notions about physicians' financial incentives but strongly respond negatively when these are explained.21 As the public becomes better informed, incentive design will have to take patients' expectations into account if a backlash is to be avoided. Some economic incentives may be acceptable, but patients have to believe that it is implausible that these would fundamentally alter clinical judgments.

- **Responsibility for population health.** Medicine and public health have had divided responsibilities in the past, sometimes with opposing ideologies, goals, and interests.22 New interest in health promotion and disease prevention in medicine and interest in population health for economic reasons among health plans have the potential to bring public health and medical efforts together. Public health practitioners and physicians now more clearly share common interests in addressing issues of community health.23 Many HMOs have public health programs for their enrollees, and a substantial number engage in community efforts more generally, although these are more characteristic of nonprofit plans.24 Investments in community health are small relative to total revenues, but some plans have innovative programs for the underserved, young people, and other community groups. The growth of large managed care plans with high population penetration provides more incentive than before to address health issues as they affect populations.

Even competing managed care organizations with a significant share in a particular market could collaborate in public health efforts that serve the entire population. It is commonly suggested that health plans will have little interest in nonenrollees and, with enrollees churning among plans, will have little motivation to invest in long-term outcomes. The present environment of very rapid change and large uncertainties makes collaboration difficult. With increased market stability, this will be an area where medical profes-
sionals can join interests with health plans and others. Only some promotion and prevention efforts have been established as cost-effective, but a stronger public health coalition can develop a strong science base for such efforts and more-effective programs that serve both the community and health plans.\textsuperscript{23}

**Forging new patient partnerships.** Many physicians regard primary care as less challenging and rewarding than specialty practice, but managed care has helped to encourage the primary care function. Much of primary care can seem routine and boring unless the physician views problems in the broader context of people’s lives and concerns. Moreover, as patients become more articulate in their insistence that they have a voice in treatment choices and decisions and that their preferences be given important priority, physicians will have to establish stronger collaborative relationships with them.\textsuperscript{26} Health plans, sensitive to satisfying and retaining patients, also will press physicians to develop their interpersonal competence in patient relations.

High-quality care requires physicians to understand patients’ goals and preferences and to adjust treatment and rehabilitation to increase the probability of their realization. Some encouragement for stronger patient alliances comes from the increasing number of physicians and greater competition to attract and retain patients. Also, growth in the proportion of female physicians, who have stronger psychosocial orientations to patient care than male physicians have, increases attention to the quality of relationships.\textsuperscript{27}

Causation is difficult to attribute, but the association found between participatory relationships and patient satisfaction and loyalty is a hopeful indication that developing such relationships can be fruitful.\textsuperscript{28} Training in interviewing and other primary care skills increases physicians’ capacity to develop participatory skills and to detect patients’ problems.\textsuperscript{29} Discussions commonly refer to the “art of medicine” as if it were some mystifying talent or unusual personality characteristic, but most of what patients experience as physicians’ “interpersonal competence” is teachable.\textsuperscript{30} This set of skills influences how patients regard doctors, relate to them, and cooperate in treatment.

**Participation in an evidence-based culture.** Large practice variations are a continuing issue in medical practice. The new professionalism will place increased responsibility on physicians to have clear rationales for their decisions. Physicians and other interested groups require forums to think about appropriate norms and how to preserve a clinical perspective that protects patients’ interests without neglecting the interests of all plan members.

Physicians need to be participants in an evidence-based culture.
"Doctors still remain a powerful force and have far more credibility with the public than insurance plans have."

Doctors are trained to be active problem solvers and value their own clinical experience most especially. One advantage of this approach is that physicians can respond to contingencies that may differ from standard cases reported in the literature. However, a doctor's personal experience may provide a biased sample of effectiveness. As the world literature had continued to grow and become more complex, beyond the capacity of any one physician, organized efforts such as the Cochrane Collaboration have developed to systematically review randomized clinical trials to establish the evidence base for various interventions.31

The technology now available to any medical office allows physicians to gain access to these efforts and to participate in the evidence-based culture as consumers, contributors, or both. Skills in informatics, clinical epidemiology, and the decision sciences are more important than ever before.32 Most physicians, whatever their level of skills, can gain by participating in this new culture; discussing results and unanswered questions with their colleagues; and thinking about how best to implement evidence-based treatment decisions in a context of uncertainties, strong patient preferences, and entrepreneurial promotion of various medical modalities. In the case of big-ticket items such as “last-chance” therapies, decisions need to be made at the health plan level. But many other decisions must evolve from thoughtful communication and deliberation by doctors and their patients.

Implementing A New Professionalism

Creating a new professionalism will not be easy, and many barriers exist. Physicians’ complaints about the changing conditions of their work, while sometimes distorted, are not unfounded. The balance of power in health care has clearly shifted away from them, but doctors still remain a powerful force and have far more credibility with the public than insurance plans or managed care companies have.33 Corporate medicine needs the good will of physicians.

The issue for physicians is how they can build a new professional culture and countervailing influence to corporate medicine through associations that are not simply self-serving. Medical politics and the organizations representing doctors are highly fragmented, expressing the status, power, and income aspirations of each specialty. The frustration physicians feel is increasingly expressed in calls for
unionization. In 1999 the American Medical Association (AMA) began its efforts to develop a physicians' union that could collectively bargain over terms of employment. Such a union will require a long uphill effort and, if it gains ground, will probably be viewed by the public more as an effort to preserve self-interest than one to promote professional goals. Unions can offer useful protections to their members but commonly serve to support mediocrity and the status quo. It is difficult to visualize how an era of medical professional excellence can evolve through unionization.

Possible change could come through evolution of medical professional organizations, such as the various colleges and specialty organizations, as more forceful proponents of medical excellence and as active representatives of individual doctors in conflict with health plans. By cooperating to develop clear norms of rights and responsibilities and using these as a basis for collaboration and negotiation with health plans, such organizations may be able to develop useful mechanisms to resolve disputes and protect individual physicians. To be credible, such organizations must include persons with contrasting viewpoints and have hearing and decision processes that are transparently fair. If developed carefully and collaboratively, such organizations might be called on by health plans to adjudicate disputes. To the extent that such organizations can achieve public trust and legitimacy, their judgments could have force in the medical marketplace.

Alternatively, it will probably be necessary to have more neutral tribunes to define the norms of the new medical professionalism and manage disputes. Many plans already depend on independent experts to resolve conflicts where clear opposing interests are involved, and in some states such processes are required by law when services are denied. New types of organizations may have to be developed, and perhaps some aspects of the task could be delegated to organizations such as the Institute of Medicine, which have a record of bringing differing parties together to arrive at a broad consensus.

Creating workable structures may require a state and federal regulatory framework. No consensus has yet emerged on the components of such a framework, as the acrimonious debate on patients' rights in managed care indicates. But there is evidence of some convergence of interests as some large health plans, aware of their precarious public standing, voluntarily accept greater public scrutiny. Whatever the regulatory aspects, the new professionalism will depend most on the perspectives that doctors bring to their work. Thus, professional education and socialization
are crucial to its success. While many educators are making efforts
to prepare trainees for their likely futures, many of our most accom-
plished doctors are still fixated on illusory efforts to recapture the
past, making it more difficult for student physicians to learn to
exercise a new professionalism.

This work was supported in part by a Robert Wood Johnson Foundation Investig-
ator Award. The views expressed are those of the author and not the foundation.

NOTES
1. J.C. Robinson, The Corporate Practice of Medicine: Competition and Innovation in Health
   Care (Berkeley: University of California Press, 1999); and T. Bodenheimer,
   "California's Beleaguered Physician Groups—Will They Survive?" New England
2. In this paper I write generically about a new professional ethic, with the
   understanding that particular observations may not be relevant to all doctors.
   What they all share is the growing need to adapt to constraints and to evolve
   appropriate professional responses to changing circumstances.
4. J. Hadley et al., "Perceived Financial Incentives, HMO Market Penetration,
   and Physicians' Practice Styles and Satisfaction," Health Services Research 34, no.
   1, Part II (1999): 307–321; and K. Grumbach et al., "Primary Care Physicians' 
   Experience of Financial Incentives in Managed Care Systems," New England 
6. Hadley et al., "Perceived Financial Incentives."
7. S.R. Simon et al., "Views of Managed Care: A Survey of Students, Residents, 
   Faculty, and Deans at Medical Schools in the United States," New England 
   1982); M.L. Millenson, Demanding Medical Excellence: Doctors and Accountability 
   in the Information Age (Chicago: University of Chicago Press, 1997); and W.A. 
   Zelman and R.A. Berenson, The Managed Care Blues and How to Cure Them (Wash-
10. E. Freidson, Profession of Medicine: A Study of the Sociology of Applied Knowledge 
    (New York: Dodd, Mead and Company, 1970); and E. Freidson, Professionalism Reborn: 
11. M.S. Larson, The Rise of Professionalism: A Sociological Analysis (Berkeley: Univer-
14. Some regard patient advocacy and allocation as incompatible and ethically 
    inconsistent goals. See N.G. Levinsky, "The Doctor's Master," New England 
15. L.R. Churchill, Rationing Health Care in America: Perceptions and Principles of Justice 
    (South Bend, Ind.: University of Notre Dame Press, 1987); and L.M. Fleck, "Just 
    Health Care Rationing: A Democratic Decisionmaking Approach," University of
31. The Cochrane Center, established first in the United Kingdom, has centers around the world, including one in San Francisco (www.ucsf.edu/sfcc), and has inspired several new journals, including Journal of Evidence-Based Medicine, Evidence-Based Healthcare, and Evidence-Based Mental Health.