The Patient-Centered Medical Home: An Ethical Analysis of Principles and Practice

*Clarence H. Braddock III, MD, MPH[1], Lois Snyder, JD[2], Richard L. Neubauer, MD[3], and Gary S. Fischer, MD[4] For the American College of Physicians Ethics, Professionalism and Human Rights Committee and The Society of General Internal Medicine Ethics Committee**

[1]Stanford School of Medicine, Stanford, USA; [2]Center for Ethics and Professionalism, American College of Physicians, Philadelphia, USA; [3]Providence Senior Care Center, Anchorage, USA; [4]University of Pittsburgh School of Medicine, Pittsburgh, USA.

The patient-centered medical home (PCMH), with its focus on patient-centered care, holds promise as a way to reinvigorate the primary care of patients and as a necessary component of health care reform. While its tenets have been the subject of review, the ethical dimensions of the PCMH have not been fully explored. Consideration of the ethical foundations for the core principles of the PCMH can and should be part of the debate concerning its merits. The PCMH can align with the principles of medical ethics and potentially strengthen the patient–physician relationship and aspects of health care that patients value. Patient choice and these ethical considerations are central and at least as important as the economic and practical arguments in support of the PCMH, if not more so. Further, the ethical principles that support key concepts of the PCMH have implications for the design and implementation of the PCMH. This paper explores the PCMH in light of core principles of ethics and professionalism, with an emphasis both on how the concept of the PCMH may reinforce core ethical principles of medical practice and on further implications of these principles.

KEY WORDS: patient-centered medical home; ethics; professionalism; patient–physician relationship.
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INTRODUCTION

The patient-centered medical home (PCMH) has been widely promoted as a concept with promise to reinvigorate the primary care of patients and a necessary pillar of national health care reform. It is "a central resource… with a competent team, including a physician specialist in complex, chronic care management, and coordination and active involvement by informed patients".[1] While the basic tenets of the concept have been extensively reviewed, the ethical dimensions of the PCMH have yet to be fully explored.

In Joint Principles of the PCMH[2] by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association, the following have been identified as elements of the PCMH:

- A relationship with a personal physician
- A physician-led, integrated team medical practice
- Whole person orientation
- Care coordination/integration
- Quality and safety
- Enhanced access to care
- Payment to support the PCMH

There is a strong conceptual connection between these Joint Principles and the broader concept of patient-centered primary care, key attributes of which include:[3]

- Superb access to care
- Patient engagement in care
- Clinical information systems that support high-quality care, practice-based learning, and quality improvement
- Integrated, comprehensive care with smooth information transfer across a team of providers
- Ongoing, routine patient feedback to a practice
- Publicly available information on practices

The PCMH focuses on a patient-centered approach to care, including enhanced access to a personal physician who coordinates care through an integrated team with continuous relationships based on trust, an emphasis on communications and care coordination, involvement of family and caregivers, patient advocacy by providers, and care of the whole person. Consideration of the ethical foundations for the core principles of the PCMH can and should be part of the debate concerning its merits.

The PCMH concept can align with the principles of medical ethics of beneficence, nonmaleficence, respect for autonomy and justice, as embodied in the *ACP Ethics*

Richard L. Neubauer, MD. Deceased

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Manual and the *Physician Charter on Professionalism* and as described throughout this article. It presents an opportunity to reinvigorate the patient–physician relationship and aspects of health care that patients value. Patient choice and these ethical considerations are central and at least as important as the economic and practical arguments in support of the PCMH, or more so. Further, the ethical principles that support the PCMH also have implications for the design and implementation of the PCMH. For example, the principle of respect for patient autonomy is not a mandate that patients *must* be engaged in their health care. It is ethically inappropriate to make the level of patient engagement a precondition for access or provision of benefits.

This paper explores the PCMH against a backdrop of core principles of ethics and professionalism, emphasizing how the concept of the PCMH may reinforce core ethical principles of medical practice and further implications of these principles.

Position 1: Patient-centeredness should be among the primary goals of health care. Many attributes of the patient-centered medical home reinforce patient-centeredness and as such, reaffirm core principles of medical ethics and professionalism.

Within medicine, there is growing recognition of the centrality of patient-centered care to the provision of high quality care. The Institute of Medicine (IOM) lists patient-centeredness as one key element in its definition of high quality health care (along with being safe, effective, efficient, timely and equitable).[3,4] IOM defines patient-centered care as "healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care."[5] Many other organizations support the concept of patient-centered care, and there is a growing body of empirical evidence that patient-centered care enhances patient satisfaction and trust, in addition to improving health-related behaviors, such as medication adherence and ultimately, health outcomes.[6,7]

Since its founding in the 1980s, the Picker Institute has focused on patient-centered research and education. It defines patient-centered care as having the following elements: respect for patient values and preferences (including informed and shared decision making); coordination and integration of care (including clinical, ancillary and support services); information and education on clinical status; progress and prognosis that facilitate autonomy, self-care and health promotion; physical comfort including pain management; emotional support; family and friend involvement; continuity and successful transitions of care across settings; and access to care.[8]

Traditional principles of medical ethics resonate well with the concept of patient-centeredness. These principles include beneficence, a duty to promote good and act in the best interest of the patient and the health of society; nonmaleficence, the duty to do no harm to patients; and respect for patient autonomy.[9,10] The design of the patient-centered medical home can reaffirm the ethical principle of beneficence with its emphasis on attention to care of the whole person over all stages of life—acute care, chronic care, preventive services and end-of-life care.[11] Maintaining patient-centeredness and connectedness over time is currently challenging. As just one example, under current systems physicians sometimes find it difficult to maintain relationships with patients once they have been referred to hospice care.[12]

The emphasis on continuous relationships in the PCMH, and the central concepts of engaged patients, strong communications, coordinated care and involvement of family and caregivers, all strongly support the ethical principle of respect for autonomy. The PCMH also should be uniquely suited to foster culturally competent health care and health education, which support informed decision making.

The extent to which the practical implementation of the PCMH achieves ethical goals is likely to depend significantly on design features, such as the structure of physician payment and the measurement of patient satisfaction/experiences, quality/outcomes and cost of care. For instance, proposals to provide incremental additional reimbursement to physicians if their practice meets some of the practice design criteria of the PCMH may not be sufficiently targeted to encourage patient-centered behaviors. Additionally, the promotion of physician-led coordinated teams to provide improved access and efficiency may be perceived by patients, ironically, as placing a barrier between the patient and a trusted physician.

Patients who are less "activated" in their care may be regarded negatively by their caregivers in a PCMH environment, although this can be no different from, or worse, in a non-PCMH environment. Health literacy levels vary widely, raising questions about how those who are most disadvantaged in this regard may fare in such an environment. How the PCMH actually works in practice warrants further discussion and analysis to determine its alignment with ethical considerations and professionalism.

Position 2: The patient-centered medical home should provide access to a personal physician who provides coordinated comprehensive care through an integrated team, consistent with elements of medical professionalism, as patients navigate a complex medical system.

The *ACP Ethics Manual* states that physicians should work toward ensuring access to health care for all persons.[9]

Similarly, the *Physician Charter on Professionalism* articulates a "commitment to improving access to care" as one of the core aspects of professionalism.[10] The PCMH's goal to enhance access to a personal physician who leads the provision of high quality coordinated care is consistent with this dimension of professionalism. Perhaps what is most important about health care to patients—and physicians—is excellent access to care in the context of strong and trusted relationships.

Other research notes the limits of care when relationships are episodic, and shows that where there is less "connectedness"—a close relationship between a patient and a particular physician—patients are "less likely to receive guideline-consistent care."[13] This approach to measuring care should be more widely studied, especially given concerns that the PCMH may come to emphasize practice redesign and information technology more than patient-centeredness,[14] along with other attributes that foster high quality care aligned with professionalism.

Currently, however, many Americans are "medically homeless."[15] Patients without access to care face a "perilous journey"[16] as they try to navigate the health care system. The PCMH holds promise to substantively rectify this situation, bringing the health care system closer to the ideals of medical ethics and professionalism. In keeping with patient-centeredness, patients should be able to choose their physician (and therefore her/his specialty), but that physician should have overall responsibility for the first contact continuous care of the patient and for leading the health care team. Therefore, a primary care physician would be a likely choice for many patients. The focus is on establishing and maintaining a longitudinal relationship.

A subspecialist who acts as a principal care physician would be medically responsible for the overall care of the patient or should team up with a primary care colleague who will be responsible.[17] A recent taskforce on the PCMH convened by the American Society of Nephrology, for example, noted a consensus that nephrology practices would usually not wish to be a medical home, with the possible exception of doing so for dialysis or transplant recipient patients.[18] The PCMH leader should not be a "gatekeeper," and there is no incentive under the PCMH to limit appropriate referrals to specialists or subspecialists. "In almost all circumstances, patients should be encouraged to initially seek care from their principal physician. Physicians should in turn obtain competent consultation whenever they and their patients feel the need for assistance with care."[9]

Practical barriers exist to realization of this goal of the PCMH, such as a shortage of personal physicians. As has been noted in initiatives such as the Massachusetts health plan, attempting to increase access to a personal primary care physician through expansion of insurance coverage can be significantly hampered when there are not enough primary physicians for the population, or when those physicians are unevenly distributed, creating geographic barriers to access.[19] The centrality of access to a personal physician to the ethical argument for the PCMH underscores the importance of reform in both medical education and the reimbursement structure of medical care, in order to increase the number of physicians entering and remaining in primary care practice.

Another potential challenge in realization of the ideal of coordinated care through an integrated team concerns the relatively poor track record in most health care systems of true team-based care.[20] In order to achieve the potential gains demonstrated in the growing literature on effectiveness of team care, health care systems will need to adopt real reform to reorganize care delivery into interdisciplinary teams.[21] Unfortunately, despite the ethical imperative to foster shared commitments and team approaches to care across health professions,[9] how to function in a team environment is not deeply embedded in many training programs; economic competition between different types of providers may be an impediment to such a team approach; and systems to provide accountability are lacking at the present time. Hence, health professions education will need reform to enhance development of the skills of working effectively in interdisciplinary teams.

Also, as new models of team-based care develop and are tested, potential medical–legal and other implications will need to be examined, including liability (for example, corporate versus individual liability), and scope of practice and credentialing issues, especially given variations in state law. ACP and SGIM believe, as will patients, that many patients will want or need a multidisciplinary team led by a physician, as called for by the Joint Principles[2] and the Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs.[22] If nurse practitioner-led demonstration projects and pilots are tested, they should be consistent with scope of practice acts and evaluated using the same standards applied to physician-led practices.

Similarly, the financing and regulation of health care delivery will need to be reformed to provide appropriate incentives to team-based care. For example, current efforts focus on developing individual physician accountability for quality performance measures. But greater attention needs to be paid to evaluating quality at the team level.

Some have argued that performance incentives for teams to improve quality of care are a more effective approach, and that approach also supports professionalism. Rewards for individuals can backfire because the reward does not recognize intrinsic motivations, like a commitment to ethics standards.[23] Pay-for-performance in health care has worked best in the context of rewards for teams or organizations, just as incentives for teams work better in other endeavors, such as airline on-time performance.[23]

To avoid misaligned perceptions between patients and physicians, the PCMH should emphasize performance

based metrics and payments that are based on measures of patient satisfaction and experience—which reflect the importance of relationships—and risk-adjusted care coordination payments that do not provide disincentives for the care of sicker patients, the elderly, and those with complex multi-system disease.[24]

Position 3: The PCMH seeks to enhance involvement of patients, families and caregivers in patient care, thereby supporting respect for patient wishes and autonomy.

A bedrock principle of medical ethics is the primacy of patient autonomy,[9,10] and this core element of the PCMH strongly supports this principle. The PCMH and the concept of patient-centeredness that forms its foundation emphasize patient engagement, provision of health information to patients, and involvement of patients in shared decision making. In addition to the support of principles of ethics and professionalism, these approaches can have a powerful positive influence on the patient's experience of health care and on health outcomes.

There will be challenges to realizing the ideal of patient engagement. For many patients, being an actively engaged participant in their own health care is outside of their experience, or may be at odds with personal or cultural beliefs about health, health care, and relationships with health care professionals. Language or literacy barriers may make it difficult for those inclined to become engaged in their health care to effectively do so. An important ethical corollary of active engagement is the ethical obligation of clinicians and health care systems to exert every effort to bridge these barriers, while at the same time remaining sensitive and respectful toward patients and families who do not fully embrace what it means to be "engaged."

Attempts to provide patients and families, as appropriate,[25] with sufficient health information for them to be actively engaged in health care decisions will require a commitment from health systems to eliminate barriers related to literacy, language, numeracy, and technological savvy.

We have learned from recent experiments in attempting to incentivize personal responsibility that turning engagement from a desired attribute to an obligation for patients is fraught with risks.[26] The principle of respect for patient autonomy is not a mandate that patients *must* be engaged in their health care. It is ethically inappropriate to make the level of patient engagement a precondition for access or provision of benefits.

Likewise, care must be taken that the PCMH emphasis on quality and monitoring not coerce patients into agreeing to or receiving care that conflicts with their own values, goals and beliefs, or lead patients to feel in conflict with (or not welcomed by) physicians who are held to measures that the patient does not accept. Here, the concern is that all activities remain respectful of patient autonomy; that the physician respect each patient's uniqueness;[9] and that in promoting health and educating patients to enhance health, we avoid what some might view as the "tyranny of health."

Patient access to health information is another important dimension of the PCMH. Such access potentially enhances patient engagement, and can support care integration and team coordination. For example, patient viewing of laboratory results and initiation of communication with their PCMH care team will require substantial rethinking of our current health information technology infrastructure and a change in culture of physicians, team members, and their engagement with patients and families. It also raises potential new challenges with confidentiality and privacy, for with enhanced access, protection of confidentiality will likely be more difficult. Both the *ACP Ethics Manual* and *Charter* emphasize the importance of respecting confidentiality, but the *Ethics Manual* also refers to the important obligation to provide unfettered access for patients to their own personal health information.[9]

Some may worry that increasing patient engagement in the PCMH may in some instances encourage patient expectations or even entitlement to receive health care services that are of marginal medical benefit. Such an increase in requests for unnecessary diagnostic tests or ineffective treatments could place patient engagement in tension with the physician's corollary commitment to act as a responsible steward of health care resources, as noted both in the *ACP Ethics Manual* and the *Charter*. There is some reassuring evidence that one method of patient engagement, shared decision making, may actually decrease rather than increase patient demand for so-called "preference sensitive" treatments, i.e., those treatments for which there is little evidence of superior clinical benefit. For example, a Cochrane review found eight studies involving use of decision aids for surgical procedures that resulted in a significant decrease in patients receiving the procedure.[27] Nevertheless, physicians practicing in the PCMH will need enhanced skills in patient-centered shared decision making, as well as a framework and language with which to negotiate with patients.

Finally, some of the more advanced tenets of the PCMH depend on information technology (IT) that is more economically feasible for large multi-specialty groups, as opposed to small and medium sized primary care practices. In the current environment where most of primary care, especially in rural settings, is delivered by small to medium sized practices, it remains unresolved how such practices will be able to incorporate the IT needed to become a robust PCMH. Accountable care organizations (ACO) may help bridge this gap, but could raise other ethical issues that would have to be addressed, and the ACO is itself an emerging and unproven concept.

Position 4: The PCMH would actively promote ongoing practice-based system improvement and explicit attention to quality. These are under-recognized yet important dimensions of professionalism.

The *Charter* discusses the importance of a commitment to quality improvement, specifically calling on physicians to work "collaboratively with other professionals to reduce

medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care."[10] The *ACP Ethics Manual* stresses the ethical importance of active physician engagement in quality efforts and patient safety.[9] The PCMH, by integrating the system improvements paradigm into the practice environment, could help physicians meet these ethical obligations, although this must be done with sensitivity to the patient's perspective. Even as the PCMH promotes "patient-centeredness," automated processes of care could inadvertently depersonalize care and make patients feel less connected to their clinician. Importantly, the PCMH is an opportunity to help promote what patients view as measures of high quality care,[24,28] which include access to and continuity of care with trusted physicians;[29] effective communications and empathy; adequate time for office visits;[30] coordination of treatment across all providers and settings; decision making about treatment recommendations; and the role of the family in care.

CONCLUSION

The patient-centered medical home (PCMH) is emerging and evolving as a model for medical practice that may become an important pillar of national health care reform. The PCMH has the potential to align with the principles of medical ethics and professionalism, and presents an opportunity to reinvigorate the patient–physician relationship and the aspects of health care that patients value. This analysis has explored some of the promise of and concerns about the PCMH through the lens of ethics and professionalism. On balance, many of the principles of the PCMH resonate well with core tenets of ethics and professionalism, and in some cases provide a pathway to enhance the ethical practice of medicine. This analysis may help to highlight some of the practical choices and implications of design and implementation that should be considered to ensure that the PCMH does not become a failed fad, but rather a stepping stone towards a brighter future for health care in America.

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**Members of the 2009–2011 American College of Physicians Ethics, Professionalism and Human Rights Committee: Virginia L. Hood, MBBS, MPH, FACP (Chair 2009–2010); Kesavan Kutty, MD, MACP, FCCP, FRCP (L) (Chair 2010–2011); Joseph J. Fins, MD, FACP (Vice Chair 2009–2011); Jeffrey T. Berger, MD, FACP; Clarence H. Braddock, III, MD, MPH, FACP; CPT. Tatjana P. Calvano, MC, USA; Kathy Faber-Langendoen, MD, FACP; Faith T. Fitzgerald, MD, MACP; Thomas H. Gallagher, MD, FACP; Celine Goetz; Vincent E. Herrin, MD, FACP; Robert G. Luke, MD, MACP; Tanveer P. Mir, MD, MACP; Alejandro Moreno, MD, MPH, JD, FACP, FCLM; Amirala S. Pasha; J. Fred Ralston, Jr., MD, FACP; Michael C. Sha, MD, FACP; Upasna (Mini) Swift, MBBS, FACP; Alexandra Smart, MD; and Barbara J. Turner, MD, FACP. This paper was approved by the ACP Board of Regents on July 30, 2011.*

***Members of the 2010–11 Society of General Internal Medicine Ethics Committee: Clarence H. Braddock, III, MD, MPH, FACP (Chair); Eric G. Campbell, MD, PhD; Evelyn C. Chan, MD; Sarah L. Clever, MD, FACP; Matthew DeCamp, MD, PhD; Neil J. Farber, MD, FACP; Thomas H. Gallagher, MD, FACP; Lauris C. Kaldjian, MD, FACP; Eliseo J. Perez-Stable, MD, FACP; Sonja K. Rakowski, MD; Lois Snyder, JD; and Alexia Torke, MD. This paper was approved by the SGIM Council on June 29, 2011*

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Corresponding Author: *Lois Snyder, JD; Center for Ethics and Professionalism, American College of Physicians, 190 North Independence Mall West, Philadelphia, PA 19106, USA (e-mail: lsnyder@acponline.org).*

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