VIEWPOINT

Enhancing Professionalism Through Management

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Over the past several decades, leaders of medicine have bemoaned a widespread decline in professionalism. There has been a growing sense of a loss or corruption of a physician's sense of professional purpose that extends beyond any single country or practice area. The response has been an urge to reaffirm the importance of professionalism and to redouble efforts to imbue future physicians with professionalism.

What Is Professionalism and What Threatens It

Professionals are not merely businessmen and businesswomen. What distinguishes professionals is that they are dedicated to a primary goal—a moral ideal—that should guide their professional behaviors and practices. Physicians are professionals.[1] All physicians know that moral ideal, even if they do not necessarily label it as "professionalism": to promote the well-being of patients, which constitutes advancing their health and health care within the parameters of the patient's life's values and interests.[1,2] At best, making money is a secondary objective that should not compromise a physician's obligations to the well-being of patients.

Pursuing professionalism in medicine is not a simple endeavor. Any individual person's values and interests are often inchoate and conflicting. More importantly, those values and interests often evolve over a lifetime and can significantly change in the face of serious and chronic illness. Thus, physicians need to be able to help patients elucidate their values and interests, help match them with appropriate health interventions, and facilitate changes in their lives.[3]

A physician's responsibility to promote the well-being of patients is made more complex by the recognition that important factors outside of health care (primarily income, education, the environment, and autonomy in the workplace) significantly influence their patients' health and health outcomes. Higher income, higher educational attainment, and a cleaner environment are actually more important in determining patients' well-being than health care services. This fact means that to fulfill their primary responsibilities to their patients, physicians also have obligations to promote social justice. Clearly, this entails ensuring the fair distribution of resources to ensure that everyone has access to adequate health care and that disparities in access to health care services are minimized. But it also means ensuring adequate income and education that are integral in determining a patient's health. In other words, the ideal physician cannot just focus on what occurs in the confines of the hospital, examination room, or even in the much larger health care sector. The obligations of physician professionalism extend far beyond the clinical encounter.

Threats to Professionalism

Although enacting this ideal is complex and requires tremendous skill, it is not really controversial. So why all the angst about professionalism? Many threats have been identified: globalization, the explosion of medical technology, and the profusion of government regulations and rules from professional boards. Whatever litany of causes are mustered, the current concerns about the decline of professionalism are overwhelmingly driven by one thing: money.

Many of the important physician-driven problems affecting the US health care system today relate to money: conflicts of interest of clinical researchers, physician evaluations based largely on the generation of relative value units, upcoding of services provided, the creation of physician-owned specialty hospitals that select and focus on caring for paying, healthy patients, the shift of sites of care not to improve patients' outcomes but solely to enhance reimbursement, the extensive use of medically unnecessary interventions, and providing highly reimbursed medical interventions when lower-cost interventions are just as clinically effective.

The real concern about professionalism is that money is corrupting the practice of medicine—that the pursuit of monetary gain for the physician is distorting judgments about what is best for the well-being of patients. All other threats to professionalism pale in comparison.

Money and Medicine

The threat of money to the ideals of medicine is not new. But what is perplexing is that as the money in medicine has increased—as physicians, hospitals, and other health care institutions have become richer—the threat to professionalism has not decreased but increased. With more resources available, physicians should not need to compromise their judgments about their patients' well-being to live well. However, it appears that more financial resources have only increased the desire for even more, and the commitment of physicians to the moral ideal at the heart of the medical profession may have been corrupted as a result.

In 1950, when 4.6% of the gross domestic product went to health care, the average salary of a primary care physician was 2.75 times the median income, or $8800.[4] Sixty-five years later, roughly 17.4% of the gross domestic product goes to health care, and the median household income is $51 900 with nearly 50% of households having 2 income earners.[5] Today, the average salary of a primary care physician in the United States is 3.40 times the median household income, and some specialists earn 10 and 20 times that level.[6] More importantly, the majority of physicians are in 2-income families—often 2 professional incomes—so the income gap between the average US household and the physician household is even greater. Looked at another way, many, if not most, physicians are probably in the top 1%. These numbers suggest that most physicians should have all the financial security they could—or should—ever want, yet some still have managed to falter in their commitment to professionalism.

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Enhance Professionalism With Management Training

More money in health care or higher physician salaries are not the way to revive physicians' commitment to professionalism. The change needs to start in medical school. Medical school establishes the foundation upon which all subsequent training and practice rests.[3] To ensure that physicians actually demonstrate professionalism—and not just articulate the ideal—the leaders of medicine must cultivate an environment that permits and encourages a focus on patients' well-being.

How should medical education be changed to enhance professionalism? One possible way is to incorporate systematic business and management education in medical school. With money being the primary threat, it might seem paradoxical to call for more business training. But one of the great understandings of the last few decades is the fallacy of the "bad apple" theory of problems in medicine.[4] It is not the few deficient practitioners who account for errors and problems with patient safety and poor quality of care. Rather these outcomes are related to systems problems, and solutions to systems problems require an improved organizational infrastructure—the type emphasized by business education. For physicians to improve their organizations' ability to reduce errors, improve patient safety, recognize and improve quality of care, incorporate new knowledge, ensure equitable care, reduce waste, and facilitate provision of services based on patients' values and interests, physicians need better management skills.

This does not mean physicians should get master of business administration degrees. Medical students do not need finance, marketing, or microeconomics (unless they aspire to running health systems or large practices). But about half of the required courses at most of the leading business schools would enhance the ability of physicians to achieve the goals of professionalism, and include statistics, technology and operations management, strategy, entrepreneurial management, leadership, behavioral economics, and negotiations, as well as speaking and writing.

Why are these courses and this knowledge important? In the next few years, one of the most important challenges facing physician practices will be improving the processes of care, whether in a hospital-associated clinic, an integrated health care system, or multispecialty clinic. Health care delivery is an exceedingly intricate process, requiring better organization and coordination. Patients must be able to efficiently make appointments and receive screening questions and health education information; they must be examined effectively by well-trained clinicians and receive guidance about other needed services and follow-up procedures. This chain of tasks will become even more complex as practices have to integrate remote electronic monitoring, provide information about services at more sites of care, and initiate more active outreach to their patients. This is a classic problem to be addressed by operations management. Future physicians should not leave medical school without understanding data analytics and how to use them to solve basic health care delivery challenges, such as optimizing the use of physical and human resources, operating rooms, nursing personnel, and health aides. In addition, students should learn how to create process flow diagrams and to use them to identify defects in delivering care, such as errors and safety breeches, and how to optimize the processes of delivering care.

Similarly, leadership skills can be learned. Physicians can learn how to form and motivate cohesive teams, how to lead change in their organizations, and how to establish and execute on strategic goals. Most importantly, physicians can learn to create cultures of excellence that aspire to the medical ideal of putting patient well-being before all else. These are taught skills that are essential and will become even more essential as the delivery of care becomes more organized.

Where should this management training fit in the curriculum? Many medical schools are reducing the preclinical curriculum from 24 months to 15 or 12 months. That could leave time for introducing management and business courses. Each of the 8 courses might be delivered as a 1-week, intensive 40 hours of executive training tailored to the health care setting (a regular course at business school is about 32 to 40 hours in length over a semester). Then, in the fourth year, after significant clinical experiences, students could have 4 or 8 weeks—1 or 2 clerkship rotations—that examine their clinical experiences from the management perspective. This approach could provide the opportunity for students to reflect on what they have experienced in clinical rotations and how it comports with their management training and the moral ideals of being a physician that lie at the heart of professionalism.

When possible, it is probably best to have physicians who have training on these topics—whether having a master of business administration degree or not—teach these courses. Unlike consultants or business school faculty, physicians are more likely to intuitively understand and transmit the moral ideal behind professionalism and how implementing these management skills can enhance its realization in practice. However, effectively teaching these topics requires real expertise and qualified, experienced faculty, rather than inexperienced instructors, even if they are physicians.

Conclusions

Learning clinical medicine is necessary for making patient well-being the physician's primary obligation. But it is not sufficient. To promote professionalism and all that it entails (reducing errors; ensuring safe, consistent, high-quality, and convenient care; removing unnecessary services; and improving the efficiency in the delivery of services), physicians must develop better management skills during medical school. Becoming better managers will make physicians better medical professionals.

ARTICLE INFORMATION

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