

# Good enough medicine:

Are we “averaging excellence out”?



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**A**veraging excellence out? A 1996 editorial contemplated potential unanticipated consequences of where American medicine, swept along by gathering social momentum, seemed likely to wind up.<sup>1</sup>

It was the principle described by Senator Daniel Patrick Moynihan as *Defining Deviancy Down*<sup>2</sup> that raised the question. The concern was whether the “...process by which, in accommodating new ideas and new behaviors, we sometimes lose track of norms and standards...”<sup>1</sup> was likely to sacrifice excellence on an altar of the good.

Medicine in the 1990s was in the middle of a fundamental transformation, fixated on increasing efficiency in the delivery of care. Care that had been provided was beginning to be managed. And, it was working. Doctors were seeing more patients in less time. Fewer expensive tests were being done. Analogies were drawn to what happened to manufacturing earlier in the century with the near universal adoption of the assembly line approach to producing

goods. The metrics were looking good, but what about quality? How good was the medical product?

One possible answer might have been good enough. Would that mean that health care was destined to be homogenized into something that just met the lowest acceptable standard with excellence (assuming excellence somehow continued to exist) only available to the elite and wealthy?

The essence of excellence in medicine is more than doing what we know to do well. It must include a commitment to discovering what will make the better possible, and a dedication to perpetuating the best of our profession. Those things take time.

### Imbuing the rising generations

Excellence has been integral to the medical profession in this country at least since it found a solid footing in hard science. We sought to be in the avant-garde of discovery, generating the constantly evolving substance of available care. The broader collective not only shared that goal but were anxious to support it. There was a commitment to imbuing the rising generations of health professionals with the very best information and technical expertise. Many responded by embracing the challenge and the responsibility of careers in discovery and teaching.

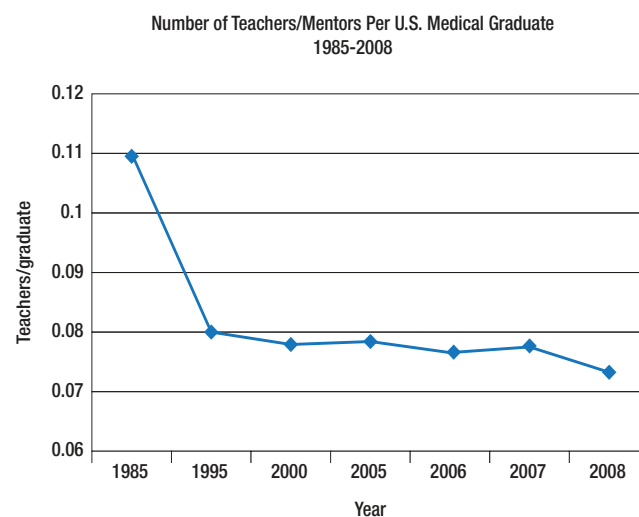
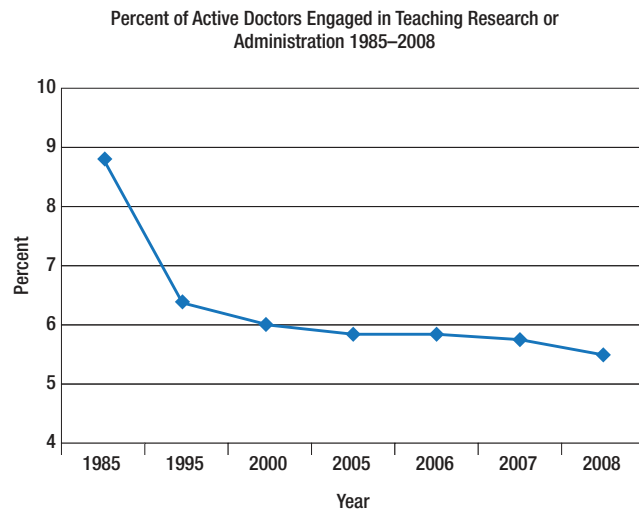
There was time to ruminate on what we saw, to ponder questions big and small, to care about what we did and to whom we did it, and to relish those precious opportunities.

Discovery, teaching, and time. It takes all three to nurture excellence. Neither a doctor's time per patient seen, nor the number and cost of ordered tests, measures excellence; they may not even measure real efficiency.

### Operational efficiency

Operational efficiency<sup>3</sup> as used in the business world is the ratio of output to input, but output isn't just numbers of product or even revenue. Output includes things like customer loyalty, innovation, and quality. And operational excellence<sup>3</sup> relates to continual improvement of the whole enterprise, not just efficiency. The fundamental transformation of American medicine that was happening in the 1990s threatened to define efficiency in the narrow context of the duration and nature of doctor-patient encounters. It would not be surprising if the efficiency numbers improved while excellence (that is, the outputs of discovery, teaching, and time) languished.

Some trends over the past two decades raise that possibility. Since 1985, a progressively smaller fraction of active medical doctors has been involved in research, teaching,



or administration.<sup>4</sup> The person-power necessary for sustaining a culture of research and education is shrinking.

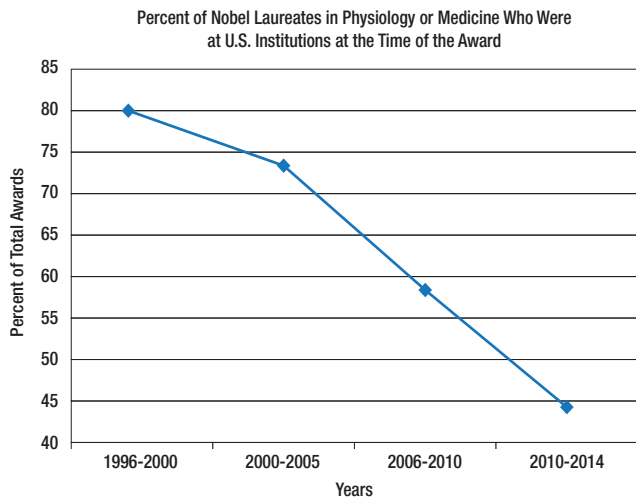
Over that same period, the numbers of teachers/mentors per practicing graduate from American medical schools has decreased.<sup>4</sup> Teaching requires teachers.

And, at the highest level, American predominance in medical discovery may be slipping.<sup>5</sup>

Discovery and teaching happen mostly in academic health centers. At their best, that is also where doctors have time to ponder what they are doing, time to think of ways they might be able to do it better, and time and resources to test novel interventions that have a chance to improve processes and outcomes.

If health care is a right, burdening us with a moral obligation to make it available to everybody, can we afford

## Good enough medicine



the luxury of investing precious resources in an inherently unpredictable and inefficient search for new truths and the elaborate education of another generation of professionals? Dare we insulate a group of privileged doctors from waiting rooms teeming with people needing and deserving their care in order to give these privileged few time to ponder?

The answer is: do we consider good enough medicine good enough, or do we choose to sustain our commitment to excellence. In the modern era, medicine has never been a static discipline, and it is advancing faster, and with longer strides, than ever before. Good enough medicine in 1990 would not be good enough today, and what is good enough today won't be good enough tomorrow. If we sacrifice investments in discovery, teaching, and time for short-term gains in "efficient" delivery of good enough care, we will destine our medicine to obsolescence. And it won't take long to get there.

Excellence is the essential infrastructure of a sustainable good and infrastructure is a fragile beast that does not tolerate neglect for very long. For an enterprise that nurtures its infrastructure, prosperity endures.

### Championing academic health centers

What will happen to America's investment in excellence, medicine's essential infrastructure, and, arguably, its most important output in the long run? If investment in research is any indication, we haven't been doing so well recently. During the decade prior to 2004, biomedical research funding from all sources in America increased at an annual rate of 6.3 percent and the United States funded more than half of all biomedical research conducted

throughout the world. Since 2004, the growth rate has decreased to 0.8 percent, and the U.S.' share of the world's research investment has decreased to 44 percent.<sup>6</sup>

Championing elite institutions is not currently a popular position, but American medicine is a special case. The U.S. has built a formidable medical enterprise that is founded on excellence and it depends on that excellence for its continuing viability. Excellence is the business of academic health centers and nurturing those institutions is not just gilding the ivory towers and coddling those sequestered there. If those academic health centers languish, we risk averaging excellence out of the equation, and sealing an ignominious fate for American medicine and for America.

### References

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