Restoring the joy in caring

Richard L. Byyny, MD, FACP

What happened to the joy of caring and the joy in medicine and "serving the suffering?"

Becoming and being a physician is a long and complex educational, clinical, and developmental process. All physicians begin with their own individual and distinct personal identity and aspirations. They complete their pre-medical education requirements, and through a highly competitive process are accepted into a medical school and then into a residency program.

Physicians learn the knowledge and skills necessary for the profession of medicine, and develop a new medical professional identity in order to think, act, and feel like physicians, and demonstrate capability and a commitment to medical professional ethics, the medical code of conduct, and a moral responsibility to enter the community of practice of medicine. Physicians enter their community of practice with knowledge, and a skill base, a foundation in biomedical science, the professional identity of a physician, extensive tacit and explicit knowledge, and an obligation to life-long learning. They continuously learn from patients and colleagues, role models, mentoring, experiential learning, and social and professional interactions and personal reflection.

Achieving competence established by the community is essential, and attained via ongoing learning and experience with collegiality as a member of the community of practice. A physician's specialty or subspecialty is a community of practice with major influence on the professional identity of its members.

A community of practice establishes and enforces compliance with medical professionalism standards, including competence, confidentiality, altruism, trustworthiness, morality, honesty, integrity, caring, compassion, responsibility, and respect. These characteristics are fundamental to being an outstanding physician and working in a profession that is defined by service rather than profit.

The organizational structure of medicine is one that is often without boundaries, but built within hierarchies and power structures that can make it difficult to maintain the important aspects of who we are and how we lead and comply with the moral standards in the businessification of medicine and health care. The ongoing support of medical communities of practice is dependent upon a trusting relationship between the community members and its leadership.

The organization of health care delivery and physician practice has been based on a devotion to a public good. What has happened in American medicine was anticipated by Paul Starr in his book "The Social Transformation of Medicine,"[1] and by Dr. Arnold Relman (AΩA, Columbia University Vagelos College of Physicians and Surgeons, 1945) in 1980 in his *New England Journal of Medicine* article, "The New Medical-Industrial Complex."[2] Relman described a "recent rise of a huge new industry that supplies health-care services for profit. Proprietary hospitals and nursing homes, diagnostic laboratories, homecare and emergency room services, hemodialysis, and a wide variety of other services,"[2] produce huge revenues, but also create the problems of overuse and fragmentation of services,

overemphasis on technology, and "cream-skimming."[2] Relman suggested that these organizations may also exercise undue influence on national health policy.

Relman described a large and growing network of private corporations engaged in the business of supplying health care services to patients for a profit—services heretofore provided by nonprofit institutions or individual practitioners.[2] These proprietary hospitals, of which half are owned by organizations specializing in hospital ownership and management or owned by groups of private investors or small companies, also provide proprietary nursing home care, home health care, laboratory services, hemodialysis, mobile CT/MRI scanning, cardiopulmonary testing, industrial health screening, rehabilitation counseling, dental care, weight loss clinics, substance-abuse programs, prepaid HMO programs, physician house call services, and hospital emergency room care. Relman asked, "Can we really leave health care to the market-place?"[2]

Relman also noted that private corporations in the health care business use treatments and services that were developed at public expense and were heavily subsidized by public funds. These entities were, and are, largely unregulated. Although physicians should have no conflict of interest in making or advising about clinical decisions, these industries often refer to physicians as "our business partners." Relman advised, "we must guard against the acquisition of unwarranted influence"[2] and recognize that a private, for-profit health-care industry could be a powerful political force in the country and could exert considerable influence on national health policy. He warned that our priorities should be the needs of patients and society first and foremost, and that we should not allow the medical-industrial complex to distort our health-care system to its own entrepreneurial ends, which is the corporatization of American health care.[2]

The corporatization of American health care

In 2020, for the first time ever,[3] less than half of U.S. physicians worked in physician-owned settings. More than 300,000 U.S. practicing physicians were employed by hospitals, and 122,000 were employed by corporations, e.g., health insurers, pharmacy chains, or private equity-backed companies. Physicians are expected to put patients first, and they should not be expected to be deferential to authority nor compliant with managerial and organizational controls that disregard patients' needs and health plan goals.

A major consequence of the lack of a universal health care system is increased dissatisfaction with the current state of affairs in the medical profession, and distressing levels of physician burnout. A 2021-2022 survey published in the Mayo Clinic Proceedings found that 63 percent of physicians reported at least one symptom of burnout, and only 30 percent were satisfied with their work-life balance, a marked change from prior years.[4] Using the Maslach Burnout Inventory the survey measured burnout on three dimensions: emotional exhaustion, depersonalization from work, and sense of personal accomplishment.

In 2019, the National Academy of Medicine published a report on physician burnout showing that many doctors' dissatisfaction with their work could be caused by an incongruence between what they cared about as medical professionals and what they were incentivized to do by the health care system.[5]

The COVID-19 pandemic may have further contributed to an increase in physician burnout. Physicians noted that the politicization of science, labor shortages, and the vilification of health care workers, being threatened or harassed by patients and other factors increased their dissatisfaction and burnout. The pandemic may also be adversely affecting nurses, as higher than normal attrition is being seen throughout the medical profession.

Today, most managers and decision-makers in health care systems are not physicians and have never cared for a patient or a community. The metrics of success most used by hospital and medical practice non-physicians are time spent per patient encounter and revenue produced per visit, procedure, or clinical encounter. All are common profit-driven company measurements of success. However, most do not value patient outcomes, clinical and treatment success, clinical improvement, or successful doctor-patient relationships.

Many years ago, I had the opportunity to meet with a nun who was the director of a highly successful hospital in a poor neighborhood in a large city. The hospital had all care-provider positions and patient appointments filled with waiting lists, excellent clinical outcomes, financial stability, and almost no political problems. I asked her about her education and degrees that prepared her to serve as the head of the hospital. She responded that she was a nurse by training and had worked as a caregiver and administrator in the hospital for many years. She saw her responsibility as being very straightforward. She simply asked one question before making any decision: What is best for the patient?

We have lost the importance and simplicity of that question. Instead, our health care system is driven by the bottom line of dollars and cents.

The United States is the only developed country in the world that has not determined that health care is a fundamental human right with universal health care for all citizens. Health care is the largest industry in the U.S., spending $4.3 trillion in 2021, which is 18.8 percent of our gross domestic product, or twice the amount on average for 13 other developed countries.[6] Life expectancy in the U.S. is 76.1 years, which is lower than all 13 other developed countries.[7] In addition, the U.S. has fewer doctors and nurses per 100,000 population than each of those 13 other countries.[8] The U.S. population is sicker with a higher prevalence of chronic conditions and insufficient access to care than in those countries.[8]

Each of the 13 countries provide universal health care coverage and institute minimal or no cost barriers so individuals can get the care they need when they need it. Most invest in high value primary care systems that are available in all communities; they reduce non-clinical burdens, administrative barriers, and medical record keeping for practitioners.

Dr. Barbara McAneny (AΩA, University of Iowa Roy J. and Lucille A. Carver College of Medicine, 1977), a private practice physician, explains, "We work in a system that too often benefits hospitals, health plans, pharma, and device companies, at the expense of physicians and patients… Physicians are frustrated when their concerns go unanswered…Physicians who actually treat patients should design the systems of health care."[9]

Many administrative tasks continue to proliferate, including insurance prior authorizations; electronic medical record reporting; and maintaining a 20-minute patient visit schedule. The American College of Physicians has developed policy recommendations and programs to address these and other administrative tasks and provide appropriate time for physicians to care for patients.

The U.S. non-system of health care makes it extremely difficult for physicians and other medical professionals who are governed by an ethical code of conduct and are committed to competence, integrity, morality, altruism, and support of the public good. This is the medical profession's social contract, a covenant of trust with patients and society that determines medicine's values and responsibilities in the care of the patient. We must recognize that physician stress, burnout, and poor personal and professional outcomes come from working in a dysfunctional health care system. The current system professes top-down, sheep-like messages that come from bureaucratic, non-physician or health professional managers with no training or experience in patient care.

Medical professional values

There is great concern about how medicine's medical professionalism and patient care are adversely affected by market incentives and bureaucratic structures that threaten physician well-being and the ability to fulfill core medical professional values. There must be clear professional expectations that are explicit and respect the physician's commitment to a great public good. These expectations must adhere to high ethical and moral standards—do right, avoid wrong, and do no harm; place the interests and care of the patient above all else; avoid business, financial, and organizational conflicts of interest; honor the social contract with patients and communities; understand the non-biologic determinants of poor health, and the economic, psychological, social, and cultural factors that contribute to health and illness—the social determinants of health; care for all patients regardless of their ability to pay, and advocate for the medically underserved; and advance the field of medicine. This can be accomplished through physicians' communities of practice.

The importance of communities of practice

Physicians, nurses, health professionals, and staff are key to leading health care delivery in medical and other health-related organizations. Physicians partnering and working collaboratively with nurses, patients, and health care providers, in conjunction with local communities are best prepared to evaluate, design, and implement systems for patient care and community health.

Unfortunately, the U.S. non-system of health care lacks planning and a commitment to high quality, affordable, excellent health care for all. The lack of a well-organized and well-run health care system has resulted in lucrative consolidated systems of hospitals; highly profitable insurance companies and pharmacy benefit managers merging and acquiring each other; pharmaceutical companies raking in billions; and multitudes of well-paid consultants, wealthy hospital and plan directors, and prosperous venture capital investors. No wonder physicians are experiencing emotional conflicts and burnout from working and practicing medicine in a dysfunctional business-oriented organization.

One approach comes from the well-established professional communities of practice. Physicians, as members of our professional communities of practice, must lead and develop the clinical practice and organization to responsibly meet the needs of patients, organizations, and communities. In each community of practice within an organization there exists a social organization that

can self-organize and function on behalf of physicians, patients, and the community. Within these communities of practice there is an opportunity for partners to meet professionally and socially to organize the practice to best meet the need of patients, physicians, nurses, and others. They can then serve the patients, organization, and each other in proposing, planning, and implementing strategies, policies, and procedures to improve care and outcomes.

I have been a member of several communities of practice, and in each we learned to work collegially with our nurses, staff, and colleagues. These communities of practice have each been both a professional and social medical organization, wherein we worked together in medical facilities, but also had professional collegiality and social interactions. We would present cases to each other to get help and education, improve patient care, and sometimes just to commiserate. We also organized periodic social events that included family, staff, and others.

Communities of practice were common when physicians owned and managed the care of patients. This is still possible. The leadership representing the physicians, nurses, and staff could prioritize time for care, and develop patient schedules to keep open one appointment slot for all providers each morning and afternoon; provide time for a weekly morning clinical conference before patients begin to arrive; provide time for physicians and staff to be together for lunches, social events, and educational meetings and activities, and other priorities to serve patients, communities, and each other. These simple actions further develop communities of practice that can then influence the future of the medical profession and the care of the patients. They also can relieve suffering and increase physicians' sense of accomplishment in caring for the patient and family.

A priority in supporting physicians, nurses, other health professionals, and those who support the care of patients is to utilize their expertise, compassion, and values to lead and guide communities of practices within medical and health care organizations. While the concept of communities of practice is not new, it has diminished over time, and is not always well utilized in health care settings. Communities of practice can complement existing structures through knowledge sharing, professional development, strategic planning, problem solving, sharing of best practices, and attracting and retaining the best talent in a healthy, productive, invigorating environment. Communities of practice are an important and essential component within large and small organizations, and private practice clinics alike.

Now is the time to regain the joy in caring, and take the first step to healing the medical profession and our AΩA members, which can begin to be achieved with physician leadership in establishment and recognition of physician communities of practice to better serve the suffering. Let the healing begin.

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